

Commissioning Strategy Plan
NHS Barking and Dagenham
2008/09 – 2012/13

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Appendix 1: NHS London Planning Assumptions

Appendix 2: Primary and Community Services Strategy

Organisation details

Organisation name

NHS Barking and Dagenham

Key contact at PCT (name, contact details)

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Commissioning Strategy Plan date

Version control – March 2009.

1. Chief Executive's introduction

Commentary

Welcome to NHS Barking and Dagenham's revised Commissioning Strategy Plan (CSP) 2008/09 to 2012/13. The CSP describes our vision for health in Barking and Dagenham and sets out five strategic goals to achieve this vision. The vision follows the "ACQuiRES" philosophy, which brings together the goals, principles and values of the organisation. The vision is that the population of Barking and Dagenham will have:

- Easily understood and accessible services that address their health needs (Access);
- A wide range of integrated services in the community to reduce the necessity of hospital attendances (Community);
- High quality services to improve the health and well-being of all our community (Quality);
- Health improvement services designed to reduce health inequalities in the health of our population now and in the future, i.e. both adults and children (Inequalities);
- Confidence that NHS resources are targeted to achieve best value (Resources);
- Services which have been designed using their experience and the input of local clinicians (Experience);
- Services which have proper levels of qualified and skilled staff, in a welcoming and appropriate environment (Staff).

In many ways Barking and Dagenham is unlike most other London Boroughs. Its industrial past and socio-economic make-up means it is more akin to many northern areas on the outskirts of industrial cities. This presents a range of challenges in terms of improving the health of local people. NHS Barking and Dagenham has recently undertaken a Joint Strategic Needs Assessment (JSNA) with the London Borough of Barking and Dagenham. This needs assessment informs both the strategic direction of service delivery, which is reflected in this plan, and also identifies local inequalities in need between different groups of people and different localities in the Borough. The organisation will work with the Borough to deliver service improvements and delivery for local people.

There are eight initiative areas described in the plan, which reflect not only the specific health and inequalities issues outlined in the JSNA, but also how the outcomes of the recent consultation "Healthcare for London" which sets out models of care for the whole of London, will be delivered locally, in particular through the primary and community services strategy and through the "Stroke", "Maternity" and "End of Life Care" initiatives. The "Next Stage" review supports the delivery of improved quality and the development of preventative services. Our initiatives are also closely linked to the North East London Commissioning Collaborative and the work being taken forward across the sector.

The national context for this strategy is set out in Government policy documents, including "Our Health, Our Care, Our Say: a new direction for community services", "Choosing Health: making healthier choices easier", the National Service Frameworks (NSFs) and, National Institute for Clinical Excellence (NICE) guidance.

NHS Barking and Dagenham will continue to work towards delivering the national existing and new targets, work with the Borough to deliver the Local Area Authority (LAA) priorities and indicators across health inequalities, the Vital Signs indicators (national, London and local), as well as the specific health outcome areas identified through the World Class Commissioning development process.

In order to continue to implement our Commissioning Strategy Plan, we will work in partnership with the Borough, with other local health organisations and voluntary and independent sector groups, as well as continuing to involve patients and the public in helping us to plan and deliver

models of care across all health sectors and settings.

Stephen Langford

Chief Executive,

NHS Barking and Dagenham

March 2009

2. Vision

2.1. Organisation vision

Commentary

In 2007, NHS Barking and Dagenham's Trust Board agreed a vision which can be summarised as:

“NHS Barking and Dagenham will improve the health status of the population and improve local services.”

This translates into a series of strategic objectives where agreed by the Board in 2008 and which still stand. These objectives map across into the initiatives, which are central to this strategy plan.

In summary, these objectives are to:

- **Improve the health and life chances of the population of Barking and Dagenham through a programme of health promotion;**
- **Protect the health of the people of Barking and Dagenham (statutory public health duties);**
- **Strengthen the primary and community infrastructure and service so that people have access to and choice over high quality, responsive and proactive local services wherever possible. This would cover those with long term conditions, urgent care and longer term health service support;**
- **Ensure that people needing access to secondary care consultations and diagnostics, in-patient or day case care have access to high quality services based locally wherever possible.**

NHS Barking and Dagenham's Board has recently identified through the World Class Commissioning (WCC) process a number of key health outcomes that they will be monitoring closely. These are broadly consistent with the revised set of Local Area Agreement targets the organisation has recently agreed with the Local Authority and the Government Office for London.



These have been chosen to reflect the areas that B&D see as being significant for the population and which are appropriate for a five year time span. NHS Barking and Dagenham has not chosen targets that it expects will be met within the next year.

3. Context

3.1. Population demographics

Commentary

Barking and Dagenham (B&D) is located at the heart of the Thames Gateway, approximately 11 miles from central London. It is a small outer London borough with housing, 29% green space and a significant amount of brownfield land from previous industrial use.

<p>Issues:</p> <p>Industrial past</p> <p>Lack Investment in health</p> <p>Increasing Diversity</p> <p>Health challenges – mortality, morbidity, lifestyle, sexual health and mental health</p> 		
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It has a population of 170,000 living in just over 69,000 households. The borough is one of the fastest growing in the country, with the population predicted to increase to 208,000 by 2020/21. The borough has a higher proportion of older people and children than the London average. Almost one quarter of the population is aged 0 -15 years, compared to the London average of 19%.




<p>Key Facts: Population</p> <ul style="list-style-type: none">○ Approx 25% of population aged 0-15 years○ 12.4% of population 65 years or over○ B&D has the lowest percentage of residents aged 16-74 with qualifications in London○ Population growth predicted to increase by approx 25% over next 20 years○ Increase in proportion of 45-64 age group over next 5 years○ Increase in diversity over next 5 years – growing more quickly than any other part of the country. <p><i>Sources: GLA Population Estimates & ONS Experimental Ethnic Estimates (2006 release)</i></p>
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Population Segmentation

In terms of understanding the population in the borough of Barking and Dagenham, recent analysis has been commissioned jointly by the PCT and the Local Authority to give a detailed 'customer insight' into the needs of the community. This is work that takes the Joint Strategic Needs Assessment down below ward level and is therefore very detailed. It covers not only health issues but also how people currently access health and social care, and how their health behaviours might be influenced. This is intended to provide the PCT with a richer picture of population need across each of the PCT priorities at small area level. From the PCT's perspective, it gives very detailed information on the main customer groups and their health interactions. This work is currently ongoing and is expected to deliver its final segmentation in Q1 2009.


This work is the next stage in the Joint Strategic Needs Assessment undertaken in 2008/09, the main purpose of which was to identify current and future health and well being needs in light of existing services, and inform future health service planning taking into account evidence of effectiveness.

Initial, early segmentation analysis of the resident population¹ identifies eight principal groups, who are distinct in terms of their expectations of and interactions with health and social care services.

Segment Percentage of Households	Characteristics	Health and Social Care Interactions
 <p>7.7%</p>	<ul style="list-style-type: none"> • Young, cohabiting couples • Few, very young children • Affluent • Well-educated • Professionals • Relatively large houses • Owned or privately rented • Internet savvy 	<ul style="list-style-type: none"> - Limited contact with council, but most likely method is by letter - Child-related interactions with health service - Issues relating to reproduction - Labour & delivery complications and perinatal period conditions - Newborn hearing checks, 6-8 week checks, Preschool exams - Unlikely to stay on at school, but perform well in GCSE's (5+ A-C Grades, inc English & maths)
 <p>9.8%</p>	<ul style="list-style-type: none"> • Young families and singles • Ethnically diverse • English not home language • Well-educated • Professional, service sector jobs • High incomes • Privately renting older flats and houses • High fear of crime 	<ul style="list-style-type: none"> - Active library borrowers - High school attendance - Children's centre users - Pupils likely to stay on at school - Leisure centre members - Theft from vehicle an issue - Long term conditions – dementia, diabetes, mental health - Contraception, terminations and STIs - Outpatient: Anaemia, head injuries, respiratory symptoms
	<ul style="list-style-type: none"> • Middle-aged families with children • Middle incomes • Low unemployment • Little ethnic diversity • Large, privately owned semi-detached houses 	<ul style="list-style-type: none"> - Pay council tax by direct debit - Leisure centre members - Green waste bins - Good GCSE grades - Long term conditions: Blood Pressure, Cancer, Diabetes, Epilepsy, Learning

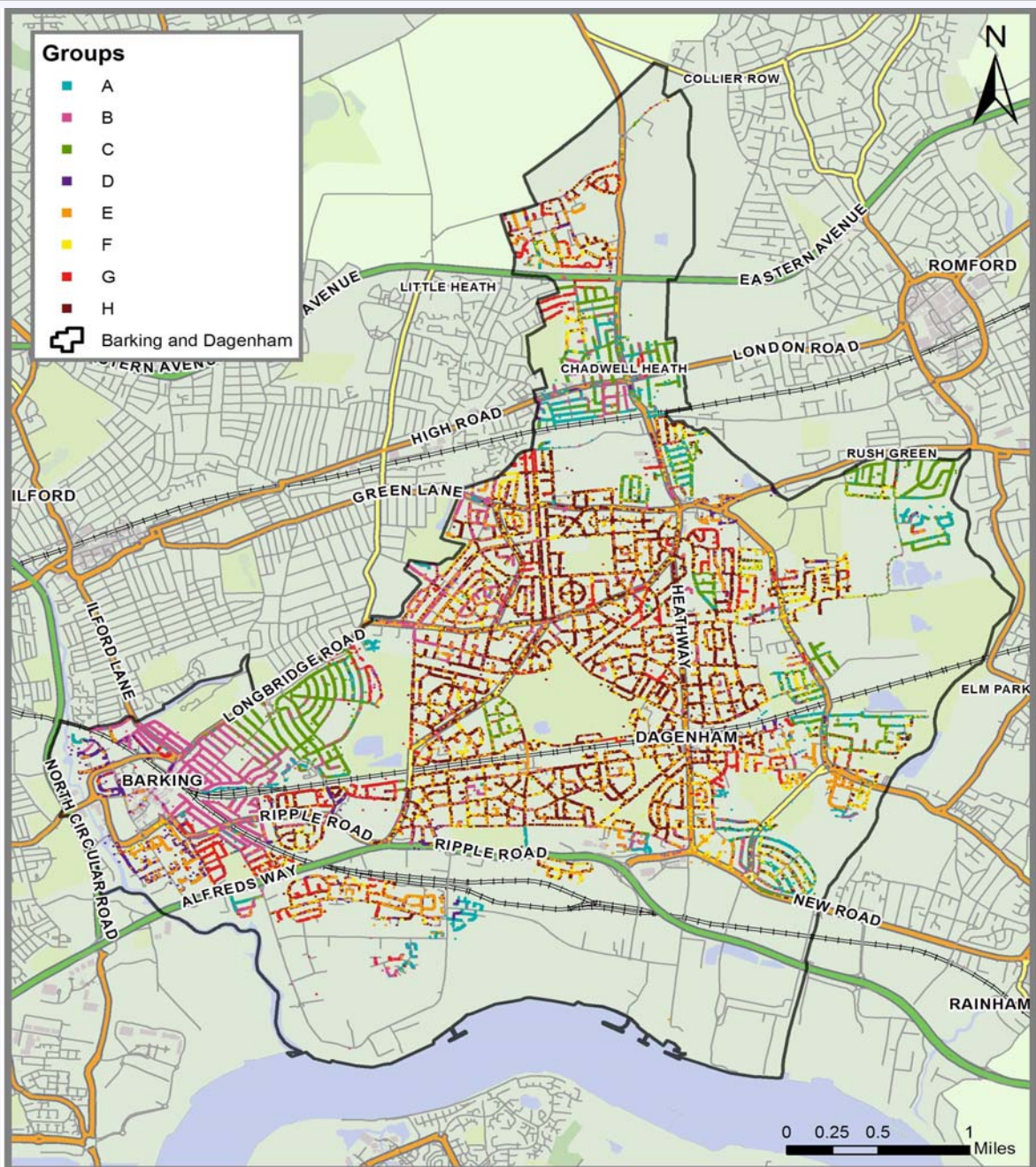
¹ Source: Experian Limited in 2008

 <p>12.7%</p>	<ul style="list-style-type: none"> • Dual car households • Savers rather than borrowers • Strong sense of community • Low fear of crime 	<p>Disabilities, Smoking, Thyroid.</p> <ul style="list-style-type: none"> - Key outpatient treatments for: Cancers, eye disorders, cerebrovascular diseases, renal failure, arthropathies, examination and investigation, specific care
<p>D</p>  <p>8.4%</p>	<ul style="list-style-type: none"> • Young adults, many single parents • Ethnically diverse • Small, rented flats • High unemployment • Low incomes – income support and job seekers allowance • Heavy users of public transport • Fear of crime • Anti-social behaviour issues in neighbourhood 	<ul style="list-style-type: none"> - Council tax arrears - Free school meals - Housing benefit - Contact council via fax, letter, telephone - Domestic violence an issue - Active library borrowers - Freedom passes, but not blue badge holders - Some mental health conditions and learning disabilities - Teenage pregnancy - Contraception, terminations and Chlamydia
<p>E</p>  <p>10.2%</p>	<ul style="list-style-type: none"> • Large, single parent families • Working class • Transient • Poorly educated • Relatively high unemployment • Low income, receiving benefits • Heavy smokers • Teenage pregnancies • Social housing • Financially vulnerable 	<ul style="list-style-type: none"> - Housing Benefit Claimants, both private renters and council tenants. - Live in council housing that has been made decent. - Disabled freedom passes. - Likely to contact the council via Letter, referral form or telephone - Council tax bills are more likely to be in debit than credit. - Lower performers at GCSE level. - Cancers: Malignant neoplasms
<p>F</p>  <p>15.3%</p>	<ul style="list-style-type: none"> • Largely older, working age • Some children • Long term residents • Working class • Limited qualifications among adults • Low incomes • Low value terraced and semi-detached • Exercised right to buy • Relatively heavy TV viewers 	<ul style="list-style-type: none"> - Active library borrowers - Disabled freedom pass - Blue Badge holders - Most likely group to contact the council - Green waste bins - Heart conditions - Many long term conditions including: Atrial Fibrillation, CHD, COPD, Dementia, Depression, Heart Failure, Palliative Care, Stroke and Thyroid
<p>G</p> 	<ul style="list-style-type: none"> • Elderly, often living alone • State pension and pension credit • Poor health • Poor diet • Emergency hospital admissions • Purpose built flats and communal establishments 	<ul style="list-style-type: none"> - Sheltered housing - Housing benefit - Unlikely to be in council tax arrears - Blue Badge holders - Homecare - In receipt of equipment from council - Long term conditions - Many outpatient conditions: symptoms

<p>6.5%</p>	<ul style="list-style-type: none"> • Public renting • Sense of community 	<p>or diseases of urinary system, renal failure, influenza and pneumonia, chronic lower respiratory diseases, in situ and benign neoplasms</p>
<p>H</p>  <p>29.3%</p>	<ul style="list-style-type: none"> • Married couples • Children • Stable, long-term residents • Limited educational attainment • Reasonable employment prospects • Ex-council housing • Mainly manual skills • Mix of social grade (although not extremes) 	<ul style="list-style-type: none"> - Not active library borrowers - Unlikely to use children's centres - Unlikely to be in council tax arrears - Unlikely to be claiming household benefit - Long term conditions CKD and COPD - Outpatient treatment for malignant neoplasms of respiratory & intrathoracic organs, chronic lower respiratory diseases, renal failure

What is as important for the PCT is that this information can then be plotted on a borough map so a graphical representation of the population at super output area level can be displayed, with associated health interactions. For planning purposes, this also helps to influence where specific services should be located.

Please see map overleaf which shows the borough map.



This segmentation is revisited in Section 4 (Strategy) as it helps also to underline the priority initiatives that have been chosen based on the needs of the population.

In transition

Barking and Dagenham is in transition. It is clear that investment is necessary to address the legacy of industrial decline and to respond to the opportunities presented by the changing socio-economic, ethnic and age profile of the borough. The many regeneration initiatives underway or planned in the next 10 years focus on both health and the wider wellbeing agenda by creating great opportunities for local people, businesses and services. These include the Local Enterprise Growth Initiative, which has secured £15.5 million to increase entrepreneurial activity, support economic growth, reduce the failure rate of locally-owned businesses, as well as up-skilling local people to take advantage of the future job opportunities.

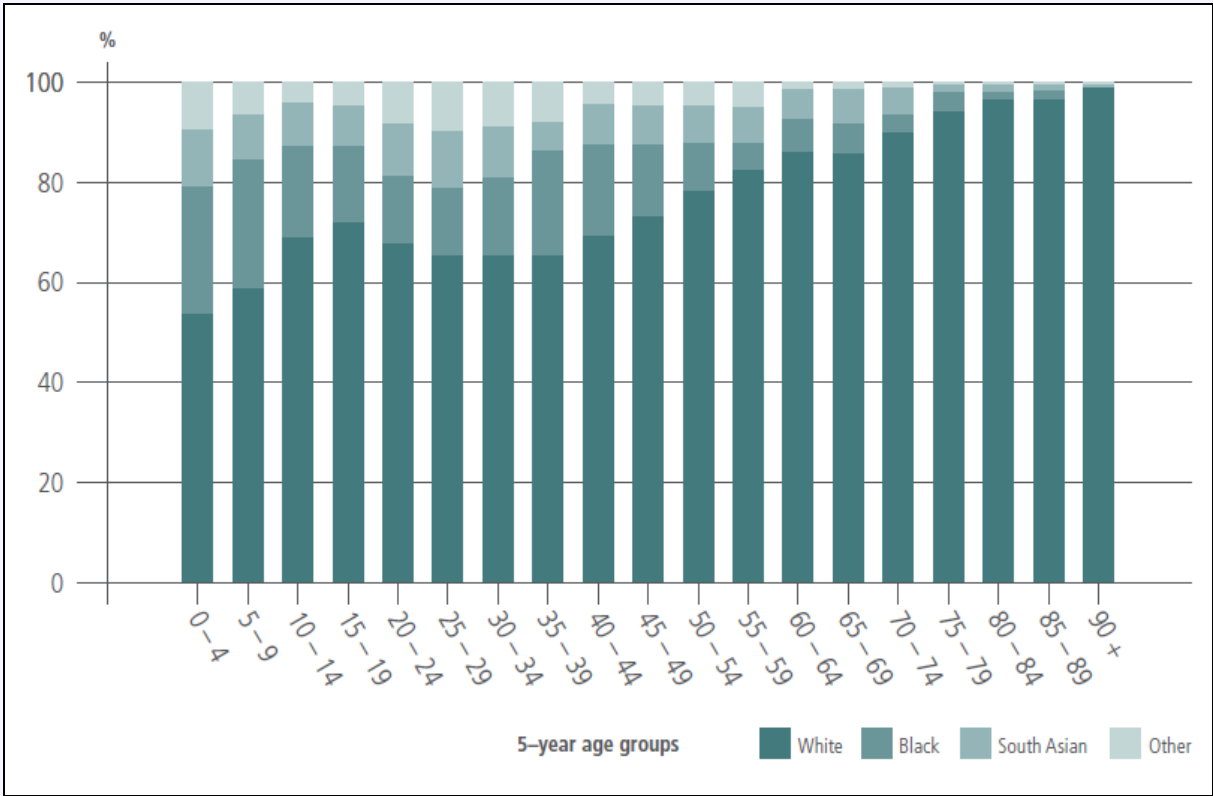
The borough is working towards improving the standard of all council homes, as well as increasing the diversity of the local housing stock through varying tenures, size and increasing the number of affordable homes. Over the next 20 years Barking Riverside will be developed with 10,800 homes planned. The development will include education, community, health, play and leisure facilities alongside new transport infrastructure. Transport infrastructure of the borough will be strengthened by the planned extension of the Docklands Light Railway to Dagenham and Barking Riverside.

Expected Population Growth

	Year 0 (Baseline)	Year 1	Year 2	Year 3	Year 4	Year 5
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Population segment						
Population ('000)	170,445	172,903	175,360	177,818	180,275	182,733
Growth (%)		1.44	2.88	4.33	5.77	7.21
Compound growth rate 2007/08 – 2011/12 (%) = 1.44+2.88+4.33+5.77+7.21=21.63					21.63/5= 4.33%	

Diversity

A current picture of ethnicity of residents (by 5 year age groups) is shown in the graph below.



The population is projected to increase by about one quarter over the next 20 years, and to become relatively younger, less deprived and more diverse. The diversity of the borough's population is growing more quickly than any other part of the country. Black and minority ethnic (BME) residents make up one quarter of the population, an increase of 15% since 2001.

Figure 1 shows the ethnicity of Barking and Dagenham residents in 2008 (Source: GLA)

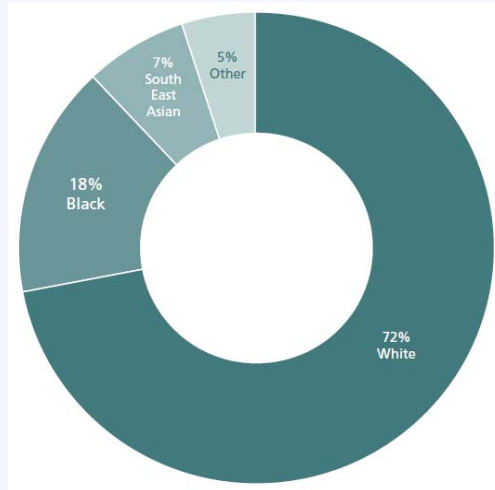


Figure 1

Twenty per cent of the population consider themselves disabled, and an estimated 6% of the population fall into the Lesbian, Gay, Bisexual or Trans-sexual group.

Twelve percent of school pupils speak English as a second language. Many families are moving to Barking from other parts of London because of affordability. There are also many children and families who are new to the UK, particularly from Eastern Europe settling in the area. This pace of change has been a source of local tension at times.

Given the nature of our population, and the inequalities issues they face, we have undertaken impact assessments on many of our policies and processes, which cover all six equality strands; the findings are subject to community consultation. The organisation has also developed a Single Equality Scheme which includes community/stakeholder input.

3.2. Population Health Needs

Commentary

Barking and Dagenham is an area with poor overall health and health outcomes. This is born out by the high mortality rates for cancers, COPD and cardiovascular disease, the high numbers of people with long term conditions, high levels of smoking and obesity and low levels of exercise. This is consistent with a socio-economically deprived borough, and reflects the significant inequalities agenda which we face.

Key Facts: Health Issues

1. **Smoking** – highest estimated smoking levels in London
2. **Food, weight and exercise** – lowest estimated levels of fruit and vegetable intake and highest level of obesity in London, both in children and adults: for reception aged children obesity prevalence is the 6th worst in the country
3. **Alcohol and other drugs of abuse** – over 1,000 problematic adult drug users, many not receiving treatment
4. **Sexual behaviour** – high teenage conceptions, high abortion rates
5. **Life expectancy** is poor for London, particularly for women, and progress is slow
6. **Death from strokes** – trend has shown a decrease, yet rates in borough higher than both London and England average

Source: Joint Strategic Needs Assessment 2008

These key facts translate into the following, born out by the interrogation of health episode data:

The three most important diseases for men and women are:

- Coronary heart disease
- Chronic obstructive pulmonary disease
- Pneumonia

Some diseases, though not comparatively high locally, are increasing:

- Infectious diseases
- Chronic liver disease
- Long term illness and disability – high levels of limiting long standing illness (20% above national average) and highest in London households with someone with such an illness (39%);
- Mental health among working age people – increasing neurotic disorders, increasing personality disorders and increasing probable psychotic disorders

What emerges from these analyses of our demographic and epidemiological data is that the key health priorities for Barking and Dagenham are:

Issue	As shown by	Commentary
Reducing mortality and morbidity from cancers, cardiovascular diseases and lung disease	<ul style="list-style-type: none"> • Lower life expectancy for men and women than the England and London average; • Higher mortality rates than England and London from circulatory diseases, respiratory disease and all cancers; • Higher rates of self- reported 	<p>The organisation also has high levels of predisposing risk factors to these conditions - smoking, poor diet, low levels of exercise and high levels of obesity.</p> <p>The organisation intends to focus both on delivering better</p>

	<p>limiting long term illness than the England and London average;</p> <ul style="list-style-type: none"> • High numbers of admissions for COPD, Heart Failure, Diabetes and Heart Disease; • Poorer outcomes for Stroke; • Poorer cancer survival rates. 	<p>outcomes for those with established disease (secondary and tertiary prevention), and preventing those at highest risk developing disease, while increasing an emphasis on primary prevention.</p>
Sexual health – teenage pregnancy and GUM access Maternity	<ul style="list-style-type: none"> • TPU and PHO statistics although recent figures show some improvement; • GUM activity data; • High levels of low-weight babies. 	<p>Given the high teenage pregnancy rate, it is likely that Chlamydia too will be high.</p>
Mental Health	<ul style="list-style-type: none"> • A higher Mental Illness Needs Index than the England average (a measure of need for inpatient mental health beds); • The PCT has a high level of self harm. • Increasing rates of hospital admissions for alcohol related harm. 	<p>However the organisation has a lower than expected death from suicide.</p> <p>We need to ensure most vulnerable populations have improved access to mental health services and shift the emphasis to preventive services.</p>
Infectious diseases	<ul style="list-style-type: none"> • A higher Tuberculosis notification rate than England (although still currently lower than the London average); • A very high HIV prevalence rate compared to the England average; • Variable uptake of childhood immunisations; • Low uptake in adults of flu immunisations. 	<p>Levels of these diseases are increasing, and they are identified as priorities for NHS London</p> <p>We need to increase uptake of childhood immunisations and uptake of flu immunisation in target adult populations</p>

This high level of ill health reflects the level of deprivation in the borough, which ranks 42nd out of 345 local authorities in England on deprivation scores used by the Office of the Deputy Prime Minister.

Expected Incidence Growth

	Year 0 (Baseline)	Year 1	Year 2	Year 3	Year 4	Year 5
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
COPD	0	52	145	242	342	451
Average incidence growth (%)	0	0.69	1.92	3.21	4.53	5.98
Compound growth rate 2006/07 – 2011/12 (%) = 3.27%				0.69+1.92+3.21+4.53+5.98= 16.33 /5		
CHD	0	-23	-8	12	45	96

Average incidence growth (%)	0	-0.33	-0.11	0.17	0.64	1.37
Compound growth rate 2006/07 – 2011/12 (%) = 0.35%				-0.33+-0.11+0.17+0.64+1.37=1.74/5		
Diabetes (Type 1)	0	8	19	29	39	48
Average incidence growth (%)	0	1.38	3.27	5.00	6.72	8.28
Compound growth rate 2006/07 – 2011/12 (%) = 4.93%				1.38+3.27+5.00+6.72+8.28=24.65/5		
Diabetes (Type 2)	0	250	530	823	1112	1419
Average incidence growth (%)	0	3.20	6.79	10.54	14.24	18.17
Compound growth rate 2006/07 – 2011/12 (%) = 10.59%				3.20+6.79+10.54+14.24+18.17=52.94/5		
Hypertension	0	281	749	1257	1780	2350
Average incidence growth (%)	0	0.76	2.07	3.48	4.91	6.48
Compound growth rate 2006/07 – 2011/12 (%)= 3.54%				0.76+2.07+3.48+4.91+6.48=17.7/5		
Treated Hypertension	0	7	93	199	317	467
Average incidence growth (%)	0	0.05	0.66	1.41	2.25	3.32
Compound growth rate 2006/07 – 2011/12 (%) = 1.54%				0.05+0.66+1.41+2.25+3.32=7.69/5		

Spearhead status

Following the Publication of the White Paper ('Choosing Health'), the then Health Secretary Dr John Reid MP announced plans to establish 'Spearhead' primary care organisations to tackle health Inequalities. NHS Barking and Dagenham is one of the 80 plus 'Spearhead' organizations serving Britain's most deprived communities that will receive major investment to pilot initiatives such as health trainers, enhanced smoking cessation services.

The next five years

As well as the challenging agenda around cardiovascular disease and COPD, the changing population will both add to this and highlight other areas.

The effect of the Thames Gateway will be to increase the population of the borough in line with the projections given. Although it is assumed many of those moving in will be younger, and the challenge will move to primary prevention of disease and ensuring access to high quality services, the current challenges are to identify unmet need, reduce mortality and disability/morbidity and with it reduce avoidable hospital admissions.

The borough is already experiencing sustained inward migration, with Black and Minority Ethnic populations now comprising 15% of the population.

The public health challenges for these populations include significant CVD risk factors (Diabetes and Stroke for Black African-Caribbean's, Heart Disease and diabetes from Smoking and diet for Eastern European populations and Heart Disease and Diabetes for South Asians.)

Challenges from infectious diseases (TB and HIV) are increasing, and the challenge posed by low and very low birth weight represents a challenge to healthy development and the risk of developing CVD and

other avoidable diseases in future generations.

The nature of our demographics (high mortality, high unmet need), suggests that a strategy which progresses in tranches addressing unmet need, reducing mortality, reducing disability and hospitalisation and then preventing disease arising in those at risk will have the greatest impact.

To implement this approach we will first put in place tertiary prevention (identifying unmet need and reducing mortality in those with established disease), then secondary prevention (identifying unmet need and reducing illness, disability and hospitalisation in those with established disease.) While we are currently investing in primary prevention (stopping people at risk developing disease) the primary preventive approach will become more prominent as tertiary and secondary preventive approaches show impact. The impact of this against a background of increasing population change is that health care activity is likely to increase over the short to medium term, with mortality beginning to decrease in the medium to longer term.

3.3. Existing Models of Care

Commentary

Access to Health Care

As a further inequality, the Borough has a history of low levels of investment in primary and community care, resulting in a high reliance on A&E and acute services for local people, with high levels of emergency admissions.

The provider landscape for Barking and Dagenham has consisted until recently of primary care provision by largely small practices, under-developed community services and secondary services provided outside the borough, usually in an acute environment. This is now changing, as the organisation addresses the challenge of poor access to primary care and community services and an over-reliance on acute facilities.

Key Facts: Current Models of Care

- Generally small general practices, dental practices, pharmacies and optometrists
- Rapidly expanding community services in 7 new LIFT buildings;
- Mental health Foundation Trust
- Acute service provision largely BHRT and various specialist services including at BLT.

The direction of travel for Barking & Dagenham is consistent with the agenda set out in Healthcare for London, with the emphasis on localising services wherever possible into community settings. This is complemented with the centralisation of services where there is significant evidence to support focussed specialised service provision.

The model for Polyclinics and our intentions in this area are set out in the Primary and Community Care Strategy which is summarised later in this section with the full strategy annexed to this plan.

3.4. Provider Landscape

	Provider/Number of providers	Amount/value of activity commissioned (In 07-08) (£m)	Provider-activity levels ('000) and any specific commentary
Primary care - GPs, prison healthcare, dentistry, and optometry	GMS – 32	12.1	475.0
	PMS - 11	7.1	162.8
	APMS – 1	1.3	28.0 (WiC & GP)
	Total 44		
	GP prescribing	23.2	
	GP Out of Hours	0.9	24.1
	GP Computing	0.3	
	GDPs 19	8.1	256.0
	CDS 1	1.13	3.0
	Optometrists 15	0.1	26.7
	Walk in Centre (Upney Lane)	0.59	24.1
	Enhanced primary care	0.6	
	Primary Care Development Fund	0.2	
	Community and intermediate services	PCT Provider arm-adults	11.76
PCT Provider arm- children		8.82	67.2
PCT Provider arm- LIFT			LIFT = 0.6 Provider Est = 7.3
PCT Provider arm- capital charges			2.9
Havering PCT		3.0	Clinical SLA £2m, plus IT
Redbridge PCT		0.7	
Newham PCT		0.1	
Free nursing care		1.8	0.4
Continuing care placements		1.4	0.1
LD placements		5.3	0.1
Other placements- YPD, palliative, children		2.2	
Clinical assessment services		0.9	
Substance misuse- DAAT		2.4	
Public Health- incl. HIV		1.2	
Other non-acute spend		1.2	
Mental health	NELMHT Community Mental health	18.9	48.1

	NELMHT- access and crisis		19.1
	NELMHT- clinical services		32.4
	NELMHT CAMHS		7.2
	ELCMHT- forensic	1.4	6.0
	Cherry Orchards	1.3	6.6
	MH ISAs	0.6	
	Ealing High secure	0.8	
	Other mental health spend	5.8	
Secondary care	BHRT	69.8	IP: 29,478 XBD: 17,108 OPFA: 35,837 OPFU: 77,076 A&E: 57,372
	BLT	10.8	IP: 1,831 XBD: 764 OPFA: 3,244 OPFU: 8,033 A&E: 1,233
	Newham General	2.2	IP: 1,011 XBD: 395 OPFA: 1,154 OPFU: 2,051 A&E: 2,230
	Whipps Cross	1.2	IP: 610 XBD: 113 OPFA: 1,125 OPFU: 2,148 A&E: 647
	ISTC	7.4	2000
	Other (x19)	8	IP: 2,534 XBD: 335 OP: 15,360 A&E: 2,691
	London Ambulance Service	5.4	Additional £159 agreed – one month pump-prime monies to assist in achieving CatB19 target in 08/09.
	Corporate services	0	
Tertiary and specialist commissioning	Specialist Contracts	8.9	

3.5. Current Developments in Commissioning

NHS Barking and Dagenham's approach to primary and community care commissioning will aim to deliver for the Barking and Dagenham population:

- Motivation and support to stay healthy;
- Empowered patients;

- Personalised services;
- Integrated & 'one-stop' care models;
- Improved access to care;
- Quality assured services.

Out of Hospital Planning

NHS Barking and Dagenham is working with NHS Havering, Redbridge and Waltham Forest to develop a common set of care pathways that support the redesign of care across primary and secondary care to shift work previously provided within the Acute Sector into a community setting where clinically and cost effective. These pathways are being developed in conjunction with Social Care across the four Boroughs and Acute Trusts.

NHS Barking and Dagenham will commission these services collaboratively with the other primary care organisations and Boroughs where this is most effective, and augment this with local service provision where appropriate. Service commissioned both collaboratively and locally will be designed to ensure consistent access and outcomes across Outer Northeast London.

Within this context, NHS Barking and Dagenham has established new out of hospital / community based services:

- Introducing a clinical assessment and treatment centre (CATS)

Predicted CATS activity provided out of our community hubs:-					
	<u>2007/08</u>	<u>2008/09</u>	<u>2009/10</u>	<u>2010/11</u>	<u>2011/12</u>
New Outpatients	2,300	4,500	6,500	8,000	9,400
Follow-ups	2,600	5,400	9,700	12,900	16,000
Total	4,900	9,900	16,200	20,900	25,400

- Providing a full range of community based diagnostic services including x-ray and MRI

Over and above the migration of outpatient work to CATS locally the organisation's primary care hubs provide the infrastructure for consultant-led outpatient clinics on an outreach basis. This model assumes the following migration of outpatients (consultant-led into the community):-

- 2008/09 - 0% (Work in the community limited to CATS)
- 2009/10 - 3% (Migration of outreach consultant led clinics begins)
- 2010/11 - 9%
- 2011/12 - 18%

NHS Barking and Dagenham's provider arm provides musculo-skeletal services from Vicarage Fields and phlebotomy from a range of community hubs.

The organisation also looks to other practitioners to provide care outside of hospital with community pharmacists providing anti-coagulation follow-ups, and optometrists providing direct referrals for cataract surgery.

Day cases provided in the community are limited to minor surgery. No assumptions are made about the provision of chemotherapy in the community. This may be procured through Wave II Independent sector procurement, subject to assurances that any procurement of community-based chemotherapy services will not fragment care pathways and continuity of care.

Therapy contracts are based on reference costs for 2006/07 and projected forwarded for out of hospital service developments.

Strengthening Community Care Services

In recent years, NHS Barking and Dagenham has commissioned the following services to strengthen

the range of community services aimed at preventing hospital admissions and supporting patients to manage their conditions within the community:

- Rapid Response and Unique Care Teams;
- Specialist teams for respiratory, heart failure and diabetes.

Primary and preventative services are also accessible in the community:

- Community based talking therapies service;
- Integrated community sexual health services;

In 2009/10 and beyond, NHS Barking and Dagenham will:

Commission a single point of access for all primary and community services through Outer North East London (ONEL) out of hospital service development in 2009/10

Commission a home health care model pilot as an extension of the Rapid Response Team service.

Utilising telemedicine and health training to support a patient's knowledge about their own condition to enable them to prevent deterioration, self-manage effectively, identify when it is worsening and respond.

Provide additional assistance with self-medication by extending the use of medicines utilisation reviews in community settings and increasing uptake of this service in community pharmacy.

Extend the condition specific expert patient programme to cover self management techniques for neurological conditions.

Improve access to psychological therapies.

Aim to enable 80% of patients to have the option to die at home in line with the Liverpool Care Pathway review for end of life care.

Improving Access to Primary Medical Services

The NHS Next Stage Review Interim Report (October 2007), reported that despite sustained investment and improvement in the NHS over the past ten years, access to primary medical care services and the quality of those services continues to vary significantly across the country.

The Department of Health ranks Barking and Dagenham 149th across the country (152 PCTs in total), in terms of having poor provision. This is using a weighted measure of numbers of primary care clinicians (under-doctoring), health outcomes and patient satisfaction with GP access.

The Government will be providing new investment of £250 million, to support primary care organisations in establishing at least 100 new general practices in the 25% of organisations with the poorest provision, and one new GP-led health centre in each primary care organisation in easily accessible locations.

Procuring new primary medical services

NHS Barking and Dagenham has undertaken an open competitive tender exercise for the procurement of three new 6-9000 list size APMS practices to be based within new primary care hubs at Porters Ave, Barking Town Centre and Barking Hospital. The practice at Barking Hospital will be integrated with other GP-led health centre and urgent care services offering walk-in and bookable GP services for non-registered patients.

Extending opening hours

In 2008/09, NHS Barking and Dagenham significantly expanded the range of extended hours with 90% of general practices providing evening and/or weekend opening arrangements. The organisation currently has 4 practices offering 8am-8pm Mon-Fri and Saturday opening and is anticipating an expansion of this figure to a minimum of 10 sites in 2009.

Increasing the GP/Nurse workforce

The national average list size per whole time equivalent (wte) GP in England is 1750 patients. In Barking and Dagenham the average list size per WTE GP at the end of March 2008 was 2035 patients. In 2007/08, NHS Barking and Dagenham agreed a plan to improve access to primary medical care and set local targets based on population increases for improvements in GP workforce

figures. NHS Barking and Dagenham is currently on track against those targets.

In order to meet the March 2009 target for additional GP recruitment, the organisation is undertaking the following:

- **+ 5.5 wte** - Recruitment of PCT employed salaried GP's – posts commenced June 2008
- **+ 4wte** - Recruitment of two new practices to open December 2008 (number of GP wte's will increase over 5 years to 12)

In addition to this, NHS Barking and Dagenham will be expecting local practices that are under doctored to recruit additional GPs and will be working with the Deanery to place GP registrars:

- **+ 8 wte** - Minimum local practice recruitment

	Mar 2007 (baseline)	Mar 2008	Mar 2009
wte GP's target	76	87	101
Actual wte GP's	76	88.45	-
Actual wte GP deficit	22.3	14.44	-

In 2009/10 the organisation will be shifting the focus of attention to practice nursing levels and establishing additional initiatives to support an increased investment in this workforce.

Improving detection and prevention strategies

Extend opportunities for near point testing and health screening for early detection of conditions such as COPD, diabetes, CVD and identification of 'risky' lifestyle factors such as smoking, lack of exercise and poor diet.

Developing new enhanced services relating to near point testing in pharmacy and general practice.

Peer review and strong performance management of prevalence and exception reporting levels.

Developing a health profile for each patient - personalised care & lifestyle improvement plan.

Providing alternatives to a patients practice

Nurse and GP-led walk-in centre services with bookable GP appointments for non-registered patients

Pharmacy First – for minor ailments, emergency hormonal contraception, smoking cessation, obesity management and near point testing

Extended dental opening hours and capacity – patients may have attended general practice seeking pain relief/antibiotics

NHS Direct and the single point of access

Phone triage and online health check and email your GP services

In-hours access review

NHS Barking and Dagenham has commissioned an independent review of general practice accessibility in core GMS hours. This will identify practices that are not operating appropriate levels of services in-line within the spirit of the GMS contracted hours and advise practices on approaches for improving primary care efficiency and accessibility for example through the introduction of new triage systems.

Keeping patients informed of their choices

Publish information to support patient choice when access health services including key quality metrics. Make full use of NHS Choices, a revamped organisation website guide to services and other appropriate communication tools for the local population.

In addition to the above schemes, NHS Barking and Dagenham has a number of key initiatives outlined in this CSP that are aimed at keeping the residents of Barking and Dagenham healthy.

Urgent Care

NHS Barking and Dagenham currently provides 2 walk-in-centres from Broad Street (Dagenham) and

Upney Lane (Barking). By the Autumn of 2009 the Walk-in-centre at Upney Lane will have migrated to Barking Hospital site.

Attendances at Upney Lane have increased by circa 50% from October 2007 following a local marketing campaign and this level of attendance is expected to be maintained in 2008/09. Attendances at Upney Lane are expected to increase by 5% per annum from 2008/09 as the service specification moves to an Urgent Care Centre co-located with GP Out of Hours service. Growth at Broad Street is expected to be circa 1% per annum.

The primary care hub at Barking Hospital will provide an urgent care centre within the community. In 2008/09 the organisation will complete the procurement of a 'health centre' for the Barking Hospital primary care hub offering 24/7 opening, bookable services for registered and unregistered patients, walk-in and minor injuries.

The Rapid Response Team will prevent emergency admissions by patients most at risk of admission in the community.

Priorities for Secondary Care

The main priorities for secondary care are based around the key national targets and priorities. This means working with our main acute provider to deliver the 18 week Referral to Treatment waiting time targets, the A&E four hour waiting time priorities and working with the hospital to achieve the requirements of "Maternity Matters".

Priorities for Tertiary (Acute) Care

NHS Barking and Dagenham's main tertiary provider is Barts and the London NHS Trust (BLT). The priorities focus on insuring that their information systems are robust and meeting the cancer waiting time targets.

Barking, Havering and Redbridge NHS Trust

NHS Barking and Dagenham purchases 85% of its non-elective and 75% of its elective work from Barking, Havering and Redbridge NHS Trust (BHRT). In 2007/8 the PCT transferred 25% of its elective baseline from BHRT into the North East London Treatment Centre (NELTC). BHRT is therefore the key provider of district general hospital services to Barking and Dagenham residents and also provides some specialist cancer and neuro-sciences care. Discussions are currently underway about where complex head and neck cancer surgery should be sited, the outcome of which is dependent on the forthcoming peer review.

BHRT has been classified as financially challenged by the Department of Health (DH), but plans to breakeven in 2010/11. The Annual Healthcheck Assessment published by the Healthcare Commission in October 2008 records the Trust's use of resources (financial management) as weak and the quality of services provided as fair for 2007/08.

The Trust performs strongly against targets for Hospital Acquired Infections (MRSA and C-Difficile) and cancer waits. NHS Barking and Dagenham is working with the Trust, and co-commissioning primary care organisations to improve services for:-

- A&E against the 98% 4-hour target
- Progress on the Referral to Treatment target
- Maternity Services
- Stroke Care as set out in the Northeast London Collaborative Commissioning Initiatives

Most Barking and Dagenham outpatient referrals go to BHRT, and NHS Barking and Dagenham working with Practice Based Commissioning (PBC) Clusters, has targeted a 5% transfer of outpatient work from BHRT into Community Clinical Assessment and Treatment Centres (CATS) per year.

Emergency patient flows for Barking and Dagenham residents go to both main sites of BHRT, at King George Hospital and Queen's Hospital. Again working with PBC Clusters the organisation is targeting

a 5% reduction per annum in A&E attendances and emergency admissions at BHRT.

North East London Foundation Trust

Community and inpatient mental health services are provided mainly by North East London Foundation Trust (NELFT) with some more specialist commissioning for forensic services from East London and the City Mental Health Trust (ELCMHT), and Care UK for ex long-term mentally ill services. NELFT are working with NHS Barking and Dagenham to provide alternative services with a greater emphasis on prevention and community services, as a result of the re-provision of inpatient services from Mascalls Park in Brentwood to Goodmayes which is closer to the Borough.

NHS Barking & Dagenham has commissioned several new service developments for 2008/09, including the development of the Improving Access to Psychological Therapy service aimed at providing interventions for people with depression, anxiety and other common mental health problems in primary and community settings, and an eating disorders service.

NHS Barking and Dagenham also contracts for a series of Mental Health Individual Service Agreements (ISAs), making placements with a number of providers. The organisation has consolidated this with a more cost effective contract with a single provider, and transferred responsibility for managing ISAs for adults and eating disorders to North East London Foundation Trust.

North East London Treatment Centre (NELTC)

Barking and Dagenham has a 5-year contract with the Independent Sector Treatment Centre (ISTC) from January 2007 to provide 3000 elective surgery episodes per year. The activity baseline for the ISTC is made up of work transferred from BHRT (80%) and additional work to support achievement of the waiting time targets (20%).

The NELTC was commissioned through Wave 1 of the DH national procurement from the Independent Sector, and the centre is run by Care UK. The Centre provides low risk elective activity for cataracts, orthopaedics and general surgery.

The contract is based on minimum take rather than Payment by Results rules and as lead organisation for the contract, NHS Barking and Dagenham is keen to maximise referrals into the ISTC, and has undertaken a number of actions to improve this, including case mix reviews, direct referrals and providing BHRT with the responsibility for transferring patients from its waiting list to the ISTC.

NHS Barking and Dagenham has appointed a Project Manager in conjunction with the Improvement Foundation to develop a series of targeted initiatives encouraging earlier presentation of cancer symptoms in neighbourhoods with the highest mortality rates.

Barts and the London NHS Trust

The Trust provides Barking and Dagenham residents with some district general hospital services and many of its specialist services across cardiac and cancer services.

Other Acute and Specialist Providers

NHS Barking and Dagenham holds over 30 contracts for acute and specialist services with key highlights as follows:-

- Increased use of Newham University Hospital Trust for emergency patient flows since the opening of the new Queen's Hospital and associated service reconfiguration at BHRT.
- Moorfields provide both cataract and specialist ophthalmology services for Barking and Dagenham residents, with an outreach clinic at Barking Hospital.
- Specialist renal services from Royal Free and Basildon and Thurrock Hospitals.
- Specialist Burns and Plastic care is purchased from Mid-Essex Hospitals.

Specialist Commissioning services are commissioned collaboratively with all primary care organisations in Northeast London through the Specialist Commissioning Team hosted by Tower

Hamlets PCT.

Many of the local acute providers within the NEL health economy are currently struggling to achieve key national targets. NHS Barking and Dagenham has sought to maximise the scope for choice of patients requiring elective treatment through the Choose and Book initiative, in an attempt to improve quality and reduce waiting times through competition. The choose and book system provides patients with the opportunity to receive care from local NHS hospitals, as well as the CATS (Clinical Assessment and Treatment Service) service and local independent sector hospitals. However, the evidence suggests that patients do not wish to travel too far for treatment, which thus reduces the potential impact of this initiative.

3.6 Activity Commissioned

Commentary

Primary Care

NHS Barking and Dagenham will focus on improving GP coverage by both increasing the number of GPs working within the Borough and by extending patient contact beyond the core hours set out in GP contracts. During 2008/09 two new practices will be established in NHS Barking and Dagenham – the LIFT developments at Porters Avenue and Barking Town Centre, with a further new practice in 2009 at the Barking Hospital site. NHS Barking and Dagenham intend to extend both in-hours and out of hour's provision from GP practices. Currently 40 out of 43 practices offer this provision.

NHS Barking and Dagenham will expand access criteria to the Broad Street Walk in Centre and has incorporated the Upney Lane Walk in Centre into the Barking Hospital procurement plan. The specification for this service will reflect the organisation's commissioning plans. A significant publicity campaign was undertaken last year to promote the two walk in centres as alternatives to A&E, and as a consequence there has been a substantial rise in attendances at these two centres in recent months.

NHS Barking and Dagenham is working with all independent contractors to improve access to services, and to repatriate work in the community previously carried out in acute settings, including:

- Provision by optometrists of digital retinal screening, direct access to cataract surgery and glaucoma screening, transferring this work from acute outpatient clinics;
- Extended units of dental activity to enhance NHS coverage in the Borough, and enhanced health promotion particularly around smoking cessation in line with the organisation's dental strategy;
- Provision of anti-coagulation follow-ups, smoking cessation support and medicine utilisation reviews (MUR) from community pharmacists.

In 2008/09 six salaried GPs were recruited to support existing GPs in operating emergency environments (such as A&E). The organisation is also exploring expansion of use of GP registrars with Deanery.

Community and Intermediate

Services, provided mostly by NHS Barking and Dagenham's provider arm, are expected to see activity increases of 5 - 6% per annum to support enhanced care outside of hospital as part of "Healthcare for London" service redesign in Outer Northeast London. The organisation focused both on the front and back door of acute hospitals in 2008/9 with admissions avoidance through Unique Care (implementing the Castlefields model with Social Care), and community teams for Heart Failure and COPD. NHS Barking and Dagenham's priorities for moving people out of hospital faster, where clinically appropriate, will focus on establishing a single point of access into community services and

establishing a Rapid Response Team (which commenced work in August 2008). This will be done in conjunction with other primary care trusts in Outer Northeast London to give acute trusts a common pathway for discharge into all Boroughs.

A 39-bed unit was opened at Grays Court in 2007 to provide an integrated intermediate care service across inpatient, day case and domiciliary and stroke rehab care. The facility provides both step-down and step-up beds, with the latter agreed with PBC clusters. Grays Court intends to ensure that patients are discharged within 6 weeks of admission to the unit. Following the A&E pressures in the community, the number of beds expanded significantly to facilitate earlier discharge out of BHRT.

Commissioning intentions for 2008/9 assume a 5% transfer of outpatient work from acute trusts to Clinical assessment and Treatment Services (CATS) in the community, following the success seen with the service during 2007/8.

From July 2007 GPs in B&D have direct access to diagnostic tests provide from Broad Street (x-ray, ultrasound and cardiac tests) and Barking Hospital site (mobile MRI), to support 18-week pathways.

Mental Health

Activity trends from 2007/08 reflect NHS Barking and Dagenham's investment in Access and Crisis Services provided by NELFT, with investment in the Assessment and Brief Intervention Team (ABIT) to triage referrals from General Practice, and to make Assertive Outreach, Crisis Resolution, and Early Intervention in Psychosis Teams comply with National Service Framework Standards. NHS Barking and Dagenham has recently invested significantly in Improving Access to Psychological Therapies, which aims to both support individuals in returning to work, and also releasing capacity in both secondary care and other primary services. Further areas that have led to additional investment include the development of an eating disorders service, and a service targeting the young onset of dementia.

Investment in community services reflects the Clinical Strategy of NELFT endorsed by NHS Barking and Dagenham Board in July 2007, and the model of care required to transfer inpatient services for Barking and Dagenham residents from Mascalls Park to Goodmayes in Ilford. Investment for 2009/10 will reflect this priority for NELFT.

Acute

NHS Barking and Dagenham commissioning intentions in this Commissioning Strategy Plan reflect those previously presented in the Healthcare for London review, with key features being:

- A 4 - 5% reduction per annum in unscheduled care presentations to acute hospitals (A&E attendances and emergency admissions), accruing from work on admissions avoidance through Unique Care, community teams for CHD and COPD, rapid response teams, and extended access to walk-in-centres and General Practice;
- A 5% transfer per annum of outpatient work from acute outpatient clinics to Clinical Assessment and Treatment Services (CATS);
- Provision of community-based services for phlebotomy and anti-coagulation, this is reflected in the reduction in Acute Direct Access activity;
- Additional elective activity to support the achievement and thereafter maintenance of the 18-week milestones.

Summary of non-acute activity commissioned

'000		Baseline	Year 1	Trend (%)
		2007/08	2008/09 forecast*	
Primary Care:				
GP practice in-hours	Consultations ¹	637.8	656.9	3.0
GP practice out-of-hours	Consultations ¹	24.1	24.1	0
Prescriptions	Number ¹	1,964	2,023	3.0

Optometry	Attendances ¹	26.7	28.0	5.0
Dentistry	Attendances ¹	256	271	5.9
Other	Attendances ¹	57.4	63.2	10
Community and intermediate:				
Community and social – bed based care	Attendances ¹	15.8	16.0	1.3
Community and social – community care	Attendances ¹	248.9	262.6	5.5
Other	Attendances ¹	17.8	18.8	5.5
Mental Health and Learning Disabilities:				
Community mental health	Numbers under care ¹	50.3	52.1	3.5
Access and crisis services	Attendances ¹	21.9	24.1	10
Clinical services	Attendances ¹	39.4	39.8	1.0
Ambulance:				
Ambulance services	Cases seen ¹	20.1	20.3	1.0
Notes				
1. Or alternative activity measure				
*Based on latest actuals plus forecast for remainder of year				

Summary of acute activity commissioned			
'000	Baseline	Year 1	
Admission	2007/08	2008/09 forecast*	Trend (%)
Elective day case	11.0	11.5	4.5
Elective ordinary	3.9	4.5	15.4
Non-elective	19.8	20.0	1.0
Outpatient (new)	44.7	41.7	-6.1
Outpatient (follow up)	100.0	93.6	-6.5
Regular attendee	1.7	1.7	0.0
Bed days (PICU, NICU, ITU, HDU Critical Care)	7.3	7.3	1.3
Mixed (HIV and Renal)	1.1	1.2	8.0
A&E Major	17.7	17.9	1.4
A&E Standard	7.2	6.8	-5.0
A&E Minor	35.5	33.6	-5.2
GP direct access attendance	288.5	313.7	8.7
Other	15.5	8.0	-48.4
*Based on latest actuals plus forecast for remainder of year - – NHSL have confirmed to use “plan”.			

3.7 Existing targets and local and national health priorities

Existing Targets

Commentary

18 week Referral to Treatment (RTT)

Analysis shows that performance in recent years has been strong in the waiting time standards for secondary care, reflecting the focus that the commissioning arm of the organisation has placed on these areas. However with the introduction of the 18 week Referral to Treatment target in 2008/09, performance against all elective waiting times standards has been compromised. This was a predictable risk area, given the scale and scope of the 18 week target.

Therefore there have been a series of inpatient 26 week and outpatient 13 week breaches in 2008/09, particularly in Quarter 3 as the December 2008 18 week referral to treatment target approached. These breaches predominately occurred at GOSH and Barts and the London Trust, with a number of outpatient breaches also occurring at BHRT.

However, following a focused approach to managing the 18 week referral to treatment pathway across the local economy, and a real turnaround achievement at BHRT, this target is now being achieved and sustained by BHRT. The partnership working between the three local PCTs and BHRT has enabled the successful implementation of an 18 week action plan which addresses discharge planning, outsourcing of patients and securing additional capacity within the Independent sector. In addition a detailed capacity plan was provided by BHRT at specialty level to support improved waiting times.

In order to improve performance against the 26 week and 13 week waiting times targets, and to sustain the 18 week target throughout 2009/10, BHRT has secured additional capacity at the Queens site, a sustainability plan is under development for the management of outsourcing demand, and negotiations are underway to secure flexible capacity within the ISTC. It is anticipated that the 18 week referral to treatment target will be sustained throughout 2009/10.

A&E

Following poor performance against this target in 2007/08, an A&E patient tracking system was introduced at BHRT (JONAS) to improve the monitoring of patients across the Queens hospital site. The introduction of this system helped pinpoint reasons for A&E breaches, and enabled these blockages to be addressed in a systematic way. Furthermore, a robust operational partnership group has been successfully running throughout 2008/09, attended by members of the acute trust and the local PCTs. This has provided an opportunity for sector-wide actions to be agreed and pressures on the achievement of this emergency target have been collectively addressed.

As the A&E 4-hour waiting times target is measured on full year performance, it is therefore now accepted that the PCT is highly unlikely to achieve this target for 2008/09. However, despite the sustained pressures placed on A&E over the winter period, performance is improving and BHRT is ahead of its trajectory to meet a year-end target position of 98.75% by the 31st March 2009. Insufficient capacity derived from sustained demand, and the additional bed pressures of achieving the 18-week target have continued to negatively affect A&E performance. However the robust economy-wide monitoring and management of this target has led to incremental improvement in performance throughout the year, and it is anticipated that this continued focus will lead to the achievement of the A&E target in 2009/10.

Ambulance waiting times

Performance against the 8 minute category A and 19 minute category B targets have been challenging for the London ambulance service throughout 2008/09, as the pressures on A&E across London have led to an increase in ambulance calls received and an overall deterioration in performance against the ambulance response targets. It should be noted that NHS Barking & Dagenham is monitored against London-wide performance for this indicator, and thus it is difficult for the PCT to individually influence performance. The local PCTs are working collaboratively to improve performance against this indicator, led by the local PCT lead (Redbridge PCT). Actions planned to improve performance in 2009/10 include;

- The PCT has given (in principle) their agreement to the development of a Transformation Programme, with Sector level Urgent Care Board and a central transformational team that will work within the local health communities. Richmond and Twickenham are progressing with the development of this programme

The PCT has proposed that a 'linked' CQUIN on Hospital Turnaround should be included in the 09/10 Contracts for both acute hospitals and the London Ambulance service

Choose and book

One of the key initiatives to support the organisation in meeting the 18 week RTT target, is the implementation of choose and book systems for all patients. By the end of July 2008, 72% of referrals has been undertaken using choose and book systems, putting NHS Barking and Dagenham in the top 10 primary care organisations in London and 10% nationally. However, the target is 90%, and the organisation continues to work closely with practices and local acute providers to improve this uptake.

Also at July 2008, 80% of B&D patients were offered the choice of at least 4 different health care providers for planned hospital care. Based on the March 2008 survey results, B&D is the 5th top organisation for Choice in London.

Cancer waiting times

For the first two quarter's of 2008/09, NHS Barking and Dagenham consistently met the 2 week wait, 31-day and 62-day cancer waiting times targets. However, in December 2008 there were 4 breaches of the 62-day cancer waiting times standard and these breaches have now pushed performance against this indicator significantly below trajectory. To ensure cancer performance against the cancer targets is maintained, these indicators will be discussed at the fortnightly economy-wide meetings throughout 2009/10.

Stroke

As a new indicator for 2008/09, Stroke performance has been challenging to manage. This is predominately due to the fact that stroke was not initially centralised at BHRT, a TIA service was not initially in place, and information recording and reporting was not robust. However, Acute Stroke facilities have now been centralised at Queens which has led to an increase in bed capacity, nursing capacity and a more streamlined pathway of care. It is anticipated that this will make a significant, positive impact on performance against this target. Furthermore, a TIA service is now in place and is subject to robust data reporting.

Drug Treatment programmes

Data from the National Treatment Agency (NTA) show that the targets associated with numbers in treatment and the numbers sustaining this treatment for 12 weeks were achieved during 2007/8, in line with the strong performance in recent years.

It is anticipated that this performance will continue in 2008/09, and data released thus far demonstrates that performance is almost in line with trajectory. Routine performance meetings between the Borough's Drugs and Alcohol Lead and NHS Barking & Dagenham's Performance lead

are scheduled to take place in 2009/10, with a series of supporting indicators to better inform this overarching indicator currently in development.

GP / PCP access

Local practices have reported achieving the 24/48 hour target for several years now. However, the recent GP Access Survey Results for 2007/08 have highlighted that whilst the organisation's satisfaction ratings are in line with other primary care organisations in the London SHA area, there is a large amount of variation and inequality in access at practice level. This is being addressed by NHS Barking and Dagenham via its improving access action plan, which focuses on:-

- Extending access to existing practices, including the enhanced hours scheme;
- Extending access through the procurement of new practices
- Extending access through new and alternative services, including community pharmacists;
- Strengthening the GP & nurse workforce;
- Improving Patient Experience & Improving Public Perception of Access;
- Schemes aimed at preventing ill health & managing demand for services.

Mortality rates

NHS Barking and Dagenham achieved the target for cardiovascular and cancer in 2007/08. Latest available data as at quarter 3 highlights that performance is above trajectory for the Cancer and All Age All Cause mortality rates, with the CVD mortality rate currently highlighted as 'Amber', reporting a rate of 110.68 per 100,000 against a target of 98.0 per 100,000.

Breast Feeding

For NHS Barking and Dagenham there are two key challenges to this indicator; firstly ensuring GPs send the 6-8 week check forms into the 'Child Health Team' within the correct quarter to ensure that this information can be captured, and secondly raising the number of women who are breastfeeding at 6-8 weeks. This indicator is further compromised by an inability to access robust data analysis from the CHIA system (thereby requiring a manual assurance exercise to be completed).

A real improvement in performance against this target has been seen throughout the year, with a reported prevalence position of 53% for Quarter 3. Unfortunately the set target for this indicator is incredibly high, with a requirement for 99.7% of babies to have a 6-8 week breastfeeding check within their required quarter, and 79.8% of babies checked being recorded as partially or fully breastfeeding. An achievable trajectory for 2009/10 has now been submitted, and it is anticipated that this target will be achieved in 2009/10.

Long Term Conditions and Older People

Long Term conditions is a key initiative area for NHS Barking and Dagenham. The organisation achieved all its targets relating to community matrons, case managers and very high intensive users (VHIU) for 2007/08.

Mental health

All the key mental health targets were achieved in 2007/08, including early intervention, crisis resolution, assertive outreach and patient followed up in 7 days. This positive performance position has continued in 2008/09, with no mental health indicators appearing as high risk. However, for quarter's 2 and 3 the PCT has reported "3" against 3 or the 4 self-assessed CAHMS questions. Internal discussions between the PCT's strategy and commissioning directorates have led to the production of an action plan to address; with a commissioning meeting with the Mental Health Provider scheduled in February 2009. The PCT is confident that a final rating of "4" against all 4 self-

assessed CAMHS questions will be achieved at year-end.

Obesity

This indicator remains a significant challenge for the PCT, and latest performance information demonstrates that the percentage of children in Year 6 recorded as Obese at quarter 3 for 2008/09 is 23.9% against a 19% target.

The 2006 baseline (which was used to set the target for this indicator) was the result of a bias sample because of the significantly lower proportion of children measured due to an 'opt in' policy. This policy was changed in 2007 to 'opt out' and supported by a public awareness campaign, hence the achieved substantial increase in measurements, achieving the target for Reception class and seeing a significant improvement in Year 6 recording.

Rates of obesity for Reception year in 2007/08 were in line with the full year target which is reassuring and reflects the positive partnership work being undertaken across the children's centres. However it is not possible, due to the sample size, to judge if this is a true downwards trend from the 2006/07 measurement of 14.4% obese. In 2009/10 the PCT will be implementing a pre-school obesity prevention programme called HENRY and strengthening the work on early parenting support and breastfeeding.

Rates of obesity in Year 6 rose in 2007/08 from 19.9% to 23.9% which is disappointing but may reflect a more accurate picture of obesity in the borough due to the increased coverage from 67.3% to 82%.

The PCT has a good partnership approach to childhood obesity with strategic leadership through the Child and Adolescent Obesity Task Force which reports to the Children's Trust and is chaired by the Joint Director of Health Improvement.

In 2009/10 there will be an additional £165K investment in childhood obesity to allow the development of an obesity implementation team to deliver MEND, HENRY and teenage obesity interventions in a coherent and sustainable manner.

MRSA / C-difficile infections

MRSA

Despite having 10 MRSA infections at the end of quarter 1, NHS Barking and Dagenham has continued to maintain the MRSA target by working with co-commissioning bodies and BHRT.

C Difficile

NHS Barking & Dagenham became lead commissioner for BHRT in 2008/09 and hence have taken on contractual leadership for ensuring that BHRT are delivering reductions in C. Difficile rates in line with trajectory. This responsibility means that unallocated C Difficile cases are allocated by default to Barking & Dagenham, and thus the PCT's figures are inflated. As the PCT's trajectory was set before it became the lead commissioner, it is suggested that it does not reflect these unallocated cases.

An outbreak of C Difficile cases in Quarter 2 means that it is unlikely that the target will be achieved for 2008/09; however an internal audit following the outbreak and the additional actions (see below) implemented will hopefully limit further outbreaks occurring. Quarter 3's performance depicts a slight increase in cases, however less cases have been seen than were anticipated, given the number of wards affected by the Norovirus and large scale bed pressures. The PCT is concentrating resources on increasing the capacity of the statutory arm to deliver more screens up until March 2009 and a deep Cleaning Program is in place for March 2009 for all provider sites

Smoking Cessation

NHS Barking and Dagenham achieved its smoking cessation target in 2007/08. This achievement

was supported by a focused action plan and additional investment. The momentum started last year has continued in 2008/09, with increased levels of quitters seen thus far this year.

Teenage Conceptions

We recognise that this is a particularly challenging target for NHS Barking and Dagenham and the local authority through the LAA. Although using the 2006 data currently as a comparator, whilst there is a downward trend overall, initial data from midwifery for new births to Under 18s suggests that there have been a slight increase in new births conceived in 2007 and a continued increase in the number of women seeking termination, which suggests the conception rate, has risen during 2007.

Working with the London Borough of Barking and Dagenham (LBBD), an action plan has been developed and a joint commissioner arrangement with LBBD has been developed to implement the action plan.

Patient experience

Historically, NHS Barking and Dagenham has performed poorly against national patient experience surveys, although surveys undertaken at the practice level through the Quality and Outcomes Framework (QOF) process suggest a higher than average level of patient satisfaction with individual practices.

This may, in part, reflect the diverse nature of the population, as recent figures have demonstrated that minority groups express less satisfaction with the NHS. Through the extensive impact assessment programme that the organisation has undertaken on its equality schemes, it has identified a number of issues to help provide services and information to these groups which should lead to improved levels of satisfaction in the future.

This work is already beginning to reflect in our patient satisfaction results; analysis of the national diabetic survey undertaken last year shows that in many areas, NHS Barking and Dagenham has moved out of the bottom quartile for patient satisfaction.

The organisation has recently developed a new committee, the Patient Experience Group that seeks to bring together information on the patient experience, from a variety of sources, such as survey results, complaints, adverse incidents, PALS contacts, etc., to develop a more rounded understanding of patient experience, and identify key areas for action.

3.8 Current Priorities for NHS Barking and Dagenham

Joint Strategic Needs Assessment

Commentary

This process, which identifies current and future health and wellbeing needs in light of existing services, and in order to inform future service planning taking into account evidence of effectiveness was undertaken in early 2008 and reported to the Board in March 2008. This assessment has supported the identification of the health and wellbeing needs and inequalities of the local population. The assessment looked at a number of issues, covering the local population including demographics over the next 2 to 5 years, social issues (deprivation, income, housing and services, crime), behaviour (e.g. smoking, food, weight and exercise, alcohol and drug use, sexual behaviour and mental wellbeing), what shortens lives and health.

As a result the recommended key health priorities for NHS Barking and Dagenham were identified as follows:

- Preparing for the increase in numbers of middle aged people and increasing diversity
- Address the issues of lifestyle – smoking, diet, exercise, obesity, alcohol, substance misuse, mental health and avoidable injury – employing social marketing techniques to influence

behaviour

- Investing in and improving the quality and efficiency of primary health care, particularly to address key long term conditions (circulatory and respiratory diseases) and other causes of disability
- Match investment and cost-effectiveness in key areas (mental health, maternity care and respiratory disease) to high level of local need.

Key Facts: Health Issues

Smoking – highest estimated smoking levels in London

Food, weight and exercise – lowest estimated levels of fruit and vegetable intake and highest level of obesity in London, both in children and adults: for reception aged children obesity prevalence is the 6th worst in the country

Alcohol and other drugs of abuse – over 1,000 problematic adult drug users, many not receiving treatment

Sexual behaviour – high teenage conceptions, high abortion rates

Life expectancy is poor for London, particularly for women, and progress is slow

Death from strokes – trend has shown a decrease, yet rates in borough higher than both London and England average

Source: Joint Strategic Needs Assessment 2008

World Class Commissioning

Commentary

World Class Commissioning will deliver better health and well-being for all so that people will live healthier and longer lives and health inequalities will be dramatically reduced. It will deliver better care for all because services will be evidence-based and of the best quality and people will have choice and control over the services that they use, so they become more personalised.

It will also deliver better value for all as investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources.

For NHS Barking and Dagenham this translates to:

- Supporting the delivery of the PCT Strategic Plan by providing the tools required for implementation of vision, goals and initiatives
- Enabling the local population to live healthier and longer
- Building clinical engagement into the heart of our commissioning process
- Developing vibrant seamless partnerships with our stakeholders to develop clear local priorities and long term strategy, to tackle local health issues
- Understanding the PCT development and commissioning needs to become 'best in class'

Following a series of discussions, eight health outcomes were selected, in addition to the two national outcome measures (health inequalities and life expectancy) to support the world class commissioning strategy. These are:

- **Smoking quitters** – whilst the organisation achieved this target, it is still a critical factor in reducing health inequalities with smoking levels estimated as the highest in London.
- **Childhood obesity** – a locally chosen indicator relating to the prevalence of obesity in primary school age children. The borough has the lowest physical activity rate in London. The

indicator is identified as a key priority in the JSNA.

- **CHD controlled blood pressure** – coverage is improving and this remains a vital indicator as identified in the JSNA in terms of life expectancy and as a key disease area in the borough.
- **Diabetes controlled blood sugar** – incident rates are expected to rise. A fall in performance was noted over the last two years.
- **Alcohol related admission** – trends have shown a significant increase in hospital related admission over the last three years. The JSNA identified drug and alcohol abuse as a key issue for the borough.
- **Percentage of deaths that occur at home** – agreed priority in the local area agreement. There has been an increasing trend in the number of deaths occurring at home.
- **Cervical / breast screening** – coverage has been historically poor. Linked to high mortality rates from all cancers and low life expectancy for women.
- **COPD mortality** – a high incidence of COPD in the borough and the highest mortality rates in the ONS cluster. Identified as one of the three key diseases for the NHS Barking and Dagenham.

Healthcare for London Priorities

Commentary

Healthcare for London is the 10 year programme to transform healthcare and standards of health in the capital which will introduce the most ambitious programme of improvements in London for 50 years. Its priorities are

- Improving the health of people from deprived communities and disadvantaged groups and their access to health services.
- Preventing ill health
- Maternity and Newborn
- Children and Young People
- Mental Health
- Acute Care and Planned Care
- Long Term Conditions
- End of Life Care

Local Area Agreement Targets

Commentary

Local Area Agreements (LAAs) are made between central and local government in a local area. Their aim is to achieve local solutions that meet local needs, while also contributing to national priorities and the achievement of standards set by central government.

In Barking and Dagenham a number of targets have been agreed which are:

- Alcohol harm related hospital admission rates
- AAA Cause Mortality
- Mortality rates from circulatory diseases
- Mortality from cancers
- Smoking quitters

- People with long term care supported to live at home
- Early access to maternity services
- Enabling people to die at home
- DTOC from hospitals
- The number of EBD
- Adults in contact with secondary mental health services settled in accommodation
- Adults in contact with mental health services in employment

The diagram on the next page illustrates the link between the PCT's World Class Commissioning Health Outcomes and the other priority areas.

Health outcomes – link to wider monitoring regimes

	Associated LAA targets	Associated HCC targets	Associated NHSL targets
Life expectancy	<ul style="list-style-type: none"> All age all cause mortality 	<ul style="list-style-type: none"> Mortality rates –circulatory disease Mortality rates from cancer Improving health outcomes for people with LTC Infant mortality 	<ul style="list-style-type: none"> All age all cause mortality, CVD mortality rate Cancer mortality rate
Health Inequalities	<ul style="list-style-type: none"> All age all cause mortality Mortality rates from circulatory diseases Mortalities from cancers People with LTC supported to live at home 	<ul style="list-style-type: none"> Mortality rates –circulatory disease Mortality rates from cancer Improving health outcomes for people with LTC Practice based registers- % diabetics called for review Emergency bed days 	<ul style="list-style-type: none"> All age all cause mortality, CVD mortality rate Cancer mortality rate Teenage pregnancy
Increasing no of smoking quitters	<ul style="list-style-type: none"> All age all cause mortality Mortality rates from circulatory diseases Mortalities from cancers Smoking quitters 	<ul style="list-style-type: none"> Mortality rates from cancer Mortality rates –circulatory disease 4 week smoking quitters 	<ul style="list-style-type: none"> All age all cause mortality CVD mortality rate Cancer mortality rate Smoking quitters
CHD controlled blood pressure	<ul style="list-style-type: none"> All age all cause mortality Mortality rates from circulatory diseases People with LTC supported to live at home 	<ul style="list-style-type: none"> Mortality rates –circulatory disease Blood pressure control in hypertensive Cholesterol levels Improving health outcomes for people with LTC Emergency bed days 	<ul style="list-style-type: none"> All age all cause mortality CVD mortality rate Smoking quitters
Diabetes controlled blood sugar	<ul style="list-style-type: none"> All age all cause mortality People with LTC supported to live at home 	<ul style="list-style-type: none"> Practice based registers- % diabetics called for review Improving health outcomes for people with LTC Emergency bed days 	<ul style="list-style-type: none"> All age all cause mortality Childhood obesity
% of all deaths occurring at home	<ul style="list-style-type: none"> Enabling people to die at home 	<ul style="list-style-type: none"> Delayed transfers of care Proportion of all deaths occurring at home 	<ul style="list-style-type: none"> Timeliness of social care assessment;
COPD mortality	<ul style="list-style-type: none"> All age all cause mortality Smoking quitters People with LTC supported to live at home 	<ul style="list-style-type: none"> Mortality rates –circulatory disease Improving health outcomes for people with LTC Emergency bed days 	<ul style="list-style-type: none"> All age all cause mortality Smoking quitters
Cervical screening	<ul style="list-style-type: none"> All age all cause mortality Mortalities from cancers 	<ul style="list-style-type: none"> Mortality rates from cancer 	<ul style="list-style-type: none"> All age all cause mortality Cancer mortality rate
Childhood obesity	<ul style="list-style-type: none"> Obesity among primary school age children in Yr 6 	<ul style="list-style-type: none"> Childhood obesity rates 	<ul style="list-style-type: none"> Childhood obesity
Reducing alcohol related admissions	<ul style="list-style-type: none"> Alcohol harm related hospital admission 		

3.9 Insights from patients, public, clinicians and local partners

Commentary

Involvement of key stakeholders in the core functions of NHS Barking and Dagenham is a fundamental aspect of delivering both world class commissioning (WCC) and Healthcare for London (HfL).

The organisation's model of engagement and insight from key partners is in line with Healthcare for London and we are building on a robust baseline to develop adequate consultation and engagement forums to take forward the evolving models from Healthcare for London.

NHS Barking and Dagenham has already established a good baseline for engagement which will be developed further over 2009/10. We recognise that national patient experience surveys have seen poor historical performance but this is not reflected in more contemporaneous surveys and feedback.

Engagement with Patients and the Public

NHS Barking and Dagenham has an established Community Empowerment team which incorporates Patient Advice and Liaison Service (PALS) and Public and Patient Involvement (PPI), and links closely with corporate communications. There is an established Health Network of around 200 local residents and a developing Young People's Health Network. The network members are supported to take part in consultations and attend corporate meetings to inform commissioning and strategic decision making for example around the diabetes action plan, the role of health visitors and the Barking Hospital development.

NHS Barking and Dagenham has a quarterly community engagement magazine (Care to Say) which has a circulation of around 7,000 copies through community venues and health and social care settings. We would like to expand this circulation next year. Additionally the organisation has invested £35k in engagement with Children and Young People. This sum has funded a series of engagement events and a contribution to a local partnership youth focus magazine. The organisation is currently reviewing our web-presence and will be investing in redevelopment of the corporate site, alongside an expansion of topic specific health improvement sites following the initial success of 52Ways.nhs.uk and BADHealth.nhs.uk.

In 2007/08 NHS Barking and Dagenham established a Patient Experience Group and Patient Experience Framework which brings together information on the patient experience, from a variety of sources, such as survey results, complaints, adverse incidents, PALS contacts, etc., to develop a more rounded understanding of patient experience, and identify key areas for action. This will be further supported by the migration of this information into a single database framework (Datix) by March 2009.

Regular consultation with the Health Network alongside regular community focus groups and engagement events allow us a cycle of consultation with the public.

Engagement with Clinicians

In line with the National Service Frameworks (NSFs), NHS Barking and Dagenham established a series of Local Implementation Teams (LIT), bringing together clinicians and commissioning partners to focus on areas such as mental health, diabetes, coronary heart disease. In addition to the LIT structures the organisation has been an active partner in the Cancer Network and Cardiac Network, which involves clinicians in shaping the overall approach to these two disease areas. These have had varying levels of success due to capacity and clinical engagement.

In 2008, NHS Barking and Dagenham worked closely with maternity clinicians around the Royal College of Obstetricians and Gynaecologists (RCOG) report, and supported the development of the local Maternity Services Liaison Committee in partnership with the neighbouring primary care organisations.

NHS Barking and Dagenham plans to create a more structured approach to LIT's with some additional commissioning capacity to support their delivery and work with local partners to reduce

replication and demands on clinicians while maximising the local focus of the work. The organisation also plans to work with partners to refresh the Children and Young People's Network and develop the Strategic Maternity Partnership Board to ensure these areas get adequate development and resource.

Engagement with Local Partners

NHS Barking and Dagenham acts as the lead commissioner for Barking, Havering and Redbridge acute trust, on behalf of two other primary care organisations in the sector. The organisation has a long history of close working relationships with the local authority, and has a well established Children's Trust leading the work across agencies towards the implementation of 'Every Child matters'. Similarly, there is now a newly established Healthier Communities Board which is managing the part of the Local Area Agreement entitled 'Active and Healthy'. This again picks up the health inequalities agenda and focuses on the broader determinants of health, improving life expectancy and reducing long term conditions. NHS Barking and Dagenham is an active member across the local strategic partnership board and is represented at a strategic level on the Partnership Board and subgroups.

The local engagement is strengthened by a series of joint appointments, including a joint Director of Health Improvement and Head of Mental Health Services role. The organisation plans to further develop joint working over 2009/10, particularly in relation to children's commissioning.

NHS Barking and Dagenham is a key partner in the local LINKS network development and is represented on the steering group, and works in partnership with the local authority around consultation surveys such as the PLACE survey and TellUs Surveys. The organisation has a strong community empowerment team which sits within the health improvement directorate, this team works closely with the communications team.

Collaborative Working

As we move forward with strategic commissioning it is important that we reflect on how best to maximise the partnership gains to working across boundaries through the Networks and Clinical engagement frameworks. To this end we have approached local primary care organisations about refreshing the Children and Young People's Network and resourcing the Strategic Maternity Partnership Board.

3.10 Financial situation

Commentary

Financial Plan 2009/10 to 2112/13

The financial plan covers the financial years 2009/10 to 2112/2113. It is predicated on the assumptions issued by NHS London on 30 October 2008 (Appendix 1). Service developments are consistent with principals set out in previous documents/plans, with refinements being made for outturn performance and updated Healthcare for London assumptions.

In summary the position is as follows:

	2009/10	2010/11	2011/12	2012/13
	£m	£m	£m	£m
Income	323.2	326.1	331.2	343.9
Expenditure	313.8	323.9	329.3	340.9

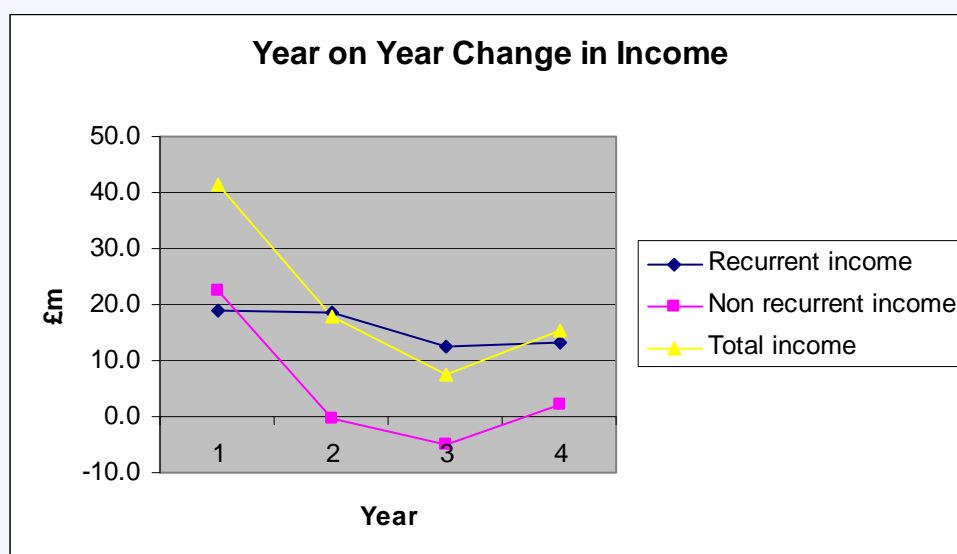
Surplus	9.4	2.2	1.9	3.0
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Income levels

Recurrent income is based on flat rate % increases as per **Appendix 1**. At this stage, no increase in funding has been built-in for population increases over the period (the material increases in population are anticipated post 2012/13). In addition, increased recurrent funding has been assumed for additional GP practices at Barking Town Centre, Porters Avenue and Barking Hospital in line with previous notifications.

Non recurrent income is based on the return of previous years surpluses and lodgements (but not previous years top-slices). The impact of non recurrent income reduces over the period of the plan. It is phased in to match the development of the local infrastructure over this period of time.

The graph below demonstrates the profile of assumed funding level changes year on year.



Expenditure levels

Appendix 2 provides a summary of the revenue and capital investment plan. It also indicates investments targeted to Healthcare for London and Thames Gateway.

At this point, provisional figures have been used for the Maternity and Trauma HfL initiatives. This will be updated over coming weeks. They are currently phased in on the same basis as the stroke figures which have been released.

The table below shows the population assumptions used to drive activity projections and resulting costs.

	Year 0 (Baseline)	Year 1	Year 2	Year 3	Year 4	Year 5
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Population segment						

Population ('000)	172,903	175,360	177,818	180,275	182,733	186388
Growth pa (%)	1.4	1.4	1.4	1.4	1.4	2.0

The material increases in population are anticipated post 2012/13, however the plan includes a number of infrastructure developments (as highlighted in Appendix 2), that are required to start in advance of this increase.

In order to remain within required surplus levels the current plan has been re-presented with a number of initiatives having to be deferred to fund the required 1% pan London Investment Fund levy in 2009/10 and 2010/11. The consequences of this will need further review in the context of the overall economic position and its impact on Thames Gateway (see also MTFs below).

Spend per setting

Outpatients (Total Attendances)

Setting	Actual 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
Major Acute or DGH	14,151	14,933	14,118	13,142	11,561	10,327
Other	-	-	-	-	-	-
Total	14,151	14,933	14,118	13,142	11,561	10,327

Non Elective Spells

Setting	Actual 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
Major Acute or DGH	32,748	35,361	35,946	36,527	36,514	36,499
Other	-	-	-	-	-	-
Total	32,748	35,361	35,946	36,527	36,514	36,499

Elective Spells

Setting	Actual 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
Major Acute or DGH	13,427	16,304	14,970	15,584	15,985	16,377
Other	1,818	2,123	2,726	3,498	4,425	5,579
Total	15,245	18,427	17,696	19,082	20,410	21,956

Other (e.g. Ward Attenders, excess bed days)

Setting	Actual 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
Major Acute	39,180	43,127	54,635	59,422	62,320	63,650

or DGH						
Other	2,686	3,177	2,744	2,122	1,256	157

Total

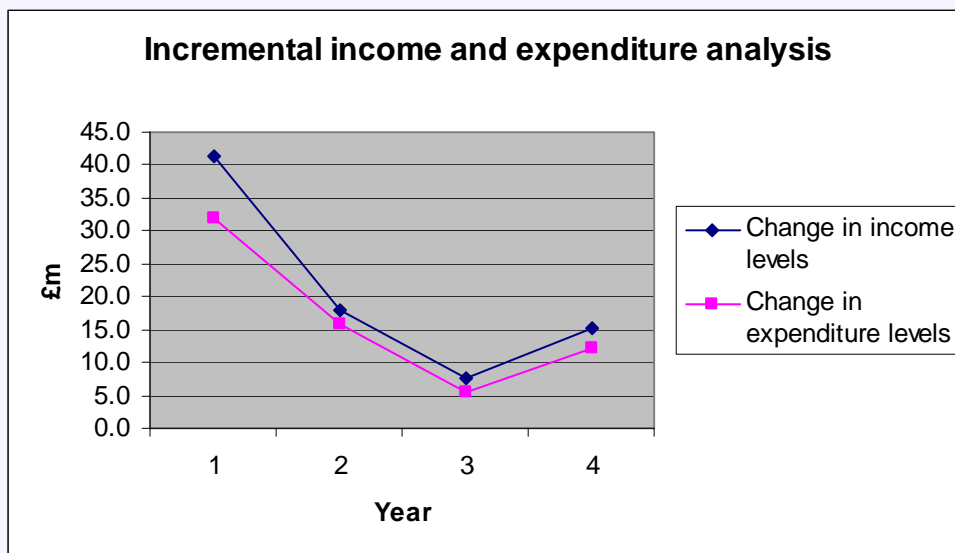
Setting	Actual 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
Major Acute or DGH	99,506	109,725	119,669	124,675	126,380	126,853
Other	4,504	5,300	5,470	5,620	5,681	5,736
Total	104,010	115,025	125,139	130,295	132,061	132,589

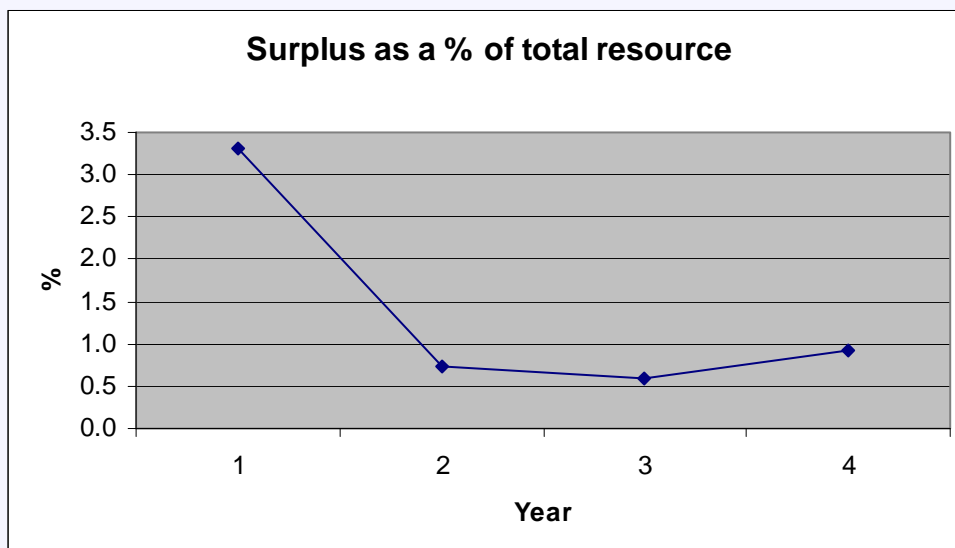
Capital programme

As agreed with NHS London (through the regular Performance meetings), the organisation will require the return of previous years under spends on capital to part fund the Barking Hospital site development (£4m).

Surplus levels

Plans are based on the PCT delivering surpluses of circa 0.8% of the recurrent resource limit over the next three years. This is represented in the graphs below.





Medium Term Financial Strategy (MTFS)

As stated above the current plan includes an assumption of a 1% levy for pan London investment. At this point NHS Barking and Dagenham's Board has not agreed to this and will need to consider the impact of deferring essential infrastructure developments. The PCT will need to reconsider its plan in the context of the ongoing local discussions on MTFS and the national position as soon as allocations and tariffs are announced.

Scenario mapping

A scenario mapping exercise has been undertaken to look at the impact a decrease of 1% would have in terms of out of hospital care and primary care access programmes.

Review of Risks

The plan is based on a series of assumptions. There are more unknowns in the system than normal and this is obviously increasing the level of risk within the plan. Key risks have been described and quantified within the WCC Financial Templates.

The impact of the assumed levy has significantly impacted on non recurrent income (through reducing the amount of surplus to be carried forward). In 2011/12 incremental income is limited. The current plan assumes investment through 2009/10 and 2011/12 will enable this, but further detailed review is required.

ALE/Use of Resources

The PCT scores to date have been:

2006/7 Excellent

2007/8 Good

Auditors felt that the standard of financial reporting had fallen as a result of the transfer to the Shared Business Service (SBS) during 2007/8 and this impacted on the overall score. The PCT has subsequently brought elements of financial reporting back in house to restore reporting to its previously high standard.

3.11 NHS Barking and Dagenham internal capabilities

Commentary

Organisation capability strengths

NHS Barking and Dagenham has broad strength across the organisation, with good clinical leadership and engagement coupled with sound management across the piece. The organisation has made significant progress in the last few years to address real deficits in primary care services. NHS Barking and Dagenham has a track record of achieving its financial duties, consistently met most of the top national priority targets, rated highly under the ALE review and 'Good' for use of resources under the Healthcare Commission assessment in 2007/08. The cancer waiting times were consistently met month-on-month and our performance relating to patient choice has been one of the strongest in London. For the first time last year, the organisation met its smoking cessation target, due to a range of focused initiatives. The targets relating to the maximum referral to-treatment time for patients (18 weeks) and the maximum wait in Accident and Emergency Departments (4 hours from arrival to discharge or admittance) were not been met in 2007/08, and the organisation continues to work closely with the local hospital trust on both issues.

NHS Barking and Dagenham has the dual advantage of being not only one of the major employers within the borough, but also one of the leading organisations driving change within the borough. An area of organisational strength has been identified in working with community partners to commission services. Both at strategic and operational level, NHS Barking and Dagenham has built a reputation as an active and effective partner, and this has made it possible for the trust to commission and deliver ambitious health objectives. The organisation works closely with the borough to identify and assess needs, define and refine service specifications and develop truly fit-for-purpose services.

NHS Barking and Dagenham has a robust strategy in place with a series of targeted initiatives for building meaningful engagement with the public and patients to shape services in a truly-consensual manner. The organisation operates a Health Network of over 150 people who are regularly consulted on local health issues. We also engage a 'Readers' Panel' of local people who regularly review and feedback on the literature and other collateral we produce. In addition to this, and for the purpose of improving patient experience of our services, a Patient Experience Group was recently established and a patient representative now sits on the Commissioning Strategy Plan Steering Group.

The organisation has a meaningful relationship with local clinicians and they are – and feel – genuinely engaged in both strategic and operational planning activities. An initiative includes running the Secondary Care Clinical Engagement programme, which facilitates our GPs to undertake joint ward rounds with consultants in participating hospitals. This initiative informs service re-design, results in shorter hospital stays and, ultimately, a far-better understanding of patient needs in primary care.

A key strength of the organisation is in identifying current needs and anticipating future trends. This is particularly important as it will ensure that commissioned services effectively address and efficiently respond to the needs of the local population. This position of strength is evidenced by the fact that NHS Barking and Dagenham is heading-up a group of five Primary Care organisations in the North East London sector to determine the needs assessments for palliative care. Also, NHS Barking and Dagenham is working with the Local Ethnic Minority Partnership Agency, and has recently carried out a targeted healthcare needs assessment with this Agency. We believe that these facts provide strong evidence that NHS Barking and Dagenham's Commissioning Directorate has the analytical and understanding of health needs expertise required for the new commissioning regime.

NHS Barking and Dagenham was the first PCT in the country to procure an APMS practice on the open market and the trust is currently on its third GP practice tendering process. The organisation is

proud to be widely-regarded as a leading light in accessing alternative markets for the provision of GP services. The organisation also achieved sustained improvement in efficiency by market testing for Clinical Assessment Treatment Services through open tender for two new premises.

The leadership of the Trust has embraced a continuous improvement culture and both the Board and management team regularly promote the need for continuous improvement. At the operational level, there is a solid and sober appreciation of the strengths and weaknesses of all our current services and this is regularly factored-into commissioning planning and evaluation processes.

Commentary

Organisation capability gaps

One of the key gaps identified through the self assessment process under world class commissioning is to build on commissioning skills to make effective commissioning decisions for the population. This includes further developing skills to ensure excellent procurement and contracting processes, the specification of quality standards and outcomes, facilitation of good working relationships with providers, offering protection to service users and ensuring value for money. The organisation will also be building its knowledge base to better understand market intelligence expertise to undertake and analyse provider data, economics, capacities, capabilities and outcomes.

To do this we need to build on strong performance management frameworks to drive change and to enable performance monitoring information to be cascaded to every level of staff within the organisation, whilst ensuring a clear framework to support provider monitoring.

In order to ensure the future needs of the population are met, NHS Barking and Dagenham will be reviewing current needs assessment and ensuring processes are strengthened in order to fully understand the current and future local population's health and well-being needs, especially relating to relative inequalities in health outcomes and experience. This includes improving our skills in benchmarking services to peers in cluster, London and similar ONS organisations.

Whilst the organisation strongly engages the community in service development, work is on-going to ensure that the patient, public and the community is at the heart and involved in all our commissioning plans and processes. The organisation will work hard to ensure continuous involvement of the local community into the commissioning cycle to drive further change and reconfiguration and deliver world class quality and outcomes.

To ensure we keep staff, patients and the community engaged, the organisation will review its communication processes so that the organisation's vision and goals are fully embedded at all levels in the organisation. This will enable us to respond and cascade information on decisions made at a senior level to individual staff, improve interaction and engagement with the population in developing and promoting local health services, and developing clear processes for staff to engage in decision making processes.

3.12 Market Management

Commentary

NHS Barking and Dagenham has a track record of broadening the provider landscape through a proactive approach to service procurement, in a number of settings. It believes that the challenges within the local economy, coupled with the vision for a vibrant borough with the Thames Gateway development, will be attractive to new market entrants as well as existing providers with the drive to

provide high quality services in the future.

NHS Barking and Dagenham is already developing its procurement processes to match the demands of the new approaches to market management in a number of different areas, and in accordance with the *Principles and rules for co-operation and competition*. Early successes in this approach, and the way that existing providers have responded to the challenges arising from new market entrants have been very encouraging, and the organisation wishes to maximise the potential benefits that this initiative can realise, including:

- Driving up the quality of existing providers;
- Introducing new, innovative providers into the health economy;
- Providing a transparent approach to procurement;
- Allowing new and existing providers to diversify, thus bringing their skills and expertise into new services;
- Economies of skill and scope by allowing the vertical integration of providers into new services, or through the alliances between different providers from a variety of backgrounds.

It is recognised that providers cannot work in isolation when the service they provide form only part of a patient's care pathway, and thus NHS Barking and Dagenham must ensure that the inter-dependencies with other providers in the system are both acknowledged and developed, to ensure that the patient pathway runs as smoothly as possible. This is a key element to the development of a successful polyclinic, which may house several services run by a multiplicity of providers.

NHS Barking and Dagenham's commissioning focus is moving away from defining specifications and inputs to the care pathway, to a focus on outcomes through various aspects of the care pathway. The Map of Medicine is a key vehicle to deliver this and it is believed that the procurement processes outlined above, combined with this focus on outcome commissioning of services, will lead to a more integrated approach to care pathway management underpinned by sound clinical engagement.

NHS Barking and Dagenham has already undertaken a number of procurements in keeping with this approach:-

Primary care

NHS Barking and Dagenham was the first in the country to successfully procure an APMS contract for GP services through a national tendering exercise. This is now being extended, with three national procurements for general practices operating out of new sites across the borough of Barking and Dagenham, with two commencing service in December 2008 and January 2009.

Community services

One of the tenders outlined above includes the option to bid to manage the Walk in Centre currently run by the organisation's Provider Arm. This will complement the route by which the management of the Broad Street Walk in Centre was determined. NHS Barking and Dagenham recently tendered and awarded the contract for the provision of an integrated sexual health service, combining community and acute services under one management. All new community services will be procured following national procurement guidance and the organisation's corporate governance framework, and will include specialist services such as the CVD technicians' service, aimed at identifying patients at risk of CVD.

Acute services

During 2007/8, NHS Barking and Dagenham procured a Clinical Assessment and Treatment Service (CATS), providing outpatient services for Gynaecology, Urology, Dermatology, ENT and headache clinics. These services, along with the musculoskeletal service, provide alternatives to traditional outpatient services, by offering clinics within the community setting, run by a variety of providers. These services are seen as a fore-runner to the polyclinic/health centre services that will be developed in the future within Barking and Dagenham

Other new market entrants include the North East London Treatment Centre, which provides

treatment for uncomplicated procedures in variety of specialties, and the Independent Sector Diagnostic Centre (ISDC), which has provided significant support to NHS Barking and Dagenham in reducing waiting times for diagnostic tests. During the next year, the wave two Independent Sector (IS) elective scheme will commence, providing a range of services in NE London, including:

- Acute home care - early discharge;
- Stroke - early discharge;
- Sexual Health;
- Renal services;
- Home Chemotherapy.

NHS Barking and Dagenham implemented "Free Choice" for acute services in April 2008, with patterns of GP referrals now extending to local independent sector providers. GPs in Barking and Dagenham are amongst the largest referrers through free choice in London.

This will provide a level of competition for both acute and community providers within the area.

Voluntary / third sector commissioning

NHS Barking and Dagenham has a history of working closely with the voluntary/third sector to provide a range of services. This applies not only to traditional service areas such as palliative care/hospice services, but in other areas such as the low vision service, and the organisation's transport service. More recently, the organisation established a challenge fund, and funded staff to help the voluntary sector to prepare bids for this fund, which aims to encourage third sector engagement in the delivery of health services in the Borough. This is seen as an exciting initiative which will help sustain the important work that voluntary groups do to support the community, and will also provide NHS Barking and Dagenham with another vehicle for relaying important messages to the wider public.

4 Strategy

4.1 NHS Barking and Dagenham's Objectives

Commentary

In Section 2.1 we introduced our objectives, which are to:

- **Improve the health and life chances of the population of Barking and Dagenham through a programme of health promotion;**
- **Protect the health of the people of Barking and Dagenham (statutory public health duties);**
- **Strengthen the primary and community infrastructure and service so that people have access to and choice over high quality, responsive and proactive local services wherever possible. This would cover those with long term conditions, urgent care and longer term health service support;**
- **Ensure that people needing access to secondary care consultations and diagnostics, in-patient or day case care have access to high quality services based locally wherever possible.**

They provide us with one of the building blocks on which our strategy is built and to influence how we prioritise our initiatives. These also link to our core values which are discussed in section 4.2.

4.2 NHS Barking and Dagenham's core values

Commentary

The two strands of health inequalities and health access together have set the direction for NHS Barking and Dagenham. The core values are the foundation for the way the organisation seeks to address these issues.

The '**ACQUIRES**' philosophy was agreed following discussion with the Board, the Professional Executive Committee (PEC), the Practice Based Commissioning (PBC) leads, and the Health Scrutiny Panel. It brings together the goals, principles and the values of NHS Barking and Dagenham.

It shows that the population of Barking and Dagenham will have:

- **easily understood and accessible services that address their health needs (Access);**
- **a wide range of integrated services in the community to reduce the necessity of hospital attendances (Community);**
- **high quality services to improve the health and well-being of all our community (Quality);**
- **health improvement services designed to reduce health inequalities in the health of our population now and in the future, i.e. both adults and children (Inequalities);**
- **confidence that NHS resources are targeted to achieve best value (Resources);**
- **services which have been designed using their experience and the input of local clinicians (Experience);**
- **services which have proper levels of qualified and skilled staff, in a welcoming and**

appropriate environment (Staff).

More specifically over the next five years we expect to:

Access

- Maximise the services being provided locally within the Borough particularly for those with long term conditions. This includes improving access to primary care services, and ensuring access to secondary or more specialised services wherever possible from Barking Hospital and our new Health Centres, instead of from acute hospitals. It also includes ensuring that there is a health improvement programme focused on local health issues, and presented in a way that engages the population;
- Promote services which are accessible at times particularly valued by patients needing the service, and which are culturally sensitive. In particular extended hours for general practice and access to unscheduled care (including mental health) within the borough, access 24/7 at the Barking Hospital Urgent Care Centre, and easy access to sexual health services;
- Meet the national 18 week wait target and expect continuous improvement in waits for all our services, through ensuring adequate capacity and efficient systems;
- Provide well-targeted, locally accessible and high quality services which are focused on helping children and young people meet the five outcomes set out in 'Every Child matters'.

Community

- Adopt principles of high technology specialist care for the few, generalist care for many and self-care for most. This will be supported by more community based support thus ensuring that hospital attendance and admission is a last resort. This is particularly relevant to those with long term conditions such as cardio-vascular disease and chronic lung disease;
- Ensure that those services provided in community settings for both medical and mental health are integrated with parallel services provided by social care;
- Plan for the new population in the Thames Gateway area in a way that strengthens the partnership with the local authority/other partners and reflects the public health information we have;
- Provide strong support for children who have extra needs, giving particular attention to identifying and supporting children with complex needs and those who are most at risk from harm.

Quality

- Ensure that all its providers can demonstrate adherence to agreed standards of service delivery;
- Work closely with its providers to ensure that service developments are integrated with other services, are part of wider health economy planning with agreed user involvement, and consistent with a shared view of service strategy for the population;
- Ensure that the services it commissions meet at least minimum annual procedure or diagnosis volumes per clinician in line with government guidelines, and is underpinned by robust audit programs that identifies inconsistencies in performance;

Inequalities

- Actively address local health inequality issues in the existing population through specific targeted programmes that cover primary, secondary and tertiary prevention. These should particularly address long term conditions, lifestyle issues contributing to poor health,

cancers and sexual health;

- Ensure easiest access for those with the greatest need to achieve increasing equality of health outcomes, in particular life expectancy;
- Require service providers to demonstrate that they are targeting hard to reach groups e.g. those with TB;
- Support a shift in the balance of spending from treatment to prevention, especially in relation to obesity, smoking and sexual health.

Resources

- Actively commission services where there is a clear demonstrable evidence base of improved clinical outcomes;
- Achieve best value for money by adopting intelligent, needs led commissioning principles, ensuring a locally driven process where appropriate, but engaging at all levels from pan-London to General Practice;
- Encourage a wide range of providers from within and outside the NHS (including the third sector), in order to ensure best value;
- Ensure that patient care is improved through the use of electronic patient records which provide readily available and accurate clinical and management information;
- Optimise the use of our buildings to affect the shift of care from acute to community settings taking into account the requirements of Healthcare for London.

Experience

- Use external information e.g. Healthcare Commission reviews and Dr Foster analyses to strengthen decision-making;
- Ensure that actions and plans of the organisation is supported by active engagement with service users and members of the community, including engagement with children, young people and their families;
- Require services to demonstrate ongoing systematic capture and use of meaningful quantitative and qualitative patient feedback by clinical and management teams, and provide NHS Barking and Dagenham with regular management information on such exercises;
- Encourage services where constructive learning relationships and dialogue with clinicians encourages openness to improvement and change;
- See an improvement in patient survey results.

Staff

- Actively manage the development of the workforce and support them in acquiring skills appropriate for new ways of working;
- Actively support the skills and culture shift towards more nurse and therapist led service provision;
- Ensure staff are trained to be culturally sensitive, so that they are aware of, and can respond to, the needs of different communities.

4.3 Rationale for Chosen Initiatives

Commentary

The starting point for selecting our initiatives is based on:

- Our vision (highlighted in Section 2)
- Our objectives and core values (highlighted in Section 4.1 and 4.2)
- Our knowledge of our local population, their health needs and the current models of care (as detailed in Context sections 3.1 to 3.3)
- How we are performing against existing targets (section 3.5.1)
- Other priorities, such as World Class Commissioning and Joint Strategic Needs Analysis (sections 3.5.1 to 3.5.2 to 3.5.3)

We also wanted to focus attention on some longer as well as shorter term benefits, so we looked to develop initiatives that reflect the breadth of our objectives. Below is a matrix which sets out how the organisation is viewing each of the objectives:

Objective	Timeline
Health and life chances of the population of B&D	Medium and long term
Health Protection	Short, medium and long term
Strengthening primary/community health infrastructure	Short, and medium
Ensuring access to high quality secondary care	Short and medium term

Based on these criteria we identified a range of possible initiatives associated with these objectives, and prioritised them against the following:

Barking and Dagenham Criteria

- Does this initiative address a key health issue for the population of B&D?
- Will this initiative impact on the health inequalities in B&D?
- Will this initiative impact on the population's ability to access good quality health services?

NHS London criteria

- Will this initiative support getting the Health Economy back into financial balance through more efficient use of primary care and secondary services?
- Is this initiative consistent with 'Care Closer to Home'?
- Is there an evidence base to support likely impact on health outcomes?
- Is this affordable?
- Is this deliverable?

Healthcare for London Priorities

- Will this improve the health of people from deprived communities?
- Will this help to prevent ill health?
- Will this help specific groups, such as the newly born, children, young people etc?
- Will this focus on long term conditions or end of life care?

In order to achieve our objectives we need to be able to fundamentally change the architecture of service delivery and identify specific initiatives that are focussed on the health needs of our

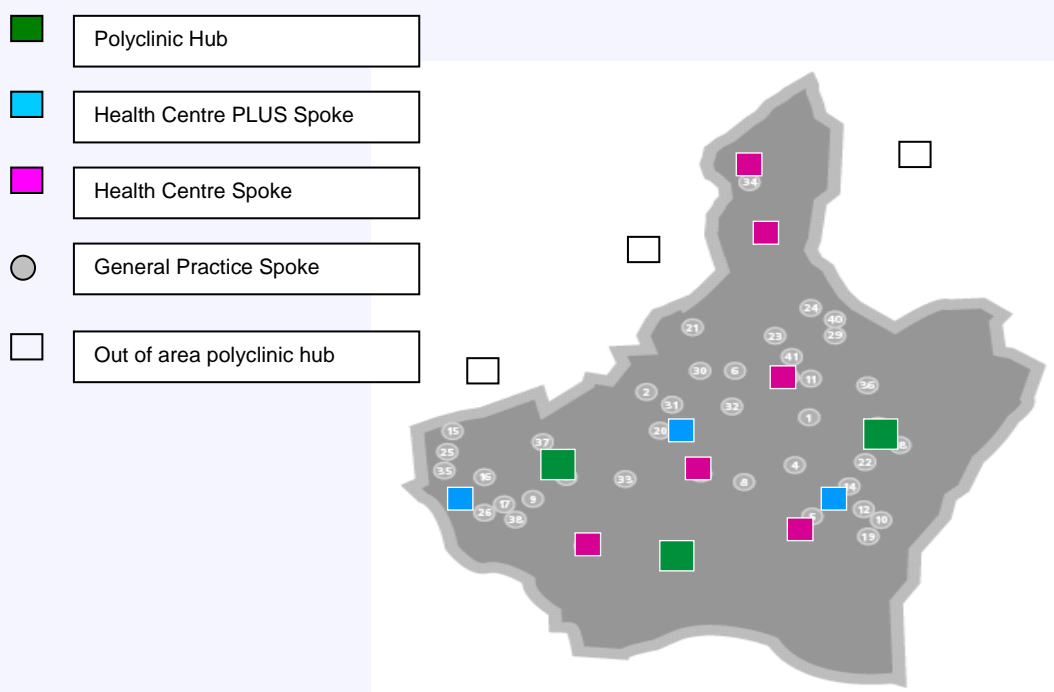
population. The following four sections encompass how this change will be delivered.

4.4 Primary and Community Services Strategy including Polyclinic Model

Commentary

The Primary and Community Services Strategy sets the context and direction of travel for primary and community care services. The full strategy is attached to this plan at Appendix 2 and two key sections are summarised here – the NHS Barking and Dagenham Polyclinic model and the Blueprint for Service Delivery.

NHS Barking and Dagenham Polyclinic Model



Please note: More detailed map showing defined localities and roads commissioned for final public facing consultation document.

The polyclinic vision in Barking and Dagenham is based on providing quality assured services from appropriate and accessible locations, at times which are convenient to patients.

A federated polyclinic model has been adopted with polyclinic hubs housing a full range of polyclinic services with spokes to other polyclinics centres, health centres, community services (e.g. general practices, pharmacies, rapid response team, and intermediate care facility) and the patient's home.

The services designated in each facility have been based on the critical mass required to secure the greatest quality of care, value for money and accessibility. Each polyclinic hub therefore, has a core service offering include a general practice for residents in the immediate locality, alongside a range of more specialist services for borough-wide and cross-borough populations.

A network of new and renovated, purpose-built health centres procured through the LIFT programme will link into three planned polyclinic hubs at Barking Hospital, Barking Riverside and East Dagenham.

Polyclinic Hubs	Health Centre PLUS Spokes	Health Centre Spokes	General Practice Spokes
Barking Hospital Barking Riverside East Dagenham	Broad Street Barking Town Centre Porters Avenue	Thames View Grey's Court Church Elm Lane Vicarage Fields Marks Gate	All general practices in Barking and Dagenham.
New developments opening over next 3 years	All in place or opening in 08/09	Currently in place with further centres proposed at Jullia Engwell and Goresbrook	Transitioning towards a model of general practice spokes with a minimum list size of 4,000 patients

The table below demonstrates which health centres are aligned with which polyclinics for the defined borough wards:

A	Barking Hospital Polyclinic		Borough Wards: Parsloes / Mayesbrook / Longbridge / Abbey / Eastbury / Barking / Gascoigne / Becontree / Valence
	Porter's Avenue	Health Centre PLUS	
	Barking Town Centre	Health Centre PLUS	
	Julia Engwell	Health Centre	
B	Barking Riverside Polyclinic		Borough Wards: Barking Riverside / Creekmouth /
	Thamesview	Health Centre	
C	East Dagenham Polyclinic		Borough Wards: South Dagenham / Goresbrook / Village / Eastbrook / Albion / Heath
	Broad Street Medical Centre	Health Centre PLUS	
	Five Elms	Health Centre	
	Church Elm Lane	Health Centre	
D	Residents more likely to access Redbridge or Havering polyclinics		Borough Wards: Whalebone / Chadwell / Marks Gate
	Marks Gate	Health Centre	
	Chadwell Heath	Health Centre	

Barking Hospital Polyclinic Hub

Building work on the Barking Hospital has already commenced and this polyclinic hub is due to open 2009/10.

Barking Riverside Polyclinic Hub

NHS Barking and Dagenham has initiated premises planning on a brownfield site for the Barking Riverside polyclinic hub. This provides an opportunity to develop a hub that incorporates the full range of polyclinic services, housing a general practice for an estimate new population of 30,000. At the moment the timescales for this development are unclear because the wider development is dependent on there being an extension to the DLR. However we are planning on the basis that the building is ready for service commencement in 2013.

East Dagenham Polyclinic Hub

NHS Barking and Dagenham is currently undertaking needs assessment and planning for a third polyclinic hub site in East Dagenham. This will house the full

range of polyclinic services with a specific focus on health and well being services and moving towards an integrated organisation model. It is envisaged that the WIC at Broad Street will be transitioned towards a GP-led Health Centre model to be based at the more accessible location of the East Dagenham Polyclinic Hub. Work on this hub is beginning, and we are planning on the basis that this build will be ready for occupation in late 2011.

The timetable of this earlier development is subject to the finalisation of the detailed financial plan for 2009/10 following the confirmation of acute contract costs.

Together these new facilities will provide an environment in which the HfL vision for services can be developed in Barking and Dagenham. All service providers in the polyclinic hubs will take advantage of their co-location to deliver a joined-up approach to care and seamless service for the patient.

Capital investment in primary care premises will continue to ensure that patients registered in polyclinic hubs or at spoke sites will receive care from modern facilities with capacity to house multidisciplinary teams and the widest range of general practice core and enhanced services.

Barking and Dagenham is a relative small London Borough with a population of roughly 170,000. Whilst the polyclinic hubs planned can be align relatively neatly to most wards and localities, the shape of Borough is such that a number of residents may seek access to services in neighbouring boroughs. Barking and Dagenham residents may choose to access services from polyclinic hubs at King George's Hospital and Loxford in Redbridge. Likewise residents may choose to access urgent care, outpatient and diagnostic services from the Queens Hospital site in Havering.

For example, in the most northern Marks Gate area residents are likely to seek access to a Redbridge based polyclinic at the King George site via the A12 in preference to attending polyclinic hubs in the immediate borough. Options for transport, registration and service access will need to be agreed with Redbridge in this instance. There is also a large health centre at Marks Gate which will be a key point of access to a wide range of health services in the immediate locality.

Blueprint for Service Planning

NHS Barking and Dagenham's approach to primary and community care commissioning will aim to deliver for the Barking and Dagenham population:

Motivation and support to stay healthy;

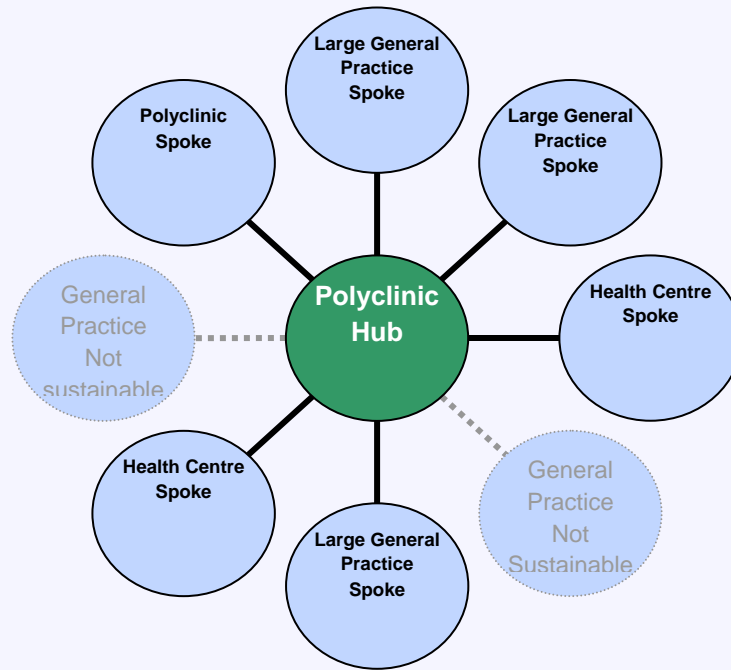
- Empowered patients;
- Personalised services;
- Integrated & 'one-stop' care models;
- Improved access to care;

- Quality assured services.

NHS Barking and Dagenham has identified a range of care settings for primary and community care services consistent with local authority locality planning model.

Setting	Range Of Services (Illustrative Only)
Accessible anywhere 24/7 by phone / email / online	Single point of access for all primary and community services, NHS Direct, order repeat prescriptions, collect routine test results, your health profile, online GP, appointment booking.
Available in your home	24/7 rapid response, unique care, telehealth monitoring devices, district nursing/ community midwifery / health visiting, GP home visits, end of life care
Located in every borough locality	GP practice (inc. enhanced services for LTC's and diagnostics), dental practice, optometrist, community pharmacy (inc. Pharmacy First services), children's centres, counselling and talking therapies, expert patients programme, smoking cessation groups, health promotion in schools, community empowerment team : inc. Health trainers.
Located in every polyclinic hub	Full range of polyclinic services. For example, GP practice, outpatient clinics, full range of diagnostics, (e.g. phlebotomy, minor surgery, x-ray), support for long term conditions, unplanned and urgent care services, community services, health and social care advice and resources.

Each federated polyclinic is aligned to specific borough wards for common services providing a basis for connecting dental, pharmacy, optometry services and for aligning and integrating other community services. The network will also provide an area focus within which general practice providers can develop collaborative working arrangements to provide a more comprehensive range of extended primary care services.



a

In addition to the core offering of services in each federated polyclinic network, number of more specialised

services (some of which are catering for a number of London Borough's) are planned for key sites:

More specialised services unique to specific sites

Barking:

At Barking Hospital (Hub) – Urgent care centre, maternity/birthing unit, sexual health services

At Barking Town Centre (Spoke) – specialist centre for children and women

At Porters Avenue Centre (Spoke) – specialist centre for long term conditions

Riverside:

At Barking Riverside – **full polyclinic specification**

Dagenham:

At East Dagenham Polyclinic (Hub) – GP-led health centre , specialist teams for respiratory, heart failure and diabetes, and CATS at Broad Street (Spoke) or on site.

At Grey's Court – Intermediate Care Facility

4.5 Provider Arm Strategy

NHS Barking and Dagenham has a signed Service Level Agreement (SLA) with its provider arm for 2008/09 setting out service specifications, activity baselines and key performance indicators for quality achievement. Formal SLA reviews are held on a monthly basis.

The PCT is working towards formal separation of the Commissioning and Provider Arm by April 2009. In August 2008, NHS Barking and Dagenham commissioned an option's appraisal on the future of its provider services. This was set in the context of the development of World Class Commissioning (WCC) and the 2008/09 Operating Framework and the Co-operation and Competition Framework. The work undertaken explored a range of alternative management and governance structures for the future development of provider arm services, which resulted in three options for Board consideration in December 2009:

- To build an Arms Length Provider Organisation (APO);
- Immediate open-market divestment;
- Immediate transition to a local NHS organisation and market testing in 2 years time.

The Board agree the final option, and the provider arm will transfer to North East London Foundation Trust on 1 April 2009 for a period of 2 years.

Service Developments

In 2008/09 developments in

In 2008/09 developments in community and intermediate care include:-

- The development of a school advisor service, providing comprehensive health advice and support for children of school age;
- The establishment of a stroke rehabilitation service at Grays Court;
- The provision of HPV vaccine to all 13 year old girls;
- The recruitment of salaried GPs to back fill the current establishment of GPs to provide support for urgent care services.

The major weaknesses associated with the commissioning of provider services is the small level of competition, the governance issues associated with commissioning of an internal service and the concerns over the long term future of the provider arm in its current state. Against this, NHS Barking and Dagenham is now undertaking a more rigorous approach to the commissioning of services in line with the national procurement guidance, and there are more providers entering the market to stimulate competition. There is a healthy tension that exists between the commissioning and the provider functions within the organisation that promotes good commissioning outcomes, and the provider arm has a flexible approach to the delivery of services.

In 2009/10, the new national contract will form the basis of the contract with the organisation's provider arm.

4.6 The Out of Hospital Agenda

Commentary

Out of Hospital Planning

NHS Barking and Dagenham is working with NHS Havering, Redbridge and Waltham Forest to develop a common set of care pathways that support the redesign of care across primary and

secondary care to shift work previously provided within the Acute Sector into a community setting where clinically and cost effective. These pathways are being developed in conjunction with Social Care across the four Boroughs and Acute Trusts.

NHS Barking and Dagenham will commission these services collaboratively with the other primary care organisations and Boroughs where this is most effective, and augment this with local service provision where appropriate. Service commissioned both collaboratively and locally will be designed to ensure consistent access and outcomes across Outer Northeast London.

Within this context, NHS Barking and Dagenham has established new out of hospital / community based services:

- Introducing a clinical assessment and treatment centre (CATS)
- Providing a full range of community based diagnostic services including x-ray and MRI

Strengthening Community Care Services

In recent years, NHS Barking and Dagenham has commissioned the following services to strengthen the range of community services aimed at preventing hospital admissions and supporting patients to manage their conditions within the community:

- Rapid Response and Unique Care Teams;
- Specialist teams for respiratory, heart failure and diabetes.

Primary and preventative services are also accessible in the community:

- Community based talking therapies service;
- Integrated community sexual health services;

In 2009/10 and beyond, NHS Barking and Dagenham will:

- Commission a single point of access for all primary and community services through Outer North East London (ONEL) out of hospital service development in 2009/10;
- Commission a home health care model pilot as an extension of the Rapid Response Team service;
- Utilising telemedicine and health training to support a patient's knowledge about their own condition to enable them to prevent deterioration, self-manage effectively, identify when it is worsening and respond;
- Provide additional assistance with self-medication by extending the use of medicines utilisation reviews in community settings and increasing uptake of this service in community pharmacy;
- Extend the condition specific expert patient programme to cover self management techniques for neurological conditions;
- Improve access to psychological therapies;
- Aim to enable 80% of patients to have the option to die at home in line with the Liverpool Care Pathway review for end of life care.

Improving Access to Primary Medical Services

The NHS Next Stage Review Interim Report (October 2007), reported that despite sustained investment and improvement in the NHS over the past ten years, access to primary medical care services and the quality of those services continues to vary significantly across the country.

The Department of Health ranks Barking and Dagenham 149th across the country (152 PCTs in total), in terms of having poor provision. This is using a weighted measure of numbers of primary care

clinicians (under-doctoring), health outcomes and patient satisfaction with GP access.

The Government will be providing new investment of £250 million, to support primary care organisations in establishing at least 100 new general practices in the 25% of organisations with the poorest provision, and one new GP-led health centre in each primary care organisation in easily accessible locations.

In order to deliver the above and support out of hospital care, NHS Barking and Dagenham will:

- Procure new medical services – including a competitive tender exercise for the procurement of three new 6-9000 list size APMS practices to be based within the new primary care hubs at Porters Avenue, Barking Town Centre and Barking Hospital;
- Extend opening hours – 90% of general practices now provide extended opening hours;
- Increase GP/Nurse workforce – recruitment of salaried GPs and recruitment of 2 new practices. In 2009/10 the organisation will be shifting the focus of attention to practice nursing levels and establishing additional initiatives to support an increased investment in this workforce;
- Improve detection and prevention strategies – extend opportunities for near point testing and health screening for early detection of conditions such as COPD, diabetes, CVD;
- Provider alternatives to a patients practice – nurse and GP-led walk-in centre services;
- In-hours access review – NHS Barking and Dagenham has commissioned an independent review of general practice accessibility in core GMS hours;
- Keeping patients informed of their choices – publish information to support patient choice when accessing health services including key quality metrics.

Urgent Care

NHS Barking and Dagenham currently provides 2 walk-in-centres from Broad Street (Dagenham) and Upney Lane (Barking). By the Autumn of 2009 the Walk-in-centre at Upney Lane will have migrated to Barking Hospital site.

4.7 Identifying Initiatives to support health improvement

Commentary

The eight initiatives below have been chosen with the intention that by taking these forward we will address the longer term as well as the short term issues. They represent a balance between longer term health improvement, medium term service redesign and short term access issues. All of them impact on the health inequalities and health service access agendas. They are of course the initiatives that the PCT sees as the most important, and will be progressed alongside a number of other initiatives.

They are also aligned with the Collaborative Commissioning Initiatives developed by primary care organisations across NE London. NHS Barking and Dagenham is committed to working with the other primary care organisations in NEL to ensure the structure and process of health care delivery continues to be actively developed across the sector to ensure accessible, high quality and efficient services are commissioned (and provided) to address the current and future needs of our growing population. The process of selecting priority areas for future collaboration has been informed by the organisations local priorities, guided by the Clinical Reference Group (CRG) and reviewed by the Collaborative Commissioning Group (CCG) in order to identify areas of pressing need, where opportunities to improve health care services can most effectively be delivered through closer collaboration.

In addition to the three sector collaborative commissioning initiatives agreed in 2007/08 which were Improving Stroke Services, the effective Commissioning of Tuberculosis (TB) Services and Care Outside Hospital (ONEL only), the NEL CCG earlier in 2008/09 supported the development of End of Life Care and the re-design of the acute provider landscape for inclusion in the shared commissioning plans from 2009 onwards.

NHS Barking and Dagenham is committed to working together to achieve significant improvement in the delivery of services and will through our CSP and our emerging 2009/10 Operating Plan, support the emerging care pathways and contribute where necessary to enable the initiatives to be developed both locally and across NEL, so that patients can readily access a high quality, responsive and cost effective service which assists the organisation to address the health inequalities already discussed within this document.

The initiatives are therefore:

Initiative	Title	Explanation
1	Healthy Children, Healthy Futures (a comprehensive approach to Children's health and wellbeing which reflects 'Every Child Matters')	<ul style="list-style-type: none"> ○ General parenting support programme ○ Specific initial programmes covering: <ul style="list-style-type: none"> • childhood obesity • smoking in under 18's • young people's sexual health • childhood immunisation ○ Other CYPP priorities: <ul style="list-style-type: none"> • Child and Adolescent Mental Health • Children living with disabilities
2	Healthy Adults, Healthy Choices (a comprehensive approach to Adults' health and wellbeing)	<ul style="list-style-type: none"> ○ Prevention of Cardiovascular Disease and Cancer including a revision of smoking cessation programmes, and the development of a Health Trainers programme ○ Adult obesity programmes targeting young adults, mid-life adults and older people ○ Secondary Prevention of those with established long term conditions ○ Adult mental health – with a focus on prevention and early intervention ○ Reducing Inequalities in income and debt
3	Long Term Conditions and Unique Care	<ol style="list-style-type: none"> 2 Strengthening the primary care role in managing LTCs through new guidelines and algorithms, community services and patient self-management 3 The development of the LTC care pathways through case management 4 Maximising health promotion opportunities at every clinical encounter

		<p>5 The development of rapid response community services, working through a single point of access</p> <p>6 Step up/step down and intermediate care beds in the community</p> <p>7 Implementation of community mental health strategy (NELFT)</p> <p>8 Support/engagement of third sector with managing LTCs.</p> <p>This is part of the 'Out of Hospital' programme, which is a collaborative initiative across NE London.</p>
4	Outpatients and Diagnostics	<ul style="list-style-type: none"> o Maximisation of the use of Clinical assessment and treatment services including musculo-skeletal o Extend diagnostics and phlebotomy services o Tender out sexual health services as planned o Maximisation of use of diagnostic services through the In Health Diagnostics - link to CRS programme – PACS <p>This is part of the 'Out of Hospital' programme, which is a collaborative initiative across NE London.</p>
5	Urgent Care	<p>5.0 Maximise in-hours availability of primary care in general practice and walk-in centres</p> <p>6.0 Extended hours in general practice</p> <p>7.0 24/7 Unique Care Centre (UCC) at Barking Hospital with diagnostics support</p> <p>This is part of the 'Out of Hospital' programme, which is a collaborative initiative across NE London.</p>
6	Stroke	<ul style="list-style-type: none"> o Centralise acute intervention- 'brain attack' centres o Develop strong care pathways either side, including LAS pathways, rehabilitation, and community based treatment where appropriate <p>This is part of the Stroke services collaborative initiative across NE London.</p>
7	Maternity	<p>5 Provide approachable and supportive antenatal services in accessible and convenient settings</p> <p>6 Access to antenatal education</p> <p>7 Choice of place of birth</p> <p>8 Postnatal care</p> <p>Working with local acute hospitals and with co-commissioning primary care organisations</p>
8	End of Life Care	<p>Development of the "gold standards" framework, the Liverpool Care Pathway and Preferred</p>

		<p>Priorities of Care</p> <p>To ensure a smooth palliative care pathway is in operation</p> <p>Appoint End of Life facilitators to implement these tools across the Borough</p>
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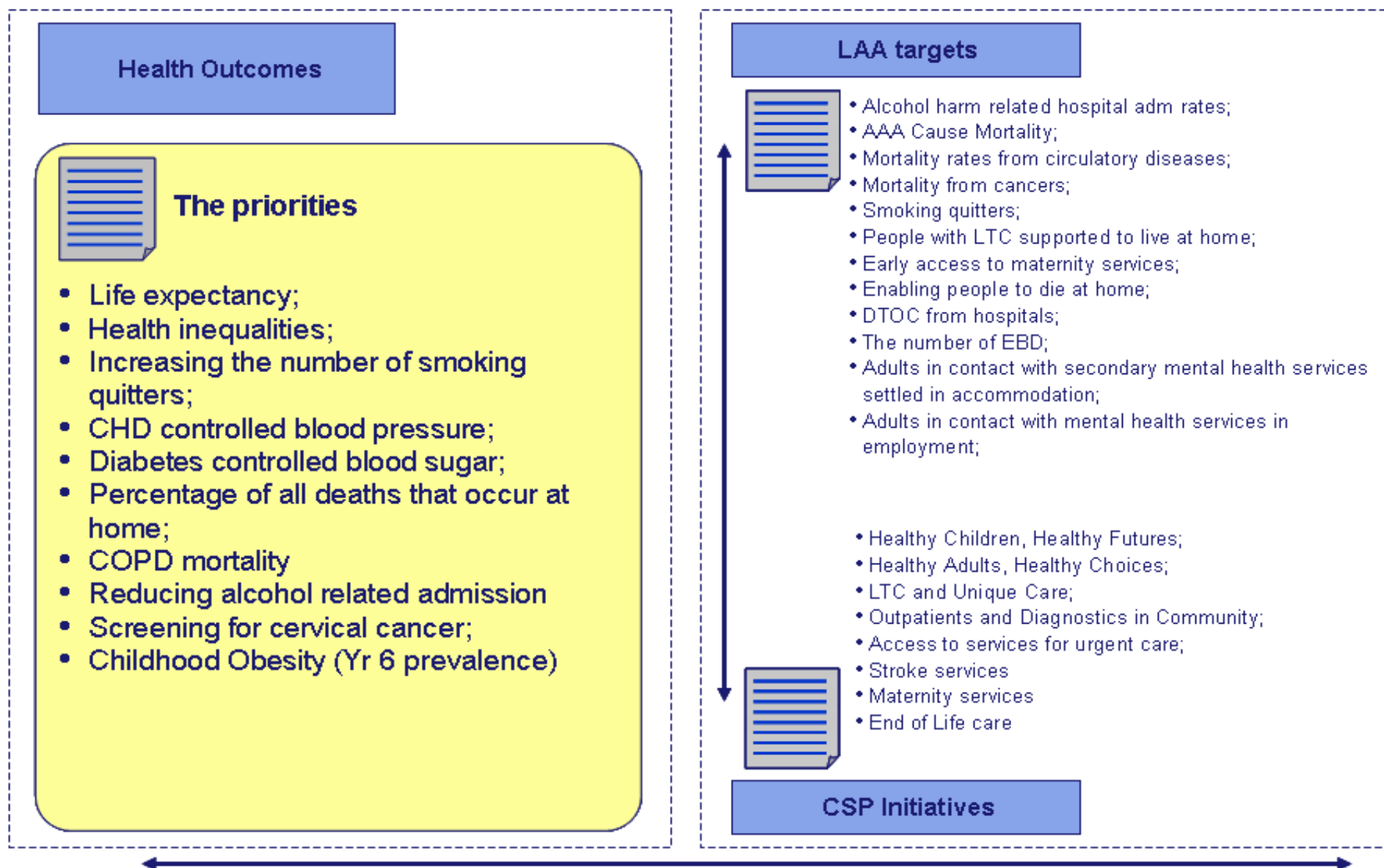
4.8 Links to World Class Commissioning health outcomes

Commentary

We took the eight priority areas from world class commissioning and demonstrated how they link with our initiatives, the agreed LAA targets and the JSNA. This validated that our chosen initiatives are both congruent with and fully support these priorities.

The interrelationships are shown in the figures below.

Health outcomes – fit with other priorities



Priority areas - local rationale

	CSP Initiative	LAA Target	JSNA	Position in London	Annual change
Increasing the number of smoking quitters	1 & 2	Yes	Yes	Bottom 10%	N/A
Childhood obesity	1	Yes	Yes	Bottom 10%	N/A
CHD controlled blood pressure	3	Yes	Yes	Bottom 10-25%	+ 4.30%
Diabetes controlled blood sugar	3	No	Yes	Bottom 10%	N/A
Alcohol related admissions	2	Yes	Yes	Bottom 10%	- 10.74
Percentage of all deaths that occur at home	2,3 & 6	Yes	End of Life Strategy	25-75%	N/A
Proportion of women offered cervical screening	2 & 4	Yes	Annual Public Health report	Bottom 10%	+ 2.1%
COPD mortality	2 & 3	Yes	Yes	Bottom 10%	- 3.7





4.9 How our initiatives link to Healthcare for London priorities

Commentary	
Improving the health of people from deprived communities and disadvantaged groups and their access to health services.	This reflects the Barking and Dagenham health needs and the organisation's objectives.
Preventing ill health	The initiatives addressing children's and adult health promotion address this priority (1 & 2)
Maternity and Newborn	Addressed within the "Maternity" initiative (7)
Children and Young People	Addressed within the 'Healthy Children, Healthy Futures' initiative (1)
Mental Health	This has been addressed through the work we have done within the Long Term Conditions and Unique Care initiative (3 & 4)
Acute Care and Planned Care	This is addressed through our work to ensure the appropriate setting for all care (4), and in the work the organisation is doing through World Class Commissioning. Stroke Care is a separate initiative, and addresses the acute and rehabilitation components of the care pathway (6)
Long Term Conditions	This is explicitly addressed through the LTC initiative (3)
End of Life Care	This is explicitly addressed through the End of Life

4.10 How our initiatives link to our community

Commentary
<p>In Section 3.1 we described the initial work on how the Barking and Dagenham community has been segmented to allow a more focussed approach to the services we provide.</p> <p>In choosing the initiatives that we have, we carried out a high level mapping to the current draft population segmentation to show which initiatives affect which group and to validate that the initiatives will encompass all groups. These are shown in the table below:</p>

Segment Percentage of Households	Characteristics	Initiative							
		Healthy Children, Healthy Futures	Healthy Adults, Healthy Choices	LTCs and Unique Care	Outpatient & Diagnostic	Urgent Care	Stroke	Maternity	End of Life Care
 <p>7.7%</p>	<ul style="list-style-type: none"> • Young, cohabiting couples • Few, very young children • Affluent • Well-educated • Professionals • Relatively large houses • Owned or privately rented • Internet savvy 								
 <p>9.8%</p>	<ul style="list-style-type: none"> • Young families and singles • Ethnically diverse • English not home language • Well-educated • Professional, service sector jobs • High incomes • Privately renting older flats and houses • High fear of crime 								
 <p>12.7%</p>	<ul style="list-style-type: none"> • Middle-aged families with children • Middle incomes • Low unemployment • Little ethnic diversity • Large, privately owned semi-detached houses • Dual car households • Savers rather than borrowers • Strong sense of community • Low fear of crime 								
 <p>8.4%</p>	<ul style="list-style-type: none"> • Young adults, many single parents • Ethnically diverse • Small, rented flats • High unemployment • Low incomes – income support and job seekers allowance • Heavy users of 								

	<p>public transport</p> <ul style="list-style-type: none"> • Fear of crime • Anti-social behaviour issues in neighbourhood 								
<p>E</p>  <p>10.2%</p>	<ul style="list-style-type: none"> • Large, single parent families • Working class • Transient • Poorly educated • Relatively high unemployment • Low income, receiving benefits • Heavy smokers • Teenage pregnancies • Social housing • Financially vulnerable 								
<p>F</p>  <p>15.3%</p>	<ul style="list-style-type: none"> • Largely older, working age • Some children • Long term residents • Working class • Limited qualifications among adults • Low incomes • Low value terraced and semi-detached • Exercised right to buy • Relatively heavy TV viewers 								
<p>G</p>  <p>6.5%</p>	<ul style="list-style-type: none"> • Elderly, often living alone • State pension and pension credit • Poor health • Poor diet • Emergency hospital admissions • Purpose built flats and communal establishments • Public renting • Sense of community 								
<p>H</p>  <p>29.3%</p>	<ul style="list-style-type: none"> • Married couples • Children • Stable, long-term residents • Limited educational attainment • Reasonable employment prospects • Ex-council housing 								

	<ul style="list-style-type: none"> • Mainly manual skills • Mix of social grade (although not extremes) 	
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This shows that we have chosen a set of initiatives that encompasses all of the Barking and Dagenham population.

Specifically:

Initiative	Name	Approx % of population affected by initiative (based on draft segmentation figures)
1	Healthy Children, Healthy Futures (a comprehensive approach to Children’s health and wellbeing which reflects ‘Every Child Matters’)	78.2
2	Healthy Adults, Healthy Choices (a comprehensive approach to Adults’ health and wellbeing)	85.1
3	Long Term Conditions and Unique Care	73.6
4	Outpatients and Diagnostics	73.6
5	Urgent Care	51.1
6	Stroke	34.5
7	Maternity	16.1
8	End of Life Care	21.8

4.11 Equality Impact Assessment

Commentary

Equality Impact Assessments (EIAs) have been undertaken against the eight initiative areas. The initiatives have been reviewed in relation to the six equality strands, for differential impact on local communities, with a view to identifying what these might be and how they can be addressed. Our process covers nine steps, using a template developed in consultation with local community groups. The nine steps area as follows:

1. Identify the objectives of the initiative and how effective it is in promoting equality;
2. Gather and consider the data/research available to assess likely impact on equality strands, especially on access to and satisfaction with the service. If further data is required consult;
3. Assess the likely impact of the initiative on the 6 equality strands – disability, ethnicity, faith, sexuality, age and gender. Is it discriminatory, unlawful, justifiable in law? Identify any adverse impact;
4. Where adverse impact is established consider alternative ways of delivering to minimise/eliminate

unlawful discrimination and to increase positive impact;

5. Consult relevant stakeholders on proposals to remedy adverse impact;

6. Make a decision on policy changes;

7. Make arrangements to monitor and review the effectiveness of the revised policy;

8. Publish results of the Impact Assessment;

9. Develop an Equalities Action Plan

The stage reached in our EIA process is that all initiatives have been assessed (steps 1 to 3) and issues have been identified, some of which are set out in the initiatives descriptions in section 5 below. A list of what needs to be done has been worked up to minimise negative impact or unlawful discrimination across the six strands (step 4). The next stage of this work (Steps 5 to 9).

In May 2009, the PCT is planning a major consultation event with the main community fora and groups on each EIA. These groups have been provided with training to build their capacity for meaningful engagement. Financial support is also available to ensure maximum opportunity for comment.

The end result will be a full action plan for each of the eight initiatives with leads and timescales for implementation of recommendations. Progress will be reported routinely to the PCT's Equality and Diversity Group and annually to the Board.

5. Initiatives

The rationale for choosing the following initiatives has been set out in Section 4 above. They are ambitious and set out what will be done to improve health locally over the next five years. Each initiative has identified three priority areas, and these are highlighted in bold under the “Case for Change” section and reflected as priorities in the “Timeframes for Implementation” sections, under each initiative.

5.1 Initiative 1 – Healthy Children, Healthy Futures

Initiative description	
Background and Context	<i>Healthy Children, Healthy Futures</i> are priorities reflected in the Local Area Agreement targets and the targets of the Children's and Young People's Plan – the local strategic framework for Children and Young People;
Case for Change	<ul style="list-style-type: none"> • Food, weight and exercise – lowest estimated levels of fruit and vegetable intake and highest level of obesity in London; The “Tellus” survey also reflected low levels of physical activity amongst young people; • Sexual behaviour – high teenage conceptions, high abortion rates. The SRE audit showed a high level of awareness of issues but low knowledge of services and difficulties in accessing services; <p>The Initiative delivers improvements in health and well being in the following areas:</p> <ul style="list-style-type: none"> • Child and Adolescent Obesity (physical activity and healthy eating) (Vital Signs and LAA Target) • Prevention of teenage conceptions (access and awareness of sexual health services) (Vital Signs and LAA target) • Child and Adolescent Mental Health and Well Being (tier 1 & 2 prevention / intervention) • Child Oral Health (prevention and awareness of oral ill health) • Increased uptake of childhood immunisation (MMR, HiB, HPV implementation) • Health and Well being of Children and Young People with Learning Difficulties and Disabilities (access to services, respite services and services for over 5yr olds) • Health and Well Being of Looked After Children and Young People (access to services and health outcomes) • Health and Well Being of Children from minority groups
Proposed Changes	<ul style="list-style-type: none"> • Support implementation of access and connect card for young people. • Industrial scale implementation of prevention and access for sexual and reproductive health services for children and young people;

	<ul style="list-style-type: none"> • Expansion of tier 2 & 3 & 4 child and adolescent obesity services; • High profile awareness campaign to support immunisation schedule and immunisation support team established in 2008; • Expansion of oral health prevention work with children and young people; • Expansion of tier 1 & 2 services for CAMHS in school settings; • Expansion of portage services and provision for Children and Young People with Learning Disabilities over 5yrs; • Expansion of respite provision in the Borough; • Establishment of targeted smoking cessation services for young people; • Further development of web interface and engagement for young people; • Targeted services for children and young people with enhanced need (Young offenders, teen parents, looked after children, children experiencing domestic violence, children with minority identities); • Support, if partners are willing, the refreshing and development of the strategic network for children and young people's health across ONEL.
Benefits and Quality Improvements	<ul style="list-style-type: none"> • Many of the interventions for children are focused on prevention and so will have longer term impact on the overall health of adults in the borough as these children grow into adults with greater health resilience; • The approach of industrial scale is to help reduce some of the inequalities created by small scale geographically restricted interventions. This alongside development of more structured monitoring through the implementation of Access and Connect will give us a better picture of patterns of service use and help reduce inequalities; • Over 2007/08 we have developed better short term activity and output indicators for providers of services, such as the individual loss of weight of child or improvement in standardised well being indicators for mental health, self esteem scores, smoking status, self reported health status. These indicators are now being mainstreamed across initiatives to enable collation of the overall impact of the initiatives. The implementation of Access and Connect will also give a more useful population based perspective on utilisation of services by young people.
Impact on Activity	<p>The programme will increase activity for young people in the following aspects:</p> <ul style="list-style-type: none"> • physical activity – measured through individual project monitoring, physical activity in schools and extend schools measures; • uptake of healthy school meals – measured through school meals uptake indicator; • access and uptake for contraception and sexual health services – measured through activity in services, implementation of mystery shopper programme, reduction in teenage conceptions; • uptake of childhood immunisations through CHIA/RiO monitoring; • achievement of targets for health checks for looked after children and application of mimic targets for young offenders.

Financial Implications	Please refer to the detailed financial templates.
Impact on Provider Services	Although there is some growth of provider services in both acute, mental health and community settings the majority of the investment focus for the CSP is on prevention activity to prevent chronic disease developing and reducing the burden of childhood illness.
Current Status – Where are we now?	<p>Healthy Children, Healthy Futures started in 2006 following publication of the Children and Young People's Plan (2006 - 2009). The Plan is the Local Strategic Partnership framework for delivery against the Every Child Matter's agenda. Delivery of the plan is overseen by the Children's Trust. The Trust are currently revising the Plan for 2010 - 2012 based on evidence from a range of needs assessments in line with World Class Commissioning, which include:</p> <ul style="list-style-type: none"> • Health needs of looked after children • Children and Young people experiencing domestic violence • Children and Young people sexual and reproductive health needs • Mental health and well being needs of children and young people • Drug and alcohol needs of children and young people <p>NHS Barking and Dagenham is a key partner in the local Children's Trust. The Trust has made significant steps towards closer joint working, joint appointments and joint commissioning. This has been further strengthened by the alignment of the Operations part of the organisation to the six locality structures governing Children's Services in the Borough. In 2008/09 a range of new initiatives have been established which include:</p> <ul style="list-style-type: none"> - Phase one of industrial scale change for children: free swimming for under 18yrs, increased school swim sessions, 8 apprenticeships in leisure and free adult and toddler swims; - School health advisors for all secondary schools; - Children and Young people health network; - Immunisation support team to undertake MMR catch-up and support implementation of HPV; - BADHealth.nhs.uk, MyBook/MyLife and New You awareness campaigns; - refreshed children and young people's integrated sexual and reproductive health strategy & needs assessment; - commissioned CAMHS needs assessment and strategy refresh.
Success Measures	<ul style="list-style-type: none"> • 5% year on year increase in uptake of free condoms for under 18 year olds; • 5% year on year increase in number of young people accessing free swimming using 2008/09 as the baseline; • Increased uptake for childhood immunisations (including HPV), measured as per current trajectories: (Immunisation rate for children aged 2 who have been immunised for MMR: 08/09 – 76%, 09/10 – 83%, 10/11 – 90%); (immunisation rate for children aged 5 who have been immunised for MMR: 08/09 – 75%, 09/10 - 82%, 10/11 - 90%).

- Reduction in teenage conceptions (LAA Trajectory);
- Reduction in childhood obesity (LAA Trajectory);
- Reduction in the number of children reporting smoking in the Tellus survey by 5% by 2011 from a 21% baseline in 2006;
- Reduction in self-harm, anxiety and depression amongst children and young people and long term reduction in burden on tier 3 services for CAMHS; Increase by 2012 by 5% the proportion of children in the Tellus survey who felt 'happy about life at the moment' from a 68% baseline in 2007;
- Improved oral health amongst children and young people as measured the DMT scores in national oral health survey;
- Increase in proportion of young people eating 3-4 or more portions of fruit and vegetables each day in the Tellus survey by 10% by 2012 from a baseline of 36% in 2007;
- Improved health outcomes for minority groups and children and young people with enhanced need measured at an individual and population level; increased proportion of children and young people rating their health as healthy or very healthy in the Tellus survey by 5% by 2012 from a baseline of 87% in 2007 (this is a proxy as these minorities are more likely to have worse self-reported harm);
- Longer term impact on morbidity and mortality for adults across the local population – impact on All Cause Mortality in 2012, estimated 5% reduction by 2020.

Health Outcome Measures	Initiative Performance Indicators		
	Key	Second-Level	Associated
Health Outcome Measure	<ul style="list-style-type: none"> • Obesity among primary school age children in Yr 6 – by 2020 aiming to get obesity levels back to the level seen in year 2000; • Teenage pregnancy – to reduce the under 18 conception rate by 50% with 1998 position as baseline; 	<ul style="list-style-type: none"> • 4 week smoking quitters – overarching aim to reduce the number of smoking rates to 21% or less by 2010; • Alcohol harm related hospital admission rates – aiming to curb the rising trend and see a lower rate of admission; • Practice based registers- % diabetics called for review; 	<ul style="list-style-type: none"> • Early access to maternity services • Infant mortality •
JSNA Measure	<ul style="list-style-type: none"> • Immunisation - resident uptake rates – at least 	<ul style="list-style-type: none"> • Conception <16; • Conception <18; 	<ul style="list-style-type: none"> • Complaint data (primary / community care); • Index of multiple deprivation;

		<p>95% of children should receive their primary doses of diphtheria, tetanus, polio and pertussis with 90% receiving their boosters.</p>	<ul style="list-style-type: none"> • Smoking prevalence; • Trend in % DMFT 5 year olds; 	<ul style="list-style-type: none"> • Patient satisfaction surveys (primary care and hospital); • Predicted vs. known prevalence of diseases; • Projected birth rate; • Quality and Outcomes Framework.
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Timeframes for Implementation

Project	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Expansion of portage services and provision for CYP with LDD over 5yrs;		On-going	On-going	On-going	On-going	On-going
Expansion of respite provision in the borough;		On-going	On-going	On-going	On-going	On-going
Expansion of tier 1 & 2 services for CAMHS in school settings;		On-going	On-going	On-going	On-going	On-going
Expansion of tier 2 & 3 & 4 child and adolescent obesity services;		Priority	Priority	Priority	Priority	Priority
High profile awareness campaign to support immunisation schedule and immunisation support team established in 2008;		Priority	On-going	On-going	On-going	On-going
Industrial scale implementation of prevention and access for sexual and reproductive health services for children and young people;		Priority	Priority	Priority	Priority	Priority
Support implementation of access and connect card for young people.		On-going	On-going	On-going	On-going	On-going
Support, if partners are willing, the refreshing and development of the strategic network for children and young people's health across ONEL.		On-going	On-going	On-going	On-going	On-going
Targeted services for children and young people with enhanced need (Young offenders, teen parents, looked after children, children experiencing domestic violence, children with minority identities);		On-going	On-going	Priority	On-going	On-going
Establishment of targeted smoking cessation services for young people;			Priority	On-going	On-going	On-going
Expansion of oral health prevention work with children and young people;			On-going	On-going	On-going	On-going
Further development of web interface and engagement for young people;			On-going	On-going	On-going	On-going
Expansion of subsidised access to sport/leisure services through access and connect				Option	Option	Option
Free/subsidised school meals				Option	Option	Option

Stakeholder Engagement	The plans outlined in this initiative are in line with the investment objectives for the Children’s Trust and discussions with LBBD Children’s Services, the Children’s Forum and following extensive consultation with young people in the Borough.		
Equality Impact Assessment	<p>An Equalities Impact Assessment (EIA) has been undertaken for this initiative area in relation to the six equalities strands of disability, faith, sexuality, age, gender and race. Based on an initial assessment of the initiative, the EIA identified a number of recommendations. The findings (some of which are outlined below) will be further reviewed and plans developed to implement the recommendations.</p> <ul style="list-style-type: none"> • To strengthen the equality monitoring of these initiatives and ensuring that comparative data is available across all six equality groups; • Review the health information on children across all impairment groups; • Review the health information on BME children, including migrant, refugee and transient children (i.e. travellers & gypsies?) 		
Initiative Risk	Severity	Likelihood	Mitigating actions
Lack of Engagement from Local Authority	High	Low	Early discussion of plans at multi-agency obesity group. Current plans are fully signed off by all agencies and by LAA.
Insufficient provider competition results in low urgency for delivery	High	Medium	Providing effective training and commission work developing provider capacity as part of public health network programme. Develop a children’s’ health improvement commissioning strategy
Lack of engagement from community sector	High	Medium	Engage relevant community sector bodies in consultation (ongoing).
Parental consent for obesity measurement low	High	Medium	Ensure opt-out rather than opt-in for childhood obesity measurement. Work with schools to ensure they participate. Deliver engagement campaign with parents.
Project management capability lacking	Moderate	Medium	Designate project managers and provide training for them to deliver work. Programme Office now in place.

Initiative 2 – Healthy Adults, Healthy Choices

Initiative description	
Background and Context	<p>Healthy Adults, Healthy Choices brought together the establishing work on CVD, Diabetes, Stroke, Cancer, Adult Mental Health, Smoking Cessation and Adult Health Inequalities in to a multi-strand approach which fits with the Healthcare for London key themes of staying healthy, planned care and long term conditions. A range of health needs assessments underpin the work of Healthy Adults which were consolidated in 2008 through the Joint Strategic Needs Assessment (JSNA), as well as building on the existing National Service Frameworks and the learning from the Next Stage Review and the visit from the Department of Health Inequalities Support Team.</p>
Case for Change	<ul style="list-style-type: none"> • The highest burden of morbidity and mortality experienced among the residents of Barking and Dagenham is avoidable lifestyle related diseases in adults, especially cardiovascular disease; • Alcohol and other drugs of abuse – over 1,000 problematic adult drug users, many not receiving treatment. Although the Tellus survey showed low levels of use amongst young people but high levels of concerns for adult health and there are obvious links with domestic violence; • This burden of disease accounts for a disproportionate amount of early deaths (56%), and total deaths (31%) of the population of the borough. When cancers are added, over 54% of the deaths in the borough are due to cancer and circulatory disease, much of which is easily preventable by lifestyle interventions; • The life expectancy of women in the borough is going down, not up, and in particular the burden of disease in women from alcohol related liver disease and COPD is increasing rapidly, with a predicted quadrupling in incidence by 2013; • The JSNA highlighted alcohol and mental ill health as further areas of health concern, contributing not only to premature mortality but also to poor mental and social well being through domestic violence, crime, depression and anxiety. <p>Moreover, the following key targets relate to this programme:</p> <ul style="list-style-type: none"> • Reduction of CVD related mortality; • Reduction of avoidable hospital admissions; • Early detection of cancer and vascular disease; • Uptake of physical activity; • Smoking cessation targets;

	<ul style="list-style-type: none"> • Life expectancy; • Alcohol related admissions
<p>Proposed Changes</p>	<p>In 2008/2009 a single integrated programme architecture was devised to create the Adult Health Improvement programme. In 2009/10 the programme will continue to develop to deliver this integrated programme as follows:</p> <p>Tranche A: Targeting Common Risk Factors For Vascular Diseases and For Cancer.</p> <ul style="list-style-type: none"> • The delivery of a Vascular Screening programme which enables the organisation to screen every adult from the age of 40 to the age of 74 for Vascular disease, and provide them with an intervention. We will aim to screen the initial 6000 identified by the search of GP registers by June 2009, starting in October 2008. We will aim to screen 10% of the population in each year, starting with targeting those most at risk; • Expansion of the Health Trainers and Health Advocates programme to increase capacity in the programme by 45% (based on the number of referrals made in 2008-09 and the capacity needed by the Vascular Screening programme); • The roll out of a Public Health service within pharmacy, in the form of a Local Enhanced Service, to provide part of the Vascular Screening programme for the organisation but also to provide weight management and support in management of chronic conditions especially Heart Disease, Heart Failure and Diabetes; • Expansion of the Healthy Adult Exercise referral programme in line with the assumptions made for the Health Trainers programme above, to enable every adult with CVD and High CVD risk identified by the prevention pathway, and every adult with obesity requiring treatment to be able to access structured physical activity pathways by July 2009; • The delivery of health promotion and behaviour change skills across the organisation and partner agencies to enhance lifestyle change and the capacity of frontline staff to deliver it; • Delivering improved smoking cessation and tobacco control to provide an integrated approach to reducing smoking prevalence as requested in the National Support Team report; • Delivering targeted physical activity programmes for older people which will reduce vascular disease, improve stability and emotional wellbeing and contribute to independence; • Delivering targeted CVD health promotion to adults with learning disabilities and people with severe mental illness to reduce their vascular disease risk; • The roll out of targeted COPD screening for those at most risk. COPD is one of the factors which is currently causing our life expectancy in women to reduce and mortality due to COPD is increasing substantially; • The roll out of a “well women” programme to specifically target women within the programmes above; • The non exercise referral activity aspects of the Adult Obesity Strategy (Food planning and food use and transport and planning programmes).

	<p>Tranche B: Alcohol, Suicide and Public Mental Health.</p> <ul style="list-style-type: none"> Ensuring alcohol services reach those who need them most and are fit for purpose. The recent needs assessment indicated a quadrupling of women with liver disease due to alcohol in the period to 2013 if nothing is done. <p>Tranche C: Protecting Against Threats To Health.</p> <ul style="list-style-type: none"> Adult Immunisation uptake (Flu and PCV in elderly and vulnerable people). This programme will ensure currently improved uptake of flu and pcv and support the winter plan, as well as reducing avoidable hospital admissions due to flu and pneumococcal pneumonia; <p>Uptake of Screening for Retinopathy and Cancers including the Healthy Communities Collaborative. This programme will reduce retinopathies and cancers which go undiagnosed by ensuring screening is taken up early in areas with highest incidence.</p>
Benefits and Quality Improvements	<ul style="list-style-type: none"> These programmes together will continue to reduce inequalities in health and will increase the number of people in contact with primary care or preventive services; We will reverse the downward trend in life expectancy for women and increase life expectancy overall by 2012, and will meet the 2010 Public Sector Agreement (PSA) Health Inequalities Targets as a step towards this; By 2012 we will have identified 80% of all of those at increased risk of disease in the borough and targeted them to interventions.
Impact on Activity	<ul style="list-style-type: none"> Evidence suggests that this programme will continue to reduce hospital admissions and reduce and delay avoidable deaths; Reduce all ages all causes mortality from 769 per 100,000 in 2008 to 692 in 2011/12; Reduce the proportion of individuals with smoking status recorded who are smokers from a baseline of 29% in 2005/06 to 22% by 2011/12; Reduce the mortality rates attributed to CVD from 99 per 100,000 in 2008 to 96 in 2011/12; Reduce the mortality rates attributed to Cancer from 126 per 100,000 in 2008 to 120 in 2011/12.
Financial Implications	Please refer to the detailed financial templates.
Impact on provider services	This initiative is a combination of increased prevention activity to reduce the burden on primary and secondary care services as well as some shift of services from secondary to primary care provision and settings in line with Healthcare for London's strategic aims.
Current status of project (where are we now)	<p>In 2008/09 we have delivered the following aspects of the plan:</p> <ul style="list-style-type: none"> Revised smoking cessation programme with additional investment and launch of the Quit shop; Published strategies for CVD, diabetes, adult mental health promotion; Started pilot of DIVERT and SNAPSHOT domestic violence projects; Completed phase one of JSNA and agreed phase two and Experian projects in line with health information strategy;

	<ul style="list-style-type: none"> • Launched 52 ways, CVD and Stroke Awareness campaigns and supported local implementation of Diabetes UK campaign; • Reviewed physical activity programmes and developed uniform approach and marketing process to healthcare professionals; • Worked with NELFT to promote awareness of ABIT; • EHS supported register screening for vascular disease risk factors; • Established Expert Patient Programme; • Participated in visit from DH Health Inequalities Support Team visit; • Launched Health Trainers programme; • Piloted Fit and Healthy programme for staff across LSP; • Launched voluntary sector challenge fund; • Undertook equality impact assessments of programmes; • Delivered a dementia equity audit; • Launched Healthy Community Collaborative to promote early presentation of cancer symptoms; • Participated in Well London initiative in most deprived SOA in borough. 														
Success Measures	<ul style="list-style-type: none"> • Smoking quit rates; (use Vital Signs indicator) • Life Expectancy and mortality rates; (Vital Signs) • Early detection rates for retinopathy; (Vital Signs) • Uptake rates for vaccination and screening; (Vital Signs) 														
Health Outcome Measures	<table border="1"> <thead> <tr> <th data-bbox="456 911 656 979"></th> <th colspan="3" data-bbox="656 911 2047 948">Initiative Performance Indicators</th> </tr> <tr> <th data-bbox="456 948 656 979"></th> <th data-bbox="656 948 992 979">Key</th> <th data-bbox="992 948 1391 979">Second-Level</th> <th data-bbox="1391 948 2040 979">Associated</th> </tr> </thead> <tbody> <tr> <td data-bbox="456 979 656 1386">Health Outcome Measure</td> <td data-bbox="656 979 992 1386"> <ul style="list-style-type: none"> • 4 week smoking quitters – overall aim to reduce smoking rates to 21% or less by 2010; • Blood pressure control in hypertensive • CVD mortality rate – decrease the rate from heart disease and stroke (and </td> <td data-bbox="992 979 1391 1386"> <ul style="list-style-type: none"> • Alcohol harm related hospital admission rates – reduce rising trend seen between 02/03 and 06/07 and see a lower rate of admission than projected trend; • All age all cause mortality by 2010 the average life expectancy at birth in England is 78.6 years for men and 82.5 years for women; </td> <td data-bbox="1391 979 2040 1386"> <ul style="list-style-type: none"> • Adults in contact with mental health services in employment • Adults in contact with secondary mental health services settled in accommodation • Delayed transfers of care • DTOC from hospitals • Emergency bed days • People with LTC supported to live at home </td> </tr> </tbody> </table>				Initiative Performance Indicators				Key	Second-Level	Associated	Health Outcome Measure	<ul style="list-style-type: none"> • 4 week smoking quitters – overall aim to reduce smoking rates to 21% or less by 2010; • Blood pressure control in hypertensive • CVD mortality rate – decrease the rate from heart disease and stroke (and 	<ul style="list-style-type: none"> • Alcohol harm related hospital admission rates – reduce rising trend seen between 02/03 and 06/07 and see a lower rate of admission than projected trend; • All age all cause mortality by 2010 the average life expectancy at birth in England is 78.6 years for men and 82.5 years for women; 	<ul style="list-style-type: none"> • Adults in contact with mental health services in employment • Adults in contact with secondary mental health services settled in accommodation • Delayed transfers of care • DTOC from hospitals • Emergency bed days • People with LTC supported to live at home
	Initiative Performance Indicators														
	Key	Second-Level	Associated												
Health Outcome Measure	<ul style="list-style-type: none"> • 4 week smoking quitters – overall aim to reduce smoking rates to 21% or less by 2010; • Blood pressure control in hypertensive • CVD mortality rate – decrease the rate from heart disease and stroke (and 	<ul style="list-style-type: none"> • Alcohol harm related hospital admission rates – reduce rising trend seen between 02/03 and 06/07 and see a lower rate of admission than projected trend; • All age all cause mortality by 2010 the average life expectancy at birth in England is 78.6 years for men and 82.5 years for women; 	<ul style="list-style-type: none"> • Adults in contact with mental health services in employment • Adults in contact with secondary mental health services settled in accommodation • Delayed transfers of care • DTOC from hospitals • Emergency bed days • People with LTC supported to live at home 												

		<p>related diseases) in people under the age of 75 over the next 3 years;</p> <ul style="list-style-type: none"> • Mortality rates from cancers – reduce the rate in people under 75 over the next 3 years; • Mortality rates from circulatory diseases • Proportion of women offered screening for breast cancer increasing screens offered and extending the age range of women offered screens. 	<ul style="list-style-type: none"> • Cholesterol levels; • Improving health outcomes for people with LTC • Practice based registers- % diabetics called for review – ensuring that elderly diabetic patients are routinely reviewed by their by their GP 	
	JSNA Measure		<ul style="list-style-type: none"> • Immunisation - resident uptake rates • Predicted vs. known prevalence of diseases • QOF • Smoking prevalence • Standardised limiting long term illness ratio (persons in household) 	<ul style="list-style-type: none"> • Average, median and range of LOS • Complaint data (primary / community care) • Index of multiple deprivation • Self-reported health outcomes (hospital) • Top 10 causes of admission • Top 10 diagnoses causing most bed days

Timeframes for Implementation

Project	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Adult immunisation uptake;	On-going	On-going	On-going	On-going	On-going	On-going
Delivering targeted physical activity programmes for older people which will reduce vascular disease;	On-going	On-going	On-going	On-going	On-going	On-going
The delivery of a vascular screening programme;	On-going	Priority	Priority	Priority	Priority	Priority
The non-exercise referral activity aspects of the Adult Obesity Strategy;	On-going	On-going	On-going	On-going	On-going	On-going
Uptake of screening for retinopathy and cancers including the Health Communities Collaborative.	On-going	On-going	Priority	On-going	On-going	On-going
Delivering improved smoking cessation and tobacco control to provide an integrated approach to reducing smoking prevalence;		On-going	On-going	On-going	On-going	On-going
Delivering targeted CVD health promotion.		On-going	On-going	On-going	On-going	On-going
Roll out of Public Health service within pharmacy, in the form of a Local Enhanced Service, to provide part of the Vascular screening programme for the organisation;		Priority	On-going	On-going	On-going	On-going
The roll-out of targeted COPD screening;		Priority	Priority	Priority	Priority	Priority
Ensuring alcohol services reach those who need them most and are fit for purpose.			On-going	On-going	On-going	On-going
Expansion of the Healthy Adults exercise programme in line with assumptions made for the Health Trainers programme;			On-going	On-going	On-going	On-going
Expansion of Health Trainers and Health Advocates.				On-going	On-going	On-going

Stakeholder Engagement	Public Health Network, composed of 120 resident volunteers, has been engaged in consultation.		
Equality Impact assessment	<p>An Equalities Impact Assessment (EIA) has been undertaken for this initiative area in relation to the six equalities strands of disability, faith, sexuality, age, gender and race. Based on an initial assessment of the initiative, the EIA identified a number of recommendations. The findings (some of which are outlined below) will be further reviewed and plans developed to implement the recommendations.</p> <ul style="list-style-type: none"> To strength equality monitoring of all people accessing the various health improvement programmes to provide detailed year on year comparative data across all six equality groups. 		
Initiative Risk	Severity	Likelihood	Mitigating actions
Lack of clarity on delivery objectives	High	Low	<p>Ambition for Health (adult strategy) now in place.</p> <p>Produce clear commissioning plan signed off by all partners. (Underway)</p> <p>Design and deliver new template SLA (Complete) and conduct regular performance reviews. (Ongoing)</p>
Lack of engagement from local authority	High	Low	<p>Early discussion of plans at Adults Trust after approval by LA project teams. (underway)</p> <p>Ensure plans are fully signed off by all agencies and by LAA (Complete)</p>
Insufficient provider competition results in low urgency for delivery	High	Medium	<p>Develop Provider market by commissioning public health network (complete) and targeting potential providers (underway).</p> <p>Market test appropriate services for provision, commission work in manageable lots and use developmental commissioning approach (underway).</p> <p>Market Management Strategy under development.</p>
Lack of engagement from community sector	High	Medium	<p>Engage relevant community sector bodies through voluntary sector capacity building post (commissioned, in recruitment) (Ongoing)</p>
Project management capability lacking	Medium	Medium	<p>Designate project managers and provide training for them to deliver work (underway)</p> <p>Design project management plan templates and structure (in place)</p> <p>Programme Office in place (Ongoing)</p>

Initiative 3 – Long Term Conditions and Unique Care

Initiative description	
Background and Context	<p><i>Healthcare for London: A Framework for Action</i> and “High Quality Care for All: The Next Stage Review” set out the priorities for the NHS in London with a key emphasis on the improved management of Long Term Conditions.</p> <p>It is recognised that change in the way that care is managed is necessary and that benefits will be achieved by developing a more systematic approach to prevention, treatment and ongoing support and care. The organisation aims where possible to provide services to people closer to home. This alongside other developments in health & social care will enable the organisation and our partners to provide a range of interventions that will improve services to people with Long Term Conditions. The NHS and Social Care long-term conditions model provides a framework for delivering integrated services across health and social care identifying three levels of care: supported self care; disease specific management and case management.</p>
Case for Change	<p>NHS Barking and Dagenham has a high incidence of cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD) which is associated with increased mortality rates and high levels of hospital admission. The capacity and capability in primary care to provide more specialist support for long-term conditions and support for self-care has been limited and this has been reflected in external reviews such as the Healthcare Commission Review of Diabetes Services, which identified that services did not meet basic requirements of the NSF ².</p> <p>There is a need to redesign services to reduce health inequalities for patients with CVD and COPD that deliver the high level outcomes set out in national long-term condition strategy:</p> <ul style="list-style-type: none"> • People have improved quality of life, health and wellbeing and are enabled to be more dependent. • People are supported to self-care and have involvement in decisions about their care and support. • People have choice and control over their care and support so that services are built around their needs. • People can design their care around health and social care services which are integrated, flexible, proactive and responsive to their individual needs. • People are offered health and social care services which are high quality, efficient and sustainable.

² Healthcare Commission (2007). *Managing Diabetes. Improving services for people with diabetes.* Commission for Healthcare Audit and Inspection.

<p>Proposed Changes</p>	<ul style="list-style-type: none"> • Services for long-term conditions are supported by evidence based care pathways and that there are clear referral pathways in place supported by Map of Medicine and Choose and Book. Priority will be given to diabetes, CHD and respiratory disease followed by a review of neurological services. • Performance management of general practice to reduce the variation in the quality of disease registers and reported prevalence rates, ensuring that registers are up to date and used effectively for the recall of patients for review of their long-term conditions; • GP practices will be supported to develop their skills to deliver enhanced services through training and education and will have access to specialist services for support where required; • Specialist community services will be commissioned working alongside primary and secondary care services to provide specialist support to people with long-term conditions; • Services will be provided closer to home from sites across NHS Barking and Dagenham with direct access to diagnostics and will be one-stop where possible. This service model will support a shift in outpatient activity from secondary to primary care; • Patients will have access to assisted technology such as Telehealth and Telecare to support them living in their own home where needed; • Improved access to structured education, health trainers, advocacy and befriending services and expert patient programmes; • The expansion of the Unique Care service as a case management model for older people who are vulnerable to an emergency admission; • The establishment of a rapid response team in the community work closely with secondary care discharge co-ordinators and the ambulance service through a single point of access; • Utilisation of step-up beds at Grays Court as an alternative to acute admission.
<p>Benefits and Quality Improvements</p>	<ul style="list-style-type: none"> • To develop a strong culture of patient self-management; • To ensure that most care is locally based in primary care; • To prevent and manage the complications of diabetes – retinopathy, renal disease, CHD, foot problems; • To reduce premature mortality from CVD in Barking and Dagenham from current rates of 128.8/1000,000 population; • To improve clinical outcomes from patients measured through Quality and Outcome Framework data; • To reduce unplanned admissions to hospital and length of stay; • To improve the patient experience of services and help them to live healthy and protective lives.
<p>Impact on Activity</p>	<ul style="list-style-type: none"> • Community services for CHD, respiratory disease and diabetes are forecast to shift 25% of outpatient activity from secondary to primary care over the next five years; • The unique care initiative is forecast to achieve a minimum reduction in non-elective admissions of at least 10% for people over

	<p>65 years over the next five years;</p> <ul style="list-style-type: none"> • Non elective admissions for falls are expected to reduce by 40% over the next five years. 												
Financial Implications	Please refer to the detailed financial templates.												
Impact on Provider Services	<ul style="list-style-type: none"> • CHD, diabetes, respiratory and nursing support for the Unique Care service have been commissioned from the organisation's provider arm and are included in the SLA; • Specifications for new services will be tendered out in line with the organisations Standing Financial Instructions. 												
Current Status of Project (where are we now)	<p>The following services have been commissioned and are operational:</p> <ul style="list-style-type: none"> ○ A community COPD service that offers respiratory outpatient appointments, an oxygen assessment service, pulmonary rehabilitation; ○ A community CHD service focusing on the management of heart failure; ○ A community diabetes service, providing additional medical, nursing and therapist capacity and structured education programmes for type 1 and type 2 diabetics; • Step-up beds at Grays Court as an alternative to acute admission to support the community teams for COPD, Heart Failure and Unique Care; • A 'Rapid Response' team in the community working closely with the Discharge co-ordinators and the ambulance service, and through a Single Point of Access; • A Unique Care service across 24 practices in Barking and Dagenham, supporting integrated working across general practice, community services and social services; • Providing access to Telecare. 												
Success Measures	<ul style="list-style-type: none"> • Reduction in emergency admissions and length of stay by 10% over the next five years; • 90% of diabetic patients have HbA1C > 7.5 • 90% of patients with diabetes have controlled blood pressure; • All newly diagnosed diabetics can access structured education programmes; • All diabetics are recalled for diabetic retinopathy screening annually; • 25% transfer of outpatient activity from secondary to primary care by 2012; • Patient's experience of diabetes services are improved using the Healthcare Commission review as the baseline. 												
Health Outcome Measures	<table border="1"> <thead> <tr> <th></th> <th colspan="3">Initiative Performance Indicators</th> </tr> <tr> <th></th> <th>Key</th> <th>Second-Level</th> <th>Associated</th> </tr> </thead> <tbody> <tr> <td>Health</td> <td>• All age all cause mortality</td> <td>• Emergency bed days</td> <td>• 4 week smoking quitters</td> </tr> </tbody> </table>		Initiative Performance Indicators				Key	Second-Level	Associated	Health	• All age all cause mortality	• Emergency bed days	• 4 week smoking quitters
	Initiative Performance Indicators												
	Key	Second-Level	Associated										
Health	• All age all cause mortality	• Emergency bed days	• 4 week smoking quitters										

	Outcome Measure	<ul style="list-style-type: none"> • Blood pressure control in hypertensive • Cholesterol levels • CVD mortality rate • Improving health outcomes for people with LTC • Mortality rates from circulatory diseases • People with LTC supported to live at home 	<ul style="list-style-type: none"> • Practice based registers- % diabetics called for review 	<ul style="list-style-type: none"> • Adults in contact with secondary mental health services settled in accommodation • Alcohol harm related hospital admission rates • Delayed transfers of care • DTOC from hospitals • Timeliness of social care assessment
	JSNA Measure	<ul style="list-style-type: none"> • Predicted vs. known prevalence of diseases • QOF • Standardised limiting long term illness ratio (persons in household) 	<ul style="list-style-type: none"> • Average, median and range of LOS • Complaint data (primary / community care) • GPAQ (primary / community care) • Immunisation - resident uptake rates • PALS / LINKs data (primary / community care) • Smoking prevalence • Top 10 causes of admission • Top 10 diagnoses causing most bed days 	<ul style="list-style-type: none"> • Health survey • Index of multiple deprivation

Timeframes for Implementation

Project	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Commission a community diabetes service supported by an integrated care pathway that delivers: Increased access to structured education; training for GPs and practice nurses; enhanced patient education resources and advocacy and befriending support;	On-going	Priority	On-going	Option	Option	Option
Develop the capacity of the community CHD service for heart failure, cardiac rehabilitation, and arrhythmia, follow ups for valve replacements;	On-going	Priority	On-going	Option	Option	Option
Develop the capacity of the community respiratory service to Increase access to pulmonary rehabilitation, oxygen assessment, COPD management, early discharge;	On-going	Priority	On-going	Option	Option	Option
Extend Unique care to ensure NHS Barking and Dagenham coverage (action to complete 2011/12)	On-going	On-going	Priority	Option	Option	Option
Commission an integrated falls service		On-going	On-going	On-going	Option	Option
Improve quality of disease registers and reduce variation between reported and anticipated prevalence rates		On-going	On-going			
Structured education and training programme		On-going	On-going	On-going	On-going	On-going
Complete review of neurological services			On-going			
Redesign of top 50 LTC care pathways using Map of Medicine			Priority	On-going	On-going	On-going
Launch of enhanced services and specialist community services aligned with redesigned LTC care pathways				Priority	On-going	On-going
Telehealth and Telecare implementation				On-going	On-going	On-going

Stakeholder Engagement	<ul style="list-style-type: none"> • Integrated care pathways developed by stakeholders in the service, with clinical involvement from primary and secondary care. • The CHD service has been developed through the CHD Local Implementation Team (LIT) with representation from clinicians in primary and secondary care, the cardiac network, public health, commissioning, the voluntary sector and patients. • A similar process has been undertaken for COPD through the respiratory LIT and diabetes through the Diabetes LIT. The LITs' report to the Practice Based Commissioning Steering Group. • Engagement of the Diabetes User Group, Breathe Easy, British Lung Foundation, King of Hearts; • The service model for Unique Care has been developed and agreed with GPs, PCT Provider Services, Social Services and the Voluntary Sector. 		
Equality Impact Assessment	<p>An Equalities Impact Assessment (EIA) has been undertaken for this initiative area in relation to the six equalities strands of disability, faith, sexuality, age, gender and race. Based on an initial assessment of the initiative, the EIA identified a number of recommendations. The findings (some of which are outlined below) will be further reviewed and plans developed to implement the recommendations.</p> <ul style="list-style-type: none"> • To ensure that effective quantitative (equality monitoring) data/information collection and qualitative (Satisfaction) are put in place for patients with long term and unique conditions • This facilitates the efficient evaluation and comparative analysis of monitoring data to take place across all six equality groups • The % of people of BME backgrounds with long term and unique conditions to be monitored and services action taken if there is a quantifiable under take up of services • To put in place detailed human rights guidance for Clinicians and other staff treating people with long term and unique conditions 		
Initiative Risk	Severity	Likelihood	Mitigating actions
Funding available	High	Medium	Developed robust business case. Scenario planning undertaken to identify potential risk areas.
Recruitment difficulties	High	Medium	Posts substantive and at appropriate grade. Utilisation of existing staff to pump prime services. Lean Project identified blocks in the recruitment pathway which are currently being resolved. (Ongoing)
Lack of treatment guidelines	High	Medium	LITs for CHD and COPD agreed pathways and protocols

Initiative 4 – Outpatients and Diagnostics

Initiative description	
Background and Context	<p><i>Our Health, Our Care, Our Say</i> set the direction for providing more care in convenient local settings and this policy has been reinforced in <i>The Next Stage Review</i> and <i>Healthcare for London</i>.</p> <p>The Care Closer to Home demonstration sites have piloted a number of care pathways had reported a positive evaluation from the patients' perspective, with patients experiencing shorter waiting times for services and finding services more accessible than hospital clinics. The cost of Care Closer to Home services in the demonstration sites was generally lower than the same services being provided in secondary care when services costs were benchmarked against the Payment by Results (PBR) tariff (National Primary Care Research and Development Centre).</p> <p>Although patients choose to be referred locally there is a high level of dissatisfaction with hospital outpatient services. Information from the Healthcare Commission reported that patients' experience of outpatient services provided by the local acute trust was very poor. The Trust was rated in the worst 20% of performing trusts nationally. It was clear from the survey that patients want more information from their healthcare provider about their management and the service. They want to be able to access services closer to home and within shorter waiting times.</p> <p>This initiative supports the shift in outpatient services from secondary to primary care.</p>
Case for Change	<p>NHS Barking and Dagenham's population is projected to increase by 22% by 2020 with the development of the Thames Gateway (NHS London 2007), and it is acknowledged that NHS Barking and Dagenham will need to commission additional capacity for outpatient type activity in the local health economy to meet increasing demand over the next few years. Direct access to diagnostic services support care pathway redesign and faster access to treatment.</p> <p><i>Our Health, Our Care, Our Say</i> sets a policy direction for providing services closer to home which supports patients' preferences.</p>
Proposed Changes	<ul style="list-style-type: none"> • To provide additional capacity for elective care pathways to help meet the 18-week target; • To extend the choice of outpatient services offered to Barking and Dagenham residents, and to extend the range of services provided in the community; • To provide care closer to home where clinically appropriate, and maximise the range of services to be provided within the Borough; • To simplify care pathways to support the 18-week target by providing access to diagnostics prior to acute referral and promoting more direct access from community clinical assessment and treatment services into elective surgery; • Ensure that the organisations LIFT facilities are used economically and effectively;

	<ul style="list-style-type: none"> To ensure value for money – clinical assessment and treatment services are to be provided at a cost equating to 75% of national tariff.
Benefits and Quality Improvements	<ul style="list-style-type: none"> Shorter waits for diagnostic services with a turnaround of 10 working days for the independent sector provider from GP referral to GP receipt of test results. From March 2008 the SLA with acute providers assumes a maximum 6-week wait for diagnostic tests; Earlier identification of conditions requiring specialist referral and / or treatment by extending the capacity of direct access diagnostics; Reduction in inappropriate referrals into secondary care for first outpatient appointments, with the reduction accruing from up-front access to diagnostic tests and the provision of an extended range of clinical assessment and treatment services; Shorter waits for first outpatient appointments with the clinical assessment services taking on referrals previously sent to an acute setting, and the service maintaining waits within milestones set out in NHS Service Level Agreements with Acute Trusts.
Impact on Activity	<ul style="list-style-type: none"> The independent sector provision of diagnostic tests from Barking Hospital and Broad Street is assumed to provide additional capacity to support the reduction in waiting times to a maximum of 18 weeks from referral to treatment by March 2008. The SLA with our main acute provider, BHRT, maintains direct access for diagnostics at 2007/8 outturn with no reduction in contracted volumes for the establishment of the independent sector capacity; The clinical assessment and treatment services are targeted with an overall reduction in follow-up ratios compared to acute Trusts; The plan assumes a 5% transfer from acute to community services in each year. In 2008/9 plans for outpatient activity and elective activity account for any additional work that will accrue from the reduction in diagnostic waiting times;
Financial Implications	Please refer to the detailed financial templates.
Impact on provider services	<p>Workload in the acute trust will be reduced as activity suitable for primary care management is transferred out into the community providing additional capacity to reduce waiting times.</p> <p>Services will be procured in line with the rules of co-operation and competition. Potentially services can be delivered by a range of NHS and independent providers.</p>
Current status of project (where are we now)	<p>In 2008/09, NHS Barking and Dagenham is continuing the process of transferring outpatient work from an acute setting into community-based services. Prioritisation and service redesign is being carried out with the three PBC Clusters in Barking and Dagenham.</p> <p>In 2008/9 the organisation has the following services in place, and these are reflected in baseline activity levels:-</p> <ul style="list-style-type: none"> Musculo-skeletal service from the organisations Provider Arm;

	<ul style="list-style-type: none"> • Anti-coagulation follow-ups provided by GPs and Community Pharmacists; • Clinical Assessment and Treatment Services for dermatology, gynaecology, urology, ENT, headache and minor surgery; • Community COPD, CHD and diabetes services (Refer to Initiative 3); • Direct access to Independent Sector Diagnostics. <p>All of these services are established as an alternative to referral into acute outpatient clinics, and appear as an option on NHS Barking and Dagenham's Choose and Book commissioning rules.</p> <p>The services are not run as an umbrella referral management service through which all referrals in these specialties are routed for screening and triage, but as a Choice option for referral into by GPs if they think this to be clinically appropriate.</p>			
Success Measures	<ul style="list-style-type: none"> • Waiting time for diagnostics reduced to 2 weeks by 2012; • 5% transfer of outpatient activity from secondary to primary care each year for the next 5 years; • First outpatient appointment provided in the community within 4 weeks by 2009; • Extension of CATS to new specialities through commissioning of map of medicine pathways. 			
Health Outcome Measures		Key	Second-Level	Associated
	Health Outcome Measure	•	<ul style="list-style-type: none"> • 18 weeks referral to treatment and diagnostics • Providing care closer to home including 5% transfer of care from secondary to primary care • Improving health outcomes for people with LTC • Practice based registers- % diabetics called for review 	<ul style="list-style-type: none"> • Blood pressure control in hypertensive • Cholesterol levels • CVD mortality rate • Mortality rates from circulatory diseases
	JSNA Measure	•	<ul style="list-style-type: none"> • Index of multiple deprivation • Predicted vs. known prevalence of diseases • QOF • Self-reported health outcomes (hospital) • Top 10 causes of admission • Top 10 diagnoses causing most bed days 	<ul style="list-style-type: none"> • Complaint data (primary / community care) • GPAQ (primary / community care) • Health survey • No access to car or van • Standardised limiting long term illness ratio (persons in household)

Timeframes for Implementation	Project	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	Expansion of CAT services	On-going	On-going	On-going	On-going	On-going	On-going
Review of orthopaedic and optometry pathways by 2009;		Priority					
Sign-off plan of top 50 elective care pathways to transfer into community settings from 2010/11 - 2013/14		Priority					
Expansion of direct access diagnostics in line with CAT expansion and care pathway redesign		On-going	On-going	On-going	On-going	On-going	On-going
Review of dyspepsia and endoscopy pathway by 2010.				Priority			
Roll out Care Closer to Home services in orthopaedics and optometry				On-going	On-going		
Roll out Care Closer to Home services in dyspepsia and endoscopy					On-going	On-going	
Stakeholder Engagement	<p>NHS Barking and Dagenham has consulted with service users, through the PPI framework, on the design and scope of clinical assessment services. The tender process for the clinical assessment services has included Borough overview and scrutiny, GP leads and non-executive directors in the evaluation process;</p> <p>Engagement with BHRT and out provider unit is crucial to implementing the Clinicenta stroke early discharge service.</p>						
Equality Impact Assessment	<p>An Equalities Impact Assessment (EIA) has been undertaken for this initiative area in relation to the six equalities strands of disability, faith, sexuality, age, gender and race. Based on an initial assessment of the initiative, the EIA identified a number of recommendations. The findings (some of which are outlined below) will be further reviewed and plans developed to implement the recommendations.</p> <ul style="list-style-type: none"> • Put in effective quantitative (equality monitoring) and qualitative (Satisfaction) data collection • Ensure efficient evaluation and comparative analysis of monitoring data to take place across all six equality groups • Ensure up-to-date equality & human rights training for diagnostic staff • Put the necessary aids and adaptations in place to assist people with hearing and visual impairments in reception and appointment areas (i.e. electronic appointment boards, hearing loops, assist for deaf patients, etc) • 						

Initiative Risk	Severity	Likelihood	Mitigating actions
Delay in Independent Sector diagnostic provision in B&D.	Low	Low-Med	B&D residents can access services London wide and not restricted to case mix set out in original procurement. NELTC up and running and supporting diagnostic waiting times. (Ongoing)
GPs do not refer into new diagnostic services	Low	Medium	<ul style="list-style-type: none"> • Care pathways taken to protected learning time events. • PBC incentives to use the service. • The organisation has appointed an 18-week lead who will work with practices to maximise use of services.
Diagnostic test in community replicated unnecessarily in acute setting	Medium	High	Care pathway protocols. (Ongoing) Tariff unbundling for outpatient appointments with acute sector. (Ongoing) Maximise referrals into clinical assessment and treatment services. (Ongoing)
Delay in establishing clinical assessment and treatment services	Moderate	Low-Med	Continuation of current GPWSI Services. Reserves for service moved to cover acute SLA over performance.
GPs do not refer into new clinical assessment and treatment service	High	Med - High	PBC incentives to use services in place – 75% of tariff price generates PBC savings. Introduced through protected learning time. 18-week Co-coordinator to support GP referrals.

Initiative 5 – Urgent Care

Initiative description	
Background and Context	Within B&D there is a pattern of high use of A&E Departments as a route to access primary care and <i>Healthcare for London: A Framework for Action</i> identified unscheduled care as a priority issue. There has been public consultation support for proposals to improve the organisation and delivery of care.
Case for Change	The local A&E departments continue to struggle to meet and sustain the 4 hour waiting time standard and there is considerable evidence to suggest that many A&E attendances can be seen in alternative settings. Approximately two thirds of overnight admissions for children could be prevented with alternative models of care. Consultation exercises have suggested that patients would welcome more accessible services.
Proposed Changes	<ul style="list-style-type: none"> • Maximising in-hours availability of primary care in general practice, through the performance management work that will be undertaken in the coming months; • Extended hours opening in general practice, building on the successes relating to extended opening hours witnessed in 2007/08. This will be further enhanced by the three procurement initiatives for health centres identified in the primary care and community strategy. This will provide opportunities for successful bidders to be rewarded for longer opening hours providing access to surgeries in a spread of locations across the Borough; • The development of an alternative model for the delivery of urgent care for children reducing the need for overnight stay in hospital, by providing services in children’s centres, and broadening the access criteria for Upney Lane Walk in Centre to see patients under the age of 10; • Linked to this, the Barking Hospital tender provides for the opportunity to develop a 24/7 Unique Care Centre (UCC) at Barking Hospital with diagnostics support providing an enhanced alternative to A&E; • The development of a federated and a planned polyclinic will lead to a range of services delivered under one setting that will provide better access for patients with conditions that may result in a reduction in the use of urgent care services. The development of a polyclinic in Riverside will also support this in an area that will be more geographically remote from services providing urgent care treatment; • Regular campaigns will be launched to encourage the local public to make user of the local walk in centres, building on the success of recent campaigns; • NHS Barking and Dagenham will develop a local out of hours emergency dental service reducing the need for patients to travel long distances for urgent dental care;

	<ul style="list-style-type: none"> • Further investment will be made in out of hours pharmacy services, to provide local alternatives for patients who are suffering with minor ailments; • Access to more specialised urgent care, such as major trauma and critical care, together with the location and level of service provision for urgent care arising from the implementation of the Healthcare for London model, will have an enormous impact upon this priority. In developing local plans and supporting sector plans for this issue, the organisation will be alive to the need to maintain accessible services, whilst ensuring that high quality is maintained that provides the best outcomes. • Delivery of the Outer North East London (ONEL) specifications for out of hospital care, to reduce pressure on hospital capacity; • Increase in the number of beds at Grays Court to 54, with an agreement to flex more beds where required at peak times during the year.
Benefits and Quality Improvements	<ul style="list-style-type: none"> • Sustained performance against the 4 hour waiting time target; • Improved patient satisfaction associated with the delivery of urgent care for children; • Improve access to primary care services and expansion of the availability of primary care consultations both in hours and out of hours, scheduled and unscheduled; • Improve the cost effectiveness of primary care; • Reduce the use of A&E departments for minor injuries and illnesses.
Impact on Activity	<ul style="list-style-type: none"> • A move of activity from secondary care into primary care, with the driver being extended access to both general practice and Walk-In-Centres; • A reduction in A&E attendances will accrue from extended hours in primary care and the increased provision of diagnostic services surrounding Barking and Dagenham Walk-In-Centres at Upney Lane and Broad Street. • A repatriation of some A&E attendances to the Walk-In-Centres at Upney Lane as they begin to offer more diagnostic services and greater scope for 'one-stop' care; • The extended hours in primary care will divert some patients who previously would have attended Walk-In-Centres back into general practice; • NHS Barking and Dagenham is working with practices to extend the number of primary care consultations through extended hours, with access contingent on the additionality of appointments from extended hours rather than being a replacement for in-hours activity. Value for money metrics are beginning to indicate relative practice in-hours consultation rates as the organisation and practices work on improving in-hours access; • A reduction in overnight stays for children with conditions that could be seen more effectively in alternative care settings.
Financial Implications	Please refer to the detailed financial templates.

Impact on Provider Services	<ul style="list-style-type: none"> • NHS Barking and Dagenham is in the process of tendering out the Walk in Centre at Barking Hospital, which may result in new providers in the local health economy; • Acute service provision may change as a result of plans for critical care and major trauma; • Existing providers will need to be more flexible in both opening times and also in locations of delivery. 			
Current Status of Project (where are we now)	<ul style="list-style-type: none"> • In Barking & Dagenham, where there is no A&E Department, there is now a 24/7 Urgent Care Centre based at Barking Hospital which offers the same range of diagnostic and treatment opportunities as the UCCs attached to the A&E departments. This will be developed in a way that integrates the care offered by the GP Out of Hours provider (currently PELC) and the nurse-led Walk in Centre (WiC); • Additional long hours Walk in Centre and the successful extension in primary care from 7.00 to 8.00am and from 6.30 – 8.00pm and on Saturday mornings, and the impact of this on attendances at A&E is currently being monitored and evaluated. 			
Success Measures	<ul style="list-style-type: none"> • Sustained 98% achievement against the A&E waiting time target" • Improved patient satisfaction with access to services, notably GP access within 48 hours. Target consistent with vital signs trajectories, 82% able to see GP within 48 hours if wanted; • To achieve the rates for length of stays (by speciality) as agreed in the acute SLA. 			
Health Outcome Measures	Initiative Performance Indicators			
		Key	Second-Level	Associated
	Health Outcome Measure	<ul style="list-style-type: none"> • Emergency bed days • A&E 4 hour waits • 	<ul style="list-style-type: none"> • Alcohol harm related hospital admission rates • Delayed transfers of care • DTOC from hospitals • Mortality rates from circulatory diseases 	<ul style="list-style-type: none"> • All age all cause mortality • Improving health outcomes for people with LTC • Infant mortality
JSNA Measure	<ul style="list-style-type: none"> • Average, median and range of LOS • Top 10 causes of admission • Top 10 diagnoses causing most bed days 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Complaint data (primary / community care) • GPAQ (primary / community care) • No access to car or van • PALS / LINKs data (primary / community care) • Patient satisfaction surveys (hospital) • QOF • Self-reported health outcomes (hospital) 	

Timeframes for Implementation	Project	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	Tendering out of WIC at Upney Lane	Priority					
Development of federated and planned polyclinics		Priority	Priority	On-going	On-going	On-going	
Development of local out of hours emergency dental service		On-going	On-going	On-going	On-going	On-going	
Development of urgent care alternatives for children		Priority	On-going	On-going	On-going	On-going	
Implementation of Out of Hospital specifications across ONEL		On-going					
Roll out of Improving Access to Psychological Therapies waiting times		On-going	On-going	On-going	On-going	On-going	
Roll out of out of hours pharmacy services for minor ailments		Priority	On-going	On-going	On-going	On-going	
Implementation of HfL models for specialised acute urgent care			On-going				
Opening of Riverside polyclinic					Priority	On-going	On-going

Stakeholder Engagement	<p>NHS Barking and Dagenham has undertaken a 3 month consultation on the future services at Barking Hospital, and the urgent centre concept was completely supported. The organisation has also undertaken some consultation work looking at the range of services at general practices and their accessibility. The outcomes here were that people still find it difficult to access care, especially at times convenient to them- i.e. evenings and Saturday mornings.</p> <p>The HfL consultation undertaken last year suggests that the public support these proposed models.</p>
Equality Impact Assessment	<p>An Equalities Impact Assessment (EIA) has been undertaken for this initiative area in relation to the six equalities strands of disability, faith, sexuality, age, gender and race. Based on an initial assessment of the initiative, the EIA identified a number of recommendations. The findings (some of which are outlined below) will be further reviewed and plans developed to implement the recommendations.</p> <ul style="list-style-type: none"> • To recruit a 'representative workforce' at the proposed UCC, WICs, Polyclinics and other primary facilities • Put in effective quantitative (equality monitoring) data/information collection and qualitative (Satisfaction) via UCC, WICs, Polyclinics and other community based facilities • Ensure efficient evaluation and comparative analysis of monitoring data to take place across all six equality groups

	<ul style="list-style-type: none"> To safeguard human rights and, particularly, preserve the dignity and privacy of all patients, and specifically the most vulnerable 		
Initiative Risk	Severity	Likelihood	Mitigating actions
That the initiative picks up currently unmet need, and therefore A&E activity does not reduce as much as projected	High	Medium	<ul style="list-style-type: none"> Unmet need to be assessed through PPI initiatives and surveys (Ongoing) Consider a percentage of unmet need when projecting activity levels. This initiative will have a financial impact on acute services and will be monitored as part of the SLA and Quality Specification. Increased urgent capacity in other settings is already in place (e.g. Walk in Centres, GP Extended Hours, Rapid Response).
That it takes longer than expected for the population to change existing patterns of behaviour	High	Medium	<ul style="list-style-type: none"> Widespread marketing of new services, including detail about exactly what is available, and when, and story-telling in a variety of media (Ongoing). PPI and community engagement (Ongoing) Positive patient experience in other settings promoted. (Ongoing)
That the population do not trust the local solutions, and continue to utilise the UCCs and A&E departments outside the borough	High	Low	<ul style="list-style-type: none"> As above; Ensuring that there is adequate diagnostic and medical cover.

Initiative 6 – Stroke

Initiative description	
Background and Context	<ul style="list-style-type: none"> • National and local mortality trends for stroke have been decreasing over the last decade, however standardised mortality rates for B&D residents are still higher than the London and England average; • In B&D there were 235 deaths locally caused by stroke in 2006, of those 27% were in people under 75 yrs and therefore potentially preventable; • Estimated that there are 300 new stroke cases and 150 transient ischemic attacks (TIAs) per year in B&D; • Overall estimated number of people living in the community at any time with stroke and TIA is 2,656 of those 850 have moderate or severe disability; • Healthcare for London: A Framework for Action identified stroke care as a priority issue; • Public consultation supported proposals to improve the organisation and delivery of care; • Established as a first wave project by the London Commissioning Group; • Programmes for increasing physical activity, reducing smoking and healthy eating which will all have a positive impact on reducing incidence of stroke are covered in the healthy adults initiative so are not replicated here despite their recognised contribution to achieving the targets.
Case for Change	<ul style="list-style-type: none"> • Stroke is the 2nd most common cause of death in London and single most important cause of physical disability; • Stroke imposes a considerable burden on the society in terms of both death and disability; • There are inequalities involving access to, and quality of, stroke services in London; • A “Framework of Action” identified a need for planned development of specialist care;
Proposed Changes	<p>Ranges of initiatives are proposed and many already have taken place locally aiming to prevent stroke admission, improve hospital care and rehabilitation services for patients with stroke and enable patients' early return to the community.</p> <ul style="list-style-type: none"> • Service reconfiguration with the centralisation of acute services at Queen's Hospital; • Urgent development of a clear pathway from hyper acute to acute and rehabilitation care; • The knowledge and skills gap between the current and desired state of stroke services needs to be reduced by training and upgrading staff skills on the unit; • In keeping with the National Stroke Strategy and guidelines for stroke centres being developed by Healthcare for London, NHS Barking and Dagenham should seek active partnerships with BLT and other providers of stroke services in the region within a

	<p>network model;</p> <ul style="list-style-type: none"> • Prioritise the appointment of a specialist in stroke to lead the service as there is an urgent need for effective and credible clinical leadership.
<p>Benefits and Quality Improvements</p>	<p>This initiative brings parity of access and reduces inequality of provision of stroke services. As well as performing poorly against all key indicators for stroke and PSA targets (reducing the mortality rate by 2010 for heart disease, stroke and related diseases by at least 40% in people under 75, with a reduction in the inequalities gap by at least 40%), there are also wide variations in levels of access and quality outcomes between providers. Expected impacts include:</p> <ul style="list-style-type: none"> • Early intervention and rapid access will reduce morbidity and mortality for under 65s (25% of strokes); • Mortality from hypertensive disease and stroke in B&D is 29% higher than England and Wales average, and these interventions will reduce the life expectancy gap; indeed there is a PSA target to reduce inequalities from stroke deaths; • High levels of stroke incidence driven by predisposing factors such as ethnicity mix and high levels of deprivation, diabetes, hypertension and CVD; • NEL average Length of Stay (LoS) is 74% higher than the national average. These services will reduce the average LoS, with the potential for a sector wide reduction in beds (26) and bed-days (8610); • Other benefits will include an informed population able to take action for preventive self-care and seek appropriate advice and support, a reduction in the prevalence of stroke risk factors, reduced morbidity and mortality and the implementation of interventions within timescales which produce best outcomes. <p>Intermediate Care will provide:</p> <ul style="list-style-type: none"> • An improved ability to provide preventive support for those people at risk of developing stroke at a younger age; • A reduction in referrals to acute services through enhanced primary care referral and appropriate intervention. <p>A community team will work across the primary and secondary interface:</p> <ul style="list-style-type: none"> • Provide an improved ability to provide more rehabilitation in the community; • Achieve reduced length of stay in hospital; • More effective working with intermediate care to prevent readmission; the development of a service more able to address the needs of younger people at risk/suffering from stroke; • Fewer outliers receiving clinical and therapy interventions within the timescales of the stroke care pathway so achieving health outcomes. <p>Post stroke care will ensure that:</p> <ul style="list-style-type: none"> • Stroke survivors with stroke-related communication difficulties will be able to participate in activities of daily living, and receive appropriate responses when using services from trained staff; • There will be a reduction in social exclusion of people affected by aphasia;

	<ul style="list-style-type: none"> Improved opportunities to participate in employment and social activity. <p>Developing Day Services will ensure:</p> <ul style="list-style-type: none"> People with strokes will be integrated into mainstream day services; More people with strokes will be able to remain at home.
Impact on Activity	<ul style="list-style-type: none"> This initiative will greatly increase the number of patients identified as suffering from TIA and stroke, and will therefore increase the numbers of patients receiving a range of investigations and clinical interventions, including: CT scans, Cerebral angiography; Increased therapeutic activity; Increased activity in TIA clinics; Shift of activity from acute to community with early supported discharge programme; In particular we will expect to meet the 40% reduction in mortality from stroke by 2012; Better care in the acute sector might result in a LoS reduction of 8610 days.
Financial Implications	Please refer to the detailed financial templates.
Impact on provider services	BHRT is currently developing a business case that will include total capital investment required to establish the stroke services.
Current Status of project (where are we now)	<p>NHS Barking and Dagenham has developed the following strands of work over the last 12 months, all of which fall within the overall development of the stroke care pathway. Most of the initiatives have been implemented in line with the National Stroke Strategy standards but some of the planned work is in developmental stage:</p> <ul style="list-style-type: none"> Conducted a “FAST” awareness campaign in partnership with the Stroke Awareness Association in September 2008, aimed at raising public awareness of the early symptoms of stroke; A vascular screening and prevention plan will be developed in October 2008 to address specific risk factors for stroke and other cardiovascular disease and lifestyle changes; Enhanced health services were commissioned to improve vascular risk registers and stroke registers in all GP practices in B&D; GP lead for Stroke appointed earlier this year; GP lead for Stroke is also providing clinical input to enable the establishment of a community-based stroke and TIA clinic, aimed at improving secondary prevention of stroke in the community; Access to TIA services for B&D patients who come to GP surgeries has been commissioned from Newham Hospital; Commissioned multidisciplinary intermediate and outreach rehabilitation specialist stroke teams that are based at our new

	intermediate; <ul style="list-style-type: none"> Stroke action plan is in place for progress up to 2010. 			
Success Measures	<ul style="list-style-type: none"> 80% of all patients to spend >50% of their in-patient admission relating to stroke in a stroke unit by 2009 from a baseline of 65% in 2007. 60% of patients with TIA to have a CT/MRI imaging within 24hrs of admission unless there is a documented contraindication by 2009 from baseline of 25% in 2007. Reduction in mortality rate from CVD, stroke, Reduce deaths within 30 days of admission for stroke such that the improvement banding in the National Compendium indicators moves from category D to A by 2012. Increased number of people on vascular risk registers to achieve 90% of expected burden of disease by 2012. Increased number of people on stroke registers to achieve 85% of expected population by 2012. Reduced stroke hospital emergency admission rate for stroke such that the improvement banding in the National Compendium indicators moves from category C to A by 2012. 			
Health Outcome Measures	Initiative Performance Indicators			
		Key	Second-Level	Associated
	Health Outcome Measure	<ul style="list-style-type: none"> CVD mortality rate 	<ul style="list-style-type: none"> All age all cause mortality Delayed transfers of care DTOC from hospitals Emergency bed days 	<ul style="list-style-type: none"> 4 week smoking quitters Enabling people to die at home Improving health outcomes for people with LTC Mortality rates from circulatory diseases Proportion of all deaths occurring at home Timeliness of social care assessment
JSNA Measure	<ul style="list-style-type: none"> Self-reported health outcomes (hospital) 	<ul style="list-style-type: none"> Average, median and range of LOS Patient satisfaction surveys (hospital) Predicted vs. known prevalence of diseases Top 10 causes of admission 	<ul style="list-style-type: none"> Health survey No access to car or van QOF Smoking prevalence 	

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Stakeholder Engagement	At the NEL-wide event in July 2007 the sector agreed workstreams that are taking forward both the collaborative commissioning agenda and other pieces of work for e.g. health needs and cost benefit analysis to allow each PCT to have robust data to enable assessment of service configuration and bed numbers required. Work is on going with social care and the voluntary sector.																																																											
Equality Impact Assessment	<p>An Equalities Impact Assessment (EIA) has been undertaken for this initiative area in relation to the six equalities strands of disability, faith, sexuality, age, gender and race. Based on an initial assessment of the initiative, the EIA identified a number of recommendations. The findings (some of which are outlined below) will be further reviewed and plans developed to implement the recommendations.</p> <ul style="list-style-type: none"> Review and strengthen available quantitative (equality monitoring) data/information collection systems for stroke in the borough and improve patient's qualitative (Satisfaction) data on treatment received Ensure that monitoring data on stroke can be broken down to allow comparative analysis across all six equality groups. Mainstream and update equality training for staff working on stroke prevention and care To adopt detailed policy and guidance for NHS staff on preserving the dignity and privacy of people suffering from stroke. 																																																											
Initiative Risk	Severity	Likelihood	Mitigating actions																																																									
Absence of NSF for strokecare.	Medium	Low	Due for publication late summer. HfL Framework for Action has identified stroke as a priority and set out good practice.																																																									

Reduced admissions to DGHs may weaken local services.	High	Medium	The number of stroke patients identified within three hours is likely to be less than 50% and patients attending the hyper acute centre will need to be discharged to local stroke centres for rehabilitation.
Increased identification of patients with stroke and TIA and treatment against evidence based pathways will increase over all spend on specialist stroke services.	High	Medium	Robust economic appraisals of all developments. This needs to include all the costs e.g. including the less obvious ones like transfer costs between hospitals, staff retention etc. Increased costs will be off set by reducing lengths of stay and preventing avoidable strokes.
Workforce shortages particularly specialist stroke physicians, nurses and therapists may slow developments.	High	High	A workforce portrait will be undertaken by the Network Local development of staff will be considered.
Engaging staff in developments	High	Low	The Network will support further engagement with local clinicians.
LAS will be unable to identify patients who have had a stroke. Non stroke patients will be taken to the hyper acute stroke units and gaining repatriation in other hospitals may be a challenge.	High	High	Robust pathways need to be established with sector buy-in; LAS need to be trained to utilise existing tools such as FAST that will assist them in identifying patients.
Patients, families and carers may suffer increased stress and be dissatisfied with moving hospitals mid-care	High	Low	Local engagement through PPI and community networks. Better information for carers and relatives Health Trainer Scheme Consultation at each stage of pathway development.

with the potential loss of confidence and with having to travel longer distances			
Open access TIA clinics could get inundated with inappropriate patients unless frontline staff (GP's, A+E staff are trained to filter out the high risk group)	High	Low	Training and education to support front line staff to utilise existing tools such as FAST and ROSIER that assist in identifying and filtering TIA patients.

Initiative 7 – Maternity

Initiative description	
Background and Context	Maternity is an NHS London headline priority area for development and development of robust and coherent maternity services are a key part of HfL.
Case for Change	<ul style="list-style-type: none"> • 2006 Royal College of Obstetricians and Gynaecologists (RCOG) inspection of BHRT maternity services; • Review visit by RCOG in 2008 highlighted improvement; • 13% of pregnant mothers smoke during pregnancy; • 98% of births occurring with BHRT happen in either Queens or King George Hospital and approximately 2% at home; • Only 71% of women in B&D initiate breastfeeding at birth.
Proposed Changes	<p>Safer Child Birth and improved access based on need and choic</p> <ul style="list-style-type: none"> • Meet the 1:1 ratio of midwives to women in labour; • Increase obstetric consultant to meet demand in labour ward cover; • Strengthening community midwifery services for socially excluded groups, and adopting processive universalism and putting in place systems to support early assessment of pregnant women including direct access to midwives; • Increase antenatal capacity to offer booking by 10 weeks and late presenters by within 1 week; • IT systems in place to cover connectivity between BHRT and Children's Centres; • Providing approachable and supportive antenatal services in accessible and convenient settings. The key is to provide them in local settings to encourage early access to maternity care once pregnancy is confirmed; • Women to have their first full booking and hand record completed by 12 weeks of pregnancy. This pathway will be using direct access to midwives. Currently most women attend their GP surgery and are then referred on to the midwifery team. Robust communication systems will be established with a woman's GP in order that they are informed of the pregnancy and its outcomes; • To improve the continuity of care and increase the number of midwives within the community based teams thus reducing the case load for each individual midwife and reducing day care attendances at Queens. <p>Choice of antenatal education</p>

	<ul style="list-style-type: none"> • Access to antenatal education about parenting and preparation for birth. NHS Barking and Dagenham is seeking to commission a training antenatal programme to be delivered in partnership with health visitors and midwives. Reducing the number of women smoking during pregnancy is a key target for the organisation. • NHS Barking and Dagenham aims to integrate midwifery teams into the wider multidisciplinary primary and acute health teams in joint antenatal and postnatal drop-in sessions at the children centres. <p>Choice of place of birth</p> <ul style="list-style-type: none"> • NHS Barking and Dagenham is committed to increasing the number of home births and as soon as we have achieved safe one-to-one care for women in labour, we will focus attention on meeting this commitment. In addition to this we will be opening a standalone midwifery led unit at Barking Hospital which adds further choice for local women <p>Postnatal care</p> <ul style="list-style-type: none"> • The low breastfeeding initiation rate is compounded by the lack of commitment to staff training and implementation of the Baby Friendly initiative, which supports breastfeeding. NHS Barking and Dagenham wishes to introduce the role of support workers in maternity as members of the community midwifery teams supported by 1 antenatal coordinator to provide support to breastfeeding women. <p>Evidence required:</p> <ul style="list-style-type: none"> • Maternal mortality, perinatal mortality and morbidity, postnatal readmission rates; • Percentage of women offered antenatal service in accessible venue with choice of times and days of the week; • Development of infrastructure and marketing to promote the midwife as first point of contact by April 2010; • Evidence of effective shared information where appropriate with children centres e.g. CAF assessments for teenage pregnancy; • Breastfeeding initiation to meet LDP targets; • Reduction of smoking in pregnancy to meet LDP; • Percentage of women and men taking up parenting programmes with target work to more deprived areas; • Numbers of women identified with postnatal depression by midwives and percentage offered support or referred to community mental health services; • Annual patient satisfaction surveys.
<p>Benefits and Quality Improvements</p>	<p>The impact of these projects and performance management of the service specifications and quality framework is to reduce maternal and neonatal death. It is also expected to reduce the number of antenatal day care assessments, which will deliver high quality and more in maternity services meeting the needs of women.</p>

Impact on Activity	<ul style="list-style-type: none"> • Activity: Births and c-sections (scheduled and unplanned); • Obstetrics: eclampsia, ICU admissions in obstetrics, post partum hysterectomies; • Neonatal mortality: number of cases of meconium aspiration; • Risk management: number of Serious Untoward Incidents (SUIs); • Complaints: numbers of complaints in year; • Early booking: to address the 12 week booking target; • Increase breastfeeding at 6 – 8 weeks by 2% year on year to 2012 from 2007 baseline.
Financial Implications	Please refer to the detailed financial templates.
Impact on provider services	There remains substantial development of efficiencies at BHRT as the acute maternity provider, which will impact on the structures and elements. However this requires joint support from Havering and Redbridge PCTs through the Partnership Board.
Current status of Project	<ul style="list-style-type: none"> • Since the inspection there has been substantial investment in acute and community maternity services. As well as the development of the service specifications for maternity and neonatal services, a Quality Framework Schedule with clinical quality indicators forms part of BHRT's Service Level Agreement with the co-commissioning primary care organisations. • Performance management has been put in place since the lead commissioning role moved to NHS Barking and Dagenham; • There are quarterly maternity review meetings and there has been a restructuring of maternity within the acute trust to create a clinical director of women's services with clear accountability, performance management and responsibilities; • Information technology was a substantial risk area and BHRT have now rolled out the electronic patient care record to Maternity services; • NHS Barking and Dagenham is actively engaged in pan-London work on commissioning the structure of Maternity services; • There has been a Maternity Services Liaison Committee (MSLC) in place since 2007, with representation from the organisations community empowerment team. There has been investment in developing a peri-natal mental health function to address the needs of women with mental health issues during pregnancy which do not require tier 4 services; • NHS Barking and Dagenham is a partner in the developing Maternity Strategic Partnership Board and has circulated a bid to other partners for joint funding for a dedicated post to support this work; • Further work is needed to develop antenatal care, education and improve the uptake of breastfeeding; this will be developed across disciplines with an enhanced function for specialist public health nurses in ante-natal and post-natal support. This will also be strengthened by the location of a Maternity hub at the Barking Hospital site, where there are long term plans for a midwife-led delivery unit but in the short term facilities for ante-natal booking and scanning services.
Success Measures	<ul style="list-style-type: none"> • Establishment of the Joint Maternity Strategic Partnership Board by June 2010;

- Achievement of 1:33 midwife ratio by 2012 with interim of 1:37 by 2010 and 1:35 by 2011;
- Reduced maternal and neonatal deaths with the aim to reduce rolling cumulative total to less than 3 maternal deaths over 3 years and less than 10 neonatal deaths per year;
- Improved clinical outcomes measured through reduction in complications rates and emergency caesarean section;
- IT systems connecting community clinics with BHRT Maternity Systems by 2012 through the National Programme for IT initiatives;
- Breastfeeding strategy in place by 2010;
- BHRT and community services achieve UNICEFF Baby Friendly Standards by 2012;
- Undertake maternity needs assessment in 2010 and maternity equity audit in 2011 in partnership with NHS Havering and NHS Redbridge and BHRT;
- Reduction of% of women smoking during pregnancy from 13% in 2007 to 8% by 2012.

Health Outcome Measures	Initiative Performance Indicators		
	Key	Second-Level	Associated
Health Outcome Measure	<ul style="list-style-type: none"> • Smoking in pregnancy • Early access to maternity services • Infant mortality 	<ul style="list-style-type: none"> • Teenage pregnancy 	<ul style="list-style-type: none"> • Adults in contact with secondary mental health services settled in accommodation • All age all cause mortality
JSNA Measure	<ul style="list-style-type: none"> • Conception <16 • Conception <18 	<ul style="list-style-type: none"> • Average, median and range of LOS • Complaint data (primary / community care) • Health survey • Patient satisfaction surveys (hospital) • Projected birth rate • Self-reported health outcomes (hospital) • Smoking prevalence 	<ul style="list-style-type: none"> • Immunisation - resident uptake rates • Index of multiple deprivation • No access to car or van

Timeframes for Implementation	Project	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	Achieve Midwife ratio of 1:37		Priority	Priority	Priority	On-going	On-going
Establish BHRT led breastfeeding strategy.		On-going	On-going	On-going	On-going	On-going	
Establish joint strategic partnership board.		Priority					
Increased antenatal capacity		On-going	On-going	Option	Option	Option	
Undertake maternity needs assessment		On-going					
Additional PAs to provide consultant obstetric cover				Option	Option	Option	Option
Antenatal education training in partnership with health visitors				On-going	On-going	On-going	On-going
Community midwifery services for socially excluded groups				Priority	Priority	On-going	On-going
				Priority			
Direct access midwifery care pathway in place				Priority			
Undertake maternity equity audit				On-going			
Delivered IT systems connecting community clinics with BHRT					Priority	On-going	
Reduce women smoking in pregnancy to 8%					Priority	On-going	On-going
Stakeholder Engagement	Consultation for maternity services is conducted through the MSLC.						
Equality Impact Assessment	<p>An Equalities Impact Assessment (EIA) has been undertaken for this initiative area in relation to the six equalities strands of disability, faith, sexuality, age, gender and race. Based on an initial assessment of the initiative, the EIA identified a number of recommendations. The findings (some of which are outlined below) will be further reviewed and plans developed to implement the recommendations.</p> <ul style="list-style-type: none"> • The community service to monitor and use positive action to achieve a 'representative workforce' at the proposed Barking Maternity Hub • To strengthen qualitative (satisfaction) and quantitative (monitoring) data/information collection systems for community based maternity services • Ensure that midwives collect equality data and that there is synergy and information sharing with GPs and BHR data 						

Initiative Risk	Severity	Likelihood	Mitigating actions
Lack of qualified midwives or the retention of this skilled group, which affects all providers	High	Medium	Development of a recruitment and retention strategy through the Collaborative Commissioning Group.
Currently there are not robust information systems in place to support new ways of working.	High	Medium	There is a North East London Programme Team to support the CRS and ICT initiatives and the development of sector ICT strategies. (Ongoing)

Initiative 8 – End of Life Care

Initiative description	
Background and Context	<ul style="list-style-type: none"> • End of Life Care Strategy, DH, July 2008 • HfL – Care Outside Hospital • Barking and Dagenham End of Life Care baseline review, December 2007 • NICE Improving Supportive and Palliative care for Adults with Cancer, March 2004 • North East London End of Life Care Collaborative Commissioning Intentions, October 2008
Case for Change	<p>End of Life care occurs in virtually all areas of health and social care delivered by a wide range of providers from the NHS, social care, voluntary and independent sectors. Currently dying people and their carers have variable experience of care with inequalities of access and availability of key services.</p> <p>Currently most people die in hospital. The End of Life Care Strategy provides guidance to develop end of life care services.</p> <p>The complexity of end of life care means that a collaborative approach to commissioning services would promote a common approach to care delivery and outcomes, reduce inequalities and improve patient and carer experience. Healthcare for London proposes the commissioning of end of life care service providers at a sector level with the purpose of co-ordinating care and maintaining a register of people with end of life care needs.</p>
Proposed Changes	<p>End of Life Care focuses on addressing a common need within the population, rather than focusing on condition-specific end of life care services. Three tools have been developed by the Department of Health to facilitate end of life care within the community: the Gold Standards Framework, the Liverpool Care Pathway and Preferred Priorities of Care. To ensure a smooth palliative care pathway is in operation, NHS Barking and Dagenham has funded three, End of Life Care Facilitators to implement these tools across the borough. This means that patients with identified need have access to specific services which support their needs. NHS Barking and Dagenham has committed to implementing the recommendations from the NICE palliative and supportive care guidelines by December 2008, and to work with other primary care organisations in the NEL sector to support collaborative commissioning and to improve access and reduce inequalities.</p>
Benefits and Quality Improvement	<ul style="list-style-type: none"> • Implement and monitor an agreed care pathway for end of life care; • Develop co-ordinated care engaging all stakeholders; • Invest in best practice; • Assess capacity of existing resource and invest in service development where needed;

	<ul style="list-style-type: none"> • Enable the PCT to be compliant with NICE Supportive and Palliative Care Guidance and implement the national End of Life Care Strategy.
Impact on Activity	Reduction in unnecessary treatment and peaceful death, benefiting both patient and family and reduction in emergency admissions
Financial Implications	Please refer to the detailed financial templates.
Impact on Provider Services	<ul style="list-style-type: none"> • Reductions in emergency admissions for people identified as being in their last year of life / with long term conditions • Acute and community setting implementing end of life care toolkit, with assistance of End of Life Care Facilitators • Fewer patients dying in hospital • Likely to be more deaths taking place in care homes • GPs and DNs having increased workload to facilitate patients dying at home • Increased pressure on out of hours services
Current Status (where are we now)	<ul style="list-style-type: none"> • Baseline review completed, December 2007; • End of Life Care locality board meets bimonthly since April 2008, with membership from partner organisations, including NELCN, BHRT, Saint Frances Hospice and LBBD; • 27/45 GP practices and 2 care homes signed up to GSF; • St Francis Hospice fully implemented LCP; • Care homes fully implemented PPC; • Two End of Life Care Facilitator posts recruited, 1 in-reach post with BHRT pending; • Place of death: 69.4% hospital; 16.6% home; 4.9% nursing home; 2.3% care home; 4.4% hospice; 2.4% other • Paediatric palliative care needs assessment developed and commissioned on behalf of north east London network.
Success Measures	<ul style="list-style-type: none"> • Improved patient and care experience of services and a reduction in complaints citing end of life care • The end of life care workforce will be able to access appropriate education resources to meet their competency requirements with 50% of the having received appropriate training • Patients in the last year of life benefit from care that meets best practice standards with 80% of deaths benefiting from LCP • 80% patients identified as being in the last year of life benefiting from GSF • 100% patients identified as being in the last year of life having a recorded end of life/advanced care plan • 80% patients achieving their preferred place of death • 80% patients identified as being in the last year of life added to electronic end of life care registers

- All bereaved people signposted to appropriate bereavement support resources and a reduction in reported psychological disorder related to bereavement
- Increased number of deaths in the community setting, including care homes, hospice and home
- An ongoing reduction in the number of hospital deaths reducing by 2% per year to 58% in year 5

Health Outcome Measures

	Initiative Performance Indicators		
	Key	Second-Level	Associated
Health Outcome Measure	<ul style="list-style-type: none"> • Enabling people to die at home • Proportion of all deaths occurring at home 	<ul style="list-style-type: none"> • Delayed transfers of care • DTOC from hospitals 	<ul style="list-style-type: none"> • Adults in contact with secondary mental health services settled in accommodation • Emergency bed days • People with LTC supported to live at home • Timeliness of social care assessment
JSNA Measure	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Complaint data (primary / community care) • Index of multiple deprivation • Patient satisfaction surveys (hospital) • Top 10 causes of admission • Top 10 diagnoses causing most bed days

Timeframes for Implementation	Project	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	Assess capacity of existing resource and invest in service development where needed;		Priority				
	Develop co-ordinated care engaging all stakeholders;		On-going				
	Implement and monitor an agreed care pathway for end of life care;		Priority	On-going	On-going	On-going	On-going
	Invest in best practice;		On-going	On-going	On-going	On-going	On-going
	Agree collaborative commissioning arrangements for End of Life Care			Priority			
	Enable the PCT to be compliant with NICE Supportive and Palliative Care Guidance and implement the national End of Life Care Strategy.			Priority	On-going	On-going	On-going
	<p>The NICE implementation needs to be completed by December 2009, so this needs to be made a priority for 09/10;</p> <p>The CCI is a five year implementation plan with the first 3 years implementing the initiatives and the final 2 years for consolidation of the developments.</p>						
Stakeholder Engagement	Social Care, Voluntary Sector, Secondary Care and PCT representatives, with interests in different conditions, sit on the End of Life Care Locality Group.						
Equality Impact Assessment	<p>An Equalities Impact Assessment (EIA) has been undertaken for this initiative area in relation to the six equalities strands of disability, faith, sexuality, age, gender and race. Based on an initial assessment of the initiative, the EIA identified a number of recommendations. The findings (some of which are outlined below) will be further reviewed and plans developed to implement the recommendations.</p> <ul style="list-style-type: none"> • Appropriate and sensitive equalities monitoring and satisfaction surveying to be put in place for end of care services; • The service to commission a formal needs assessment to identify the specific cultural and other issues that are key in determining whether people of diverse backgrounds and religions/belief systems access community based end of life services • Detailed policy and guidance needs to be issued to staff on preserving the human rights, particularly privacy and dignity, for end of life patients in the local community 						

Initiative Risk	Severity	Likelihood	Mitigating actions
Recruitment difficulties for in-reach End of Life facilitators	High	Medium	<ul style="list-style-type: none"> • Identify potential existing skills sets amongst current staff. • Consider the use of interim staff.
Project management capabilities	Moderate	Medium	<ul style="list-style-type: none"> • Designate project managers and provide training for them to deliver work; • Consider the appointment of an interim project manager.
Funding available	Medium	Medium	<ul style="list-style-type: none"> • Developed a robust business case
Ensuring that all GPs are operating at the Gold Standard framework	Medium	Medium	<ul style="list-style-type: none"> • Undertake an audit of GP practices; • Roll out training to address gaps identified

NHS London Planning Assumptions

2008/09 – 2012/13

To: PCTs, NHS London, and Healthcare for London team

Issued-2008.v3

30th October 2008

Note

- 1) These planning assumptions have been issued to enable the production of PCT Strategic Financial Plans, and are based on SHA DoFs' best estimates at this point in time DH confirmation of allocations and the 2009/10 Operating Framework are expected in December 2008.
- 2) The Pan-London Investment Fund should be shown as a non-recurrent negative reduction on Row 137 "Other allocation" on the detailed finance inputs sheet (NHSL). This will also need to be shown as a non-recurrent change in the national template.
- 3) The +1%/-1% scenario planning should be captured in a separate table submitted alongside the finance and activity template describing the impact of such scenarios in each of the first two years (we will issue this additional table asap)

Planning Assumptions 2008/09 -2012/13

		2008/09	2009/10	2010/11	2011/12 -2012/13
1	PCT Uplift (please include a downside and upside scenario)	5.5%	5.8% +/- 1%	5.8% +/- 1%	4% +/- 1% (estimate of GDP)
2	Top Slice	No new top slices	No new top slices proposed, and no repayments to be included in plans		
3	Pan London investment fund		-1%	-1%	
4	Scenarios		-1%/+1%	-1%/+1%	
5	Lodgings (table attached)	2008/09 plans (and 2007/08 actuals) to be re-stated to include lodgings held. This will increase the bottom line surplus of those PCTs with lodgings.	Assume all lodgings are returned.	n/a	n/a

6	Carry Forward	RAB applies to PCTs			
6	Deficit recovery (PCTs)	As advised to individual PCTs			
7	Deficit recovery (Trusts)	Deliver surpluses to achieve b/even			
8	Contingency expected	Contingency fully utilised/released within FOT position	Maximum of 0.5% turnover/ resource	Maximum of 0.5% turnover/ resource	Maximum of 0.5% turnover/ resource
9	Surpluses	PCT surpluses to be reduced to a maximum of 0.8% turnover/resource over the next 3 year period.			
10	Demographic growth	GLA as source			
11	Prevalence rates	Local and national data			

12	Efficiency savings	(3.0)%	(3.0)%	(3.0)%	(3.0)%
13	Tariff Uplift (baseline less efficiency)	2.3%	2.8%	2.8%	1%
14	Pay awards (as % of pay bill)	2.75%	2.4%	2.25%	2.25%
15	Prescribing uplift	8.0%	8.0%	8.0%	8.0%
16	Primary care contracts	1.5%	1.5%	1.5%	1.5%

Notes

1. IFRS – for the purposes of the financial template, the impact of International Financial Reporting Standards should **NOT** be included, although the expectation is that the full effect of IFRS should be incorporated for each PCT as part of the FIMS plan in January 2009.

2. Breakdown of tariff 2008/09

Breakdown of 2008/09 Tariff Uplift	2008/09 over 2007/08	Assumptions
	%	
Baseline		
Increase in Pay and Prices	2.8	Incl pay awards / pay drift
Non-pay Inflation	0.6	GDP deflator at 2.75%
Drugs	0.7	Includes NICE
Clinical Negligence	0.4	Forecast local contributions
Cost of capital	0.4	PFI, depreciation
Gross pay and prices	4.7	
Efficiency	-3.0	Assumes 3.0% efficiency
Net pay and Prices	1.7	
Quality & Reform	0.6	HCAI, pay reform IM & T
Overall	2.3	

3. Breakdown of lodgings by PCT

PCT	PCT lodgings/ Bankings at the end of 07/08	PCT lodgings/ Bankings at the end of 08/09
	£'000	£'000
Barking and Dagenham	6,257	6,257
Barnet	-	-
Bexley	-	-
Brent	-	-
Bromley	3,055	-
Camden	9,418	-
City and Hackney	12,827	29,484
Croydon	6,836	6,836
Ealing	9,151	9,151
Enfield	-	-
Greenwich	4,800	1,090
H&F	10,413	10,413
Haringey	5,886	5,886
Harrow	-	-
Havering	-	-
Hillingdon	-	-
Hounslow	-	-
Islington	2,021	2,021
K&C	-	-
Kingston	-	-
Lambeth	10,661	5,035
Lewisham	-	-
Newham	6,656	3,326
Redbridge	8,665	27,329
Richmond & Twickenham	870	-
Southwark	-	-
Sutton & Merton	-	-
Tower Hamlets	21,618	21,618
Waltham Forest	855	-
Wandsworth	8,863	8,863
Westminster	10,375	10,375
Total	139,227	147,684

Appendix 2: Primary and Community Services Strategy

1.0 Introduction

This section of the Commissioning Strategic Plan sets the context and direction of travel for the NHS Barking and Dagenham Primary and Community Services Strategy (PCSS). The PCSS will be further developed with broader engagement of stakeholders and formal consultation throughout 2009/10.

NHS Barking and Dagenham's Primary and Community Services Strategy (PCSS) will set a vision for the future configuration of primary and community care services in the Borough. The completed strategy will outline steps towards a locality based model for integrated service planning consistent with the vision for polyclinics in London and the model adopted by the London Borough of Barking and Dagenham.

NHS Barking and Dagenham is completely committed to the polyclinic vision for services. This document sets out commissioning plans for polyclinics within the local context and outlines ambitious timescales for reconfiguring services and developing new premises in line with that vision.

In 2009/10 NHS Barking and Dagenham has earmarked investment in a programme of work to further develop the vision for primary and community care services which will incorporate a strategy for transforming community services along with primary care access and polyclinic proposals.

2.0 The Case for Change

The landscape of primary and community services in Barking and Dagenham has shifted dramatically in the last few years.

NHS Barking and Dagenham has delivered one of the largest LIFT programmes in the country to provide new premises with the scope to support larger general practice units and a wide range of co-located services.

NHS Barking and Dagenham led on the development of extended hours arrangements and has procured three new general practices through competitive tendering processes and a fourth procurement of a GP-led Health Centre is now underway.

Whilst the improvements made to services have been significant, challenges remain and the ongoing need for change continues.

Barking and Dagenham is one of the more deprived areas of London and residents have high health need. A higher than average number of single handed practices remains and there are significant variations in service quality and access with high A&E usage.

Factors that apply when considering the case for change include:

8.1 Rapidly Changing Population

Please note: The JSNA for Barking and Dagenham is currently in progress and will provide essential additional information to set the case for change and direct future health service planning and commissioning.

Barking and Dagenham is a small outer London borough with high levels of social housing, 29% green space and a significant amount of brownfield land from previous industrial use. It has a population of 170,000 living in just over 69,000 households.

Over the next 3-5 years

- Little overall change in the size of the population
- Increase in the proportion in aged 45-64
- Increasing diversity – estimated that in 2004, 9.8% would describe themselves as Black/Black British, 6.6% Asian/Asian British, 2.3% of mixed race and 1.6% other

Longer term

- Dramatic population growth over 20-30 years
- Increases in all age groups
- Complex age changes
- Particular increases in under 15s and over 85s
- Doubling of the numbers aged 45-64

Sources: ONS Population Projections, GLA Population Estimates & ONS Experimental Ethnic Estimates (2006 release)

The borough is one of the fastest growing in the country, with the population predicted to increase to 208,000 by 2020/21. The borough has a higher proportion of older people and children than the London average. Almost one quarter of the population is aged 0 -15 years, compared to the London average of 19%.

2.2 High Health Need

An initial JSNA assessment undertaken highlighted the following specific health issues:

- Smoking – highest estimated smoking levels in London
- Food, weight and exercise – lowest estimated levels of fruit and vegetable intake and highest level of obesity in London;
- Alcohol and other drugs of abuse – over 1,000 problematic adult drug users, many not receiving treatment;
- Sexual behaviour – high teenage conceptions, high abortion rates;
- Life expectancy is poor for London, particularly for women, and progress is slow;

The three most important diseases for men and women are:

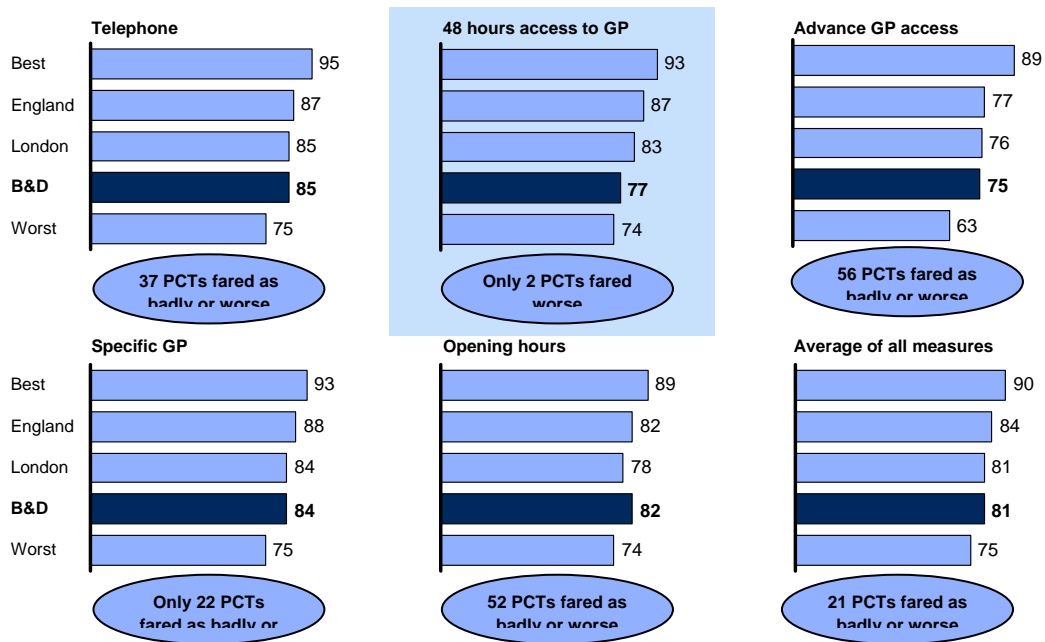
- Coronary heart disease
- Chronic obstructive pulmonary disease
- Pneumonia

Some diseases, though not comparatively high locally, are increasing:

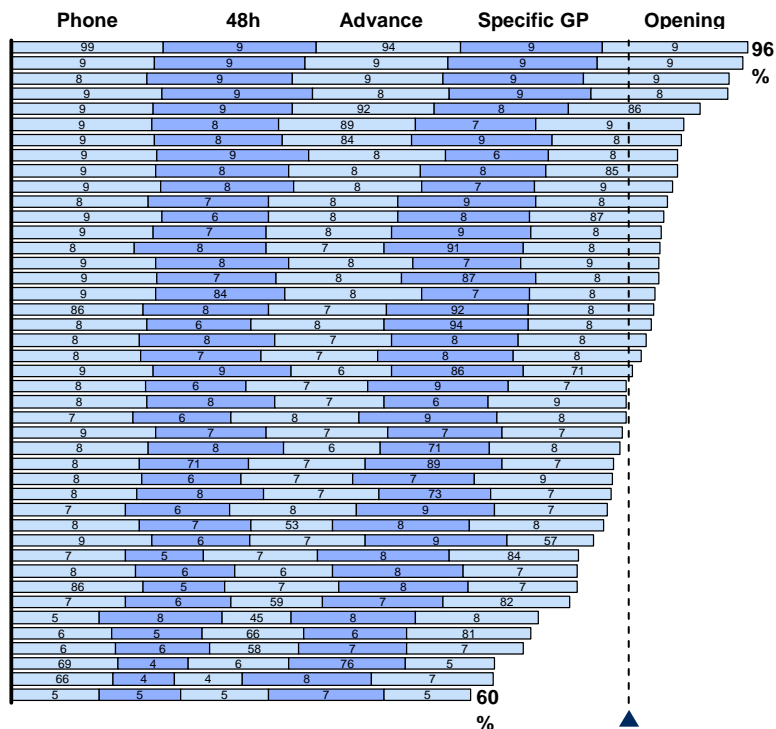
- Infectious diseases
- Chronic liver disease
- Long term illness and disability – high levels of limiting long standing illness (20% above national average) and highest in London households with someone with such an illness (39%)
- Mental health among working age people – increasing neurotic disorders, increasing personality disorders and increasing probable psychotic disorders

2.3 Variations in Access to Primary Medical Services

NHS Barking and Dagenham's performance on patient satisfaction with GP access was amongst the worst in the country in the IPSOS MORI GP patient survey 2007/08.



A number of practices in Barking and Dagenham perform well when compared with their peers nationally however, the local variation is significant. 21 practices in Barking and Dagenham scored below 80% on average across all five measures in the MORI access survey.

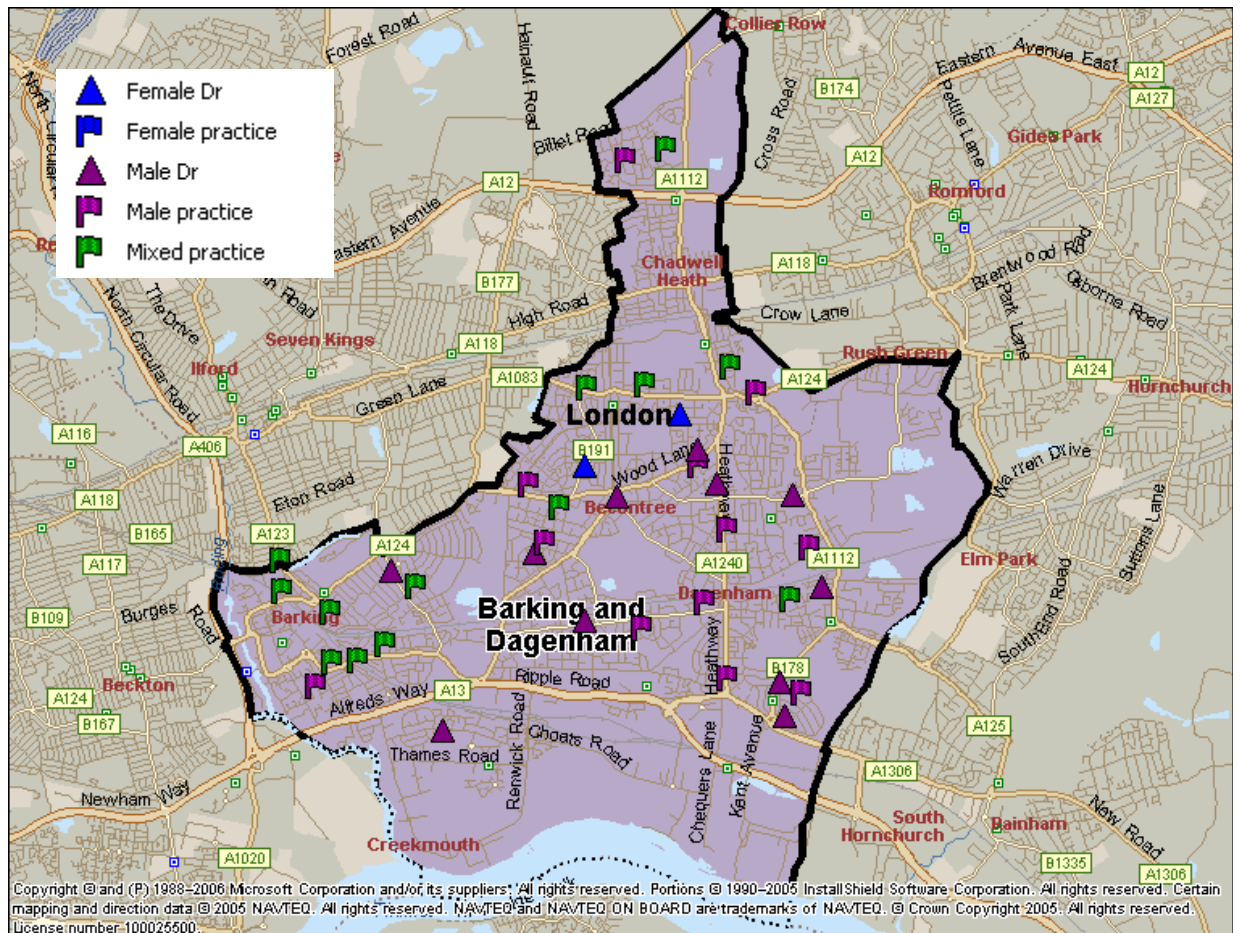


93% of practice in Barking and Dagenham are offering extended opening hours arrangements with 3 APMS practices, 1 GMS and 1 PMS practice offering full 8am-8pm and Saturday services.

Evidence suggests that a significant proportion of the population wish to exert a choice over the gender of their GP when booking an appointment. There are

currently 43 general practices in Barking and Dagenham and of these, 13 are single handed (28%) and so cannot offer a choice of gender to the patients wishing to make an appointment. 85% of all single handed general practitioners in Barking & Dagenham are male. 29 practices have more than one GP, but of these 41% are single sex, in all cases the single sex multiple partner practices are all male. Just over half of all multiple partner practices have mixed gender.

The map below shows the current general practices in Barking and Dagenham:



NHS Barking and Dagenham practices perform very highly with regards to use of the Choose and Book system and take-up of access to direct diagnostics.

Two walk-in centres are in place at the East and West of the borough at Upney Lane Medical Centre and at Broad Street Health Centre. A GP-led health centre is currently being procured for the Barking Hospital site.

Barking and Dagenham pharmacies provide an extensive range of services including:

- Minor Ailments Service ("Pharmacy First")³
- Smoking Cessation levels 1 and 2
- Sexual Health Services: emergency hormonal contraception to teenagers
- Substance misuse support: Supervised Consumption & Needle Exchange

- Anti-coagulation service
- Advice to care homes
- Access to Palliative Care Medicines rota
- Out of hours opening rota
- Medication Support to domiciliary carers

The Pharmacy White paper published in 2008 outlines a range of enhanced services to be commissioned from pharmacies – of those outlined only two are not yet contracted in Barking and Dagenham.

Pharmacies locally provide in total 4,677 prescriptions per average month (3,999 London average) and Barking and Dagenham has the second highest Medication Use Review's (MUR's) activity in London.

2.4 Variations in Quality

NHS Barking and Dagenham performance for five of the key health outcomes for World Class Commissioning (obesity, CHD controlled blood pressure, diabetes controlled blood sugar, COPD mortality and female life expectancy) is in the bottom 10% for London

There is significant variation at general practice level with regards to identifying patients with these conditions and in 2006/07 NHS Barking and Dagenham had the highest levels of exception reporting in general practices.

2.5 Variations in Premises

In Barking and Dagenham, there are 49 main general practice premises sites (11 of which are branch premises). There is a wide variation of premises that are delivering GMS/PMS/APMS services ranging from below standard converted houses and shops to fit for purpose health centres.

- 53% of GP practice premises are in GP owned below standard converted houses and shops
- 8% are in PCT owned below standard health centres
- 25% are in fit for purpose third party owned health centres
- 14% are in LIFT fit for purpose PCT leased health centres

A similar picture is true for dental surgeries with a number of dental clinics provided from converted domestic premises which cannot be adapted to comply with DDA standards.

NHS Barking and Dagenham has been implementing its Strategic Service Development Plan (SSDP) which outlines the vision of the local health community for a radically improved modern, patient centred service through the development of LIFT premises and facilities. This continues to be seen as a key component to improving primary care capacity and quality.

NHS Barking and Dagenham also has a complementary GP premises strategy to address those general medical services not included in the SSDP and to further develop GP infrastructure. This longer-term strategy, outlines the plans for smaller GP-led developments and refurbishments providing better patient access to general medical services. It also sets out the principles by which the PCT intends to manage and support the decommissioning of premises not fit for future purpose.

The ongoing need for improvements in primary care premises and the direction set out in the primary and community care strategy will inform NHS Barking and Dagenham's updated estates strategy due for completion by April 2010.

2.6 Workforce Changes

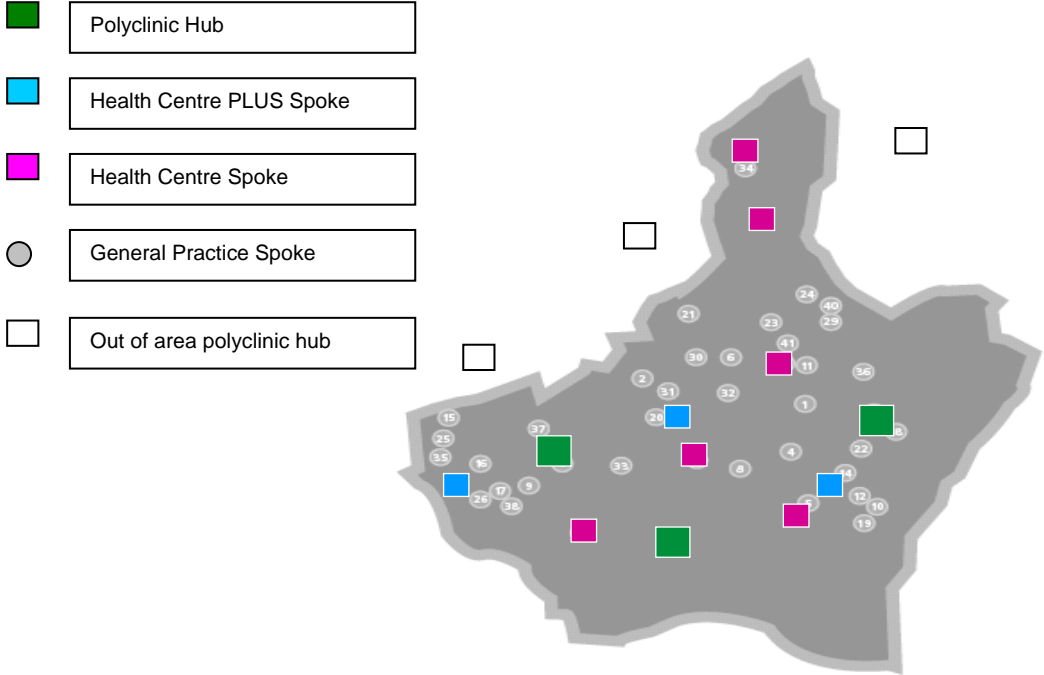
The volume and complexity of health and social care services provided in homes, practices and other out of hospital setting are growing rapidly. There is an ambitious vision of what primary care will look like in the future – delivering fast, convenient, integrated and high quality services.

Healthcare providers in Barking and Dagenham will require a workforce that is flexible, creative and able to respond to demand for increased opening hours, personalised care planning and integrated working across care pathways.

NHS Barking and Dagenham can demonstrate innovations in the use of workforce that signal the future direction. The Unique Care and Rapid Response Teams have a multidisciplinary workforce providing a more flexible and responsive service. For example the Unique Care team includes community matrons, district nurses, GP's, practice nurses, social workers and occupational therapists and provides intensive care management for a over 65's that have been identified at risk of emergency admission.

A large number of general practices in Barking and Dagenham continue to be considered underdoctored against a benchmark of 1 GP per 1800 patients. Not all practices are making best use of the opportunities afforded by employing practice nurses, nurse prescribers, HCA's and physician's assistants. Whilst the number of GP's employed in the borough has been tackled and is rising rapidly, further work is required to address the recruitment, retention and expansion of the nursing workforce in primary care.

3.0 NHS Barking and Dagenham Polyclinic Model



Please note: More detailed map showing defined localities and roads commissioned for final public facing consultation document.

The polyclinic vision in Barking and Dagenham is based on providing quality assured services from appropriate and accessible locations, at times which are convenient to patients.

A federated polyclinic model has been adopted with polyclinic hubs housing a full range of polyclinic services with spokes to other polyclinics centres, health centres, community services (e.g. general practices, pharmacies, rapid response team, and intermediate care facility) and the patient’s home.

The services designated in each facility have been based on the critical mass required to secure the greatest quality of care, value for money and accessibility. Each polyclinic hub therefore, has a core service offering include a general practice for residents in the immediate locality, alongside a range of more specialist services for borough-wide and cross-borough populations.

A network of new and renovated, purpose-built health centres procured through the LIFT programme will link into three planned polyclinic hubs at Barking Hospital, Barking Riverside and East Dagenham.

Polyclinic Hubs	Health Centre PLUS Spokes	Health Centre Spokes	General Practice Spokes
<p>Barking Hospital Barking Riverside East Dagenham</p>	<p>Broad Street Barking Town Centre Porters Avenue</p>	<p>Thames View Grey's Court Church Elm Lane Vicarage Fields Marks Gate</p>	<p>All general practices in Barking and Dagenham.</p>
<p>New developments opening over next 3 years</p>	<p>All in place or opening in 08/09</p>	<p>Currently in place with further centres proposed at Jullia Engwell and Goresbrook</p>	<p>Transitioning towards a model of general practice spokes with a minimum list size of 4,000 patients</p>

The table below demonstrates which health centres are aligned with which polyclinics for the defined borough wards:

A	<p>Barking Hospital Polyclinic</p> <p>Porter's Avenue Health Centre PLUS</p> <p>Barking Town Centre Health Centre PLUS</p> <p>Julia Engwell Health Centre</p>	<p>Borough Wards: Parsloes / Mayesbrook / Longbridge / Abbey / Eastbury / Barking / Gascoigne / Becontree / Valence</p>
B	<p>Barking Riverside Polyclinic</p> <p>Thamesview Health Centre</p>	<p>Borough Wards: Barking Riverside / Creekmouth /</p>
C	<p>East Dagenham Polyclinic</p> <p>Broad Street Medical Health Centre PLUS Centre</p> <p>Five Elms Health Centre</p> <p>Church Elm Lane Health Centre</p>	<p>Borough Wards: South Dagenham / Goresbrook / Village / Eastbrook / Albion / Heath</p>
D	<p>Residents more likely to access Redbridge or Havering polyclinics</p> <p>Marks Gate Health Centre</p> <p>Chadwell Heath Health Centre</p>	<p>Borough Wards: Whalebone / Chadwell / Marks Gate</p>

Barking Hospital Polyclinic Hub

Building work on the Barking Hospital has already commenced and this polyclinic hub is due to open 2009/10.

Barking Riverside Polyclinic Hub

NHS Barking and Dagenham has initiated premises planning on a brownfield site for the Barking Riverside polyclinic hub. This provides an opportunity to develop a hub that incorporates the full range of polyclinic services, housing a general practice for an estimate new population of 30,000.

East Dagenham Polyclinic Hub

NHS Barking and Dagenham is currently undertaking needs assessment and planning for a third polyclinic hub site in East Dagenham. This will house the full range of polyclinic services with a specific focus on health and well being services and moving towards an integrated organisation model. It is envisaged that the WIC at Broad Street will be transitioned towards a GP-led Health Centre model to be based at the more accessible location of the East Dagenham Polyclinic Hub.

Together these new facilities will provide an environment in which the HfL vision for services can be developed in Barking and Dagenham. All service providers in the polyclinic hubs will take advantage of their co-location to deliver a joined-up approach to care and seamless service for the patient.

Capital investment in primary care premises will continue to ensure that patients registered in polyclinic hubs or at spoke sites will receive care from modern facilities with capacity to house multidisciplinary teams and the widest range of general practice core and enhanced services.

Barking and Dagenham is a relative small London Borough with a population of roughly 170,000. Whilst the polyclinic hubs planned can be align relatively neatly to most wards and localities, the shape of Borough is such that a number of residents may seek access to services in neighbouring boroughs. Barking and Dagenham residents may choose to access services from polyclinic hubs at King George's Hospital and Loxford in Redbridge. Likewise residents may choose to access urgent care, outpatient and diagnostic services from the Queens Hospital site in Havering.

For example, in the most northern Marks Gate area residents are likely to seek access to a Redbridge based polyclinic at the King George site via the A12 in preference to attending polyclinic hubs in the immediate borough. Options for transport, registration and service access will need to be agreed with Redbridge in this instance. There is also a large health centre at Marks Gate which will be a key point of access to a wide range of health services in the immediate locality.

4.0 The Sustainable General Practice

NHS Barking and Dagenham recognise general practice as a principle gateway to services accessible in every neighbourhood. The PCT and local stakeholders jointly support a federated polyclinic model that in principle safeguards this care setting as a polyclinic spoke.

All general medical service providers will have referral pathways to polyclinics so that patients choosing to be registered elsewhere will still be able to access the specialist services a polyclinic can offer.

However, not all models of general practice in Barking and Dagenham are sustainable in the longer term. Many primary medical contractors in Barking and Dagenham are unable to deliver the requirements of a modern general practice due to workforce limitations, inadequate premises and outdated practices.

Reducing the number of single-handed practice units and list sizes under 4000 patients in Barking and Dagenham will provide greater scope for re-commissioning larger practices with increased opening hours and range of services.

NHS Barking and Dagenham recognise a sustainable general practice as one which provides:

- High levels of patient satisfaction and exceptional customer care
- Dynamic and flexible multidisciplinary workforce with effective use of nurse capacity
- Highly accessible services with extended opening hours
- Excellent premises
- High IT literacy and adaptability with e-booking
- Strong practice team with investment in training admin staff and a highly competent practice manager
- Range of enhanced primary care services and specialist clinics
- Focus on wellbeing and health education
- Early detection and intervention services for long term conditions
- Full engagement and participation in new initiatives such as Choose & Book and PBC

Using a service sustainability and premises suitability assessment, NHS Barking and Dagenham estimates that approximately 19 existing practices / premises require substantial improvement.

NHS Barking and Dagenham will continue to shift the structure of primary medical care towards larger multi-handed units in the following ways:

- Supporting high achieving single-handed practices to change their infrastructure and plan for future growth giving advice on mergers, capital schemes and workforce investment.
- Ensuring that all investment in new capital developments applications involving single handed practices are supported only on the basis of merged practices.
- Incentivising mergers by agreeing additional service offerings and a revised contract value.
- Setting increasing expectations for service quality and performance with benchmarks set on the basis of what is achievable with a list size of 4000 plus patients and a substantial GP and (importantly) nurse workforce. For example, 70 booked GP appointments per 1000 patients per week.
- Recognising the potential of larger units through the commissioning of additional services. For example, 6,000 plus list size practices offered the opportunity to provide full 8am-8pm and Saturday opening.
- Being fully engaged in the contestability and competition agenda. NHS Barking and Dagenham has completed three open procurements to secure providers of primary medical services and a fourth procurement for a GP-led health centre is underway.
- Managing poor performance through the balanced score card approach utilising the contractual levers available to set remedial actions and terminate contracts where remedy is not achieved. For example issuing remedial notice to all contractors that are not complying with minimum premises standards.

8.0 Blueprint for Service Planning

NHS Barking and Dagenham's approach to primary and community care commissioning will aim to deliver for the Barking and Dagenham population:

Motivation and support to stay healthy;

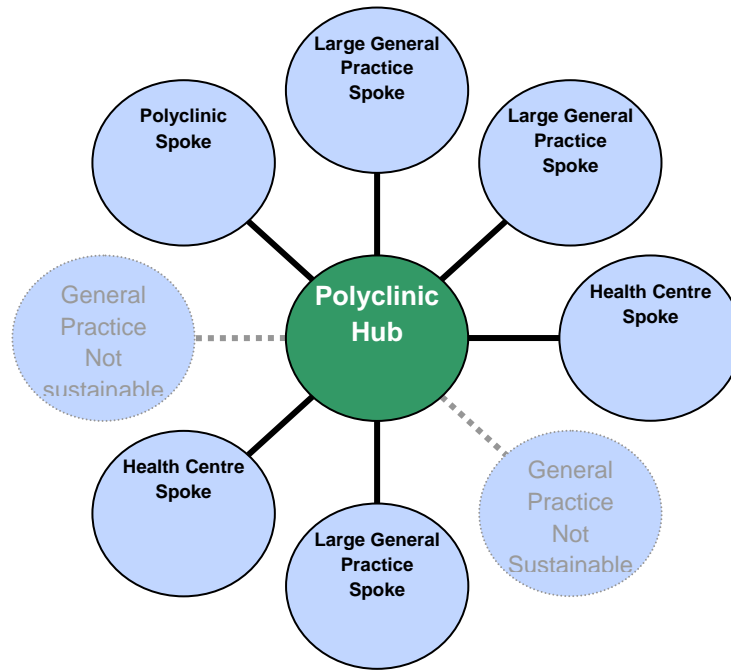
- Empowered patients;

- Personalised services;
- Integrated & 'one-stop' care models;
- Improved access to care;
- Quality assured services.

NHS Barking and Dagenham has identified a range of care settings for primary and community care services consistent with local authority locality planning model.

Setting	Range Of Services (Illustrative Only)
Accessible anywhere 24/7 by phone / email / online	Single point of access for all primary and community services, NHS Direct, order repeat prescriptions, collect routine test results, your health profile, online GP, appointment booking.
Available in your home	24/7 rapid response, unique care, telehealth monitoring devices, district nursing/ community midwifery / health visiting, GP home visits, end of life care
Located in every borough locality	GP practice (inc. enhanced services for LTC's and diagnostics), dental practice, optometrist, community pharmacy (inc. Pharmacy First services), children's centres, counselling and talking therapies, expert patients programme, smoking cessation groups, health promotion in schools, community empowerment team : inc. Health trainers.
Located in every polyclinic hub	Full range of polyclinic services. For example, GP practice, outpatient clinics, full range of diagnostics, (e.g. phlebotomy, minor surgery, x-ray), support for long term conditions, unplanned and urgent care services, community services, health and social care advice and resources.

Each federated polyclinic is aligned to specific borough wards for common services providing a basis for connecting dental, pharmacy, optometry services and for aligning and integrating other community services. The network will also provide an area focus within which general practice providers can develop collaborative working arrangements to provide a more comprehensive range of extended primary care services.



In addition to the core offering of services in each federated polyclinic network, a number of more specialised services (some of which are catering for a number of London Borough's) are planned for key sites:

More specialised services unique to specific sites

Barking:

At Barking Hospital (Hub) – Urgent care centre, maternity/birthing unit, sexual health services

At Barking Town Centre (Spoke) – specialist centre for children and women

At Porters Avenue Centre (Spoke) – specialist centre for long term conditions

Riverside:

At Barking Riverside – **full polyclinic specification**

Dagenham:

At East Dagenham Polyclinic (Hub) – GP-led health centre , specialist teams for respiratory, heart failure and diabetes, and CATS at Broad Street (Spoke) or on site.

At Grey's Court – Intermediate Care Facility

6.0 Transforming Community Services & Integration

The PCT has commissioned a piece of work to deliver the 'Transforming Community Services' agenda and develop a strategy for community services that will be integral to the primary and community care strategy.

Reviews of all provider services will dovetail with the model of services outlined and the direction of travel towards identified service localities and federated polyclinic units.

A number of service models are already in place that are indicative of the move towards a more integrated care approach and movement of services from hospital to community settings e.g. Unique Care, Rapid Response, Clinical Assessment and Treatment Services.

NHS Barking and Dagenham has recently submitted an application to pilot an integrated care organisation. Both the unique care service and integrated care pilot have been driven locally by practice based commissioners with the support and involvement of the local authority.

The forward planning timescale for Barking Riverside and East Dagenham provides further scope for engaging clinicians in the commissioning of whole care pathways to support greater integration of services.

7.0 Improving Access to Primary Medical Care

A key priority for improving primary and community care in Barking and Dagenham is improving access to a GP for the local population (see section 2.0 Case for Change).

Access to primary medical care in Barking and Dagenham has improved significantly in the last two years with significant progress and investment in addressing GP workforce levels, commissioning 93% of practices to offer extended opening hours and reviewing performance on the number of bookable GP appointments offered.

However, the substantial variation in performance across local practice services continues. In addition to addressing the single-handed practice in the Borough (see section 5.0 Sustainable General Practice), NHS Barking and Dagenham will maintain a strong focus on improving access in the following ways:

- Procuring new APMS practice services

- Ensure that any practice not providing reasonable access as defined in the GMS/PMS/APMS contract are subject to a formal performance processes. Key benchmarks against which practices are currently monitored include:

- 72 appointments per 1000 patients per week for all practices and performance manage practices delivery against this benchmark.
 - 1 telephone line per 2500 patients per week for all practices and performance manage practices delivery against this benchmark along with the average response times.
 - Use of a breach board to monitor daily breaches of the 48hr access target
 - Patient satisfaction reports
-
- Build on the success of the local extended hours scheme, increasing the number of practices offering 8am-8pm and Saturday opening from 4 to 10.
 - Build upon the success of the salaried GP scheme maintain 101 WTE GP's in Barking and Dagenham and move all practices towards the target of 1 WTE GP per 1800 patients.
 - Review the practice nurse workforce in Barking and Dagenham and move all practices towards a nursing workforce of at least 0.4 WTE per 1800 patients
 - Develop a new local enhanced service contract for access that gives incentives to practices to improve patient satisfaction rewarding strong performance.
 - Review repeat prescribing and extend these services in local general practices so that patients are routinely offered this service as appropriate.
 - Publishing information to support patient choice when accessing health services including key quality metrics.
 - Continue to invest in schemes aimed at preventing ill health to manage the demand for services such as health champions and Pharmacy First.

8.0 Further Development of the Primary and Community Care Strategy

In 2009/10 NHS Barking and Dagenham has earmarked investment in a programme of work to further develop the vision for primary and community care services which will incorporate a strategy for transforming community services along with primary care access and polyclinic proposals.

NHS Barking and Dagenham will develop and consult with key stakeholders to agree the framework for service development, marketing and future commissioning of primary care and community services.

This will be completed and signed off by the PCT Board by October 2008 with public consultation running July-September.