# Barking and Dagenham Commissioning Strategy Plan

**2012/13-2014/15**

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Barking and Dagenham

Barking and Dagenham PCT is part of the NHS Outer North East London cluster, which comprises the four PCTs of Barking and Dagenham, Havering, Redbridge and Waltham Forest.

- **Barking and Dagenham**: Population Size: 227,000, 47 GP practices
- **Redbridge**: Population Size: 270,000, 45 GP practices
- **Waltham Forest**: Population Size: 180,000, 41 GP practices
- **Havering**: Population Size: 235,000, 54 GP practices
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Foreword

This is the first year of operation for GP clinical commissioning groups and in common with our colleagues in other boroughs we are focused on the further development of our commissioning skills and to becoming fully authorised by April 2013. Developing our local plans - which are the basis of this cluster wide plan - has been a useful learning process for us, in particular listening to the views of local people and partners.

The direction of the commissioning strategy plan is to build on quality improvement, increase productivity and move care and services closer to people’s homes. Urgent care is a priority area for improvement and we will need to work collaboratively with our neighbouring CCGs, partners and patients to deliver a more cohesive service for local residents.

This year we succeeded in getting our pioneering Integrated Case Management project up and running. This has shown that real benefits in patient care can be realised by working together. We are delighted that CCG colleagues across ONEL are now rolling out this innovative integrated care project for the benefit of their own patients.

This is a CSP that will ensure that the big strategic commissioning issues are progressed during the transition period and that strategy is driven forward without losing momentum. But we will ensure that implementation is made more relevant, more clinically and locally owned and driven.

We are committed to managing a smooth transition to the new NHS arrangements – with patients seeing the benefit and receiving the services they need and deserve.

Dr G Kalkat Dr T C Mohan

Chairs Barking and Dagenham CCG
Executive summary

1. Vision and strategic goals; progress and renewed focus

The CSP sets out a vision of ensuring that sustainable, safe and high quality local health services are provided to the residents of Barking and Dagenham through clinically led commissioning.

There has been progress on the PCT’s strategic goals set in the previous Quality, Innovation, Productivity, Prevention (QIPP) plan 2011/12. Although quality concerns still remain for acute hospital services in particular, improvements have been made to systems to monitor and address quality issues and to improve the quality of health services.

Significant progress has been made on delivering strategic and transformational change; reconfiguration of acute services will go ahead following the outcome of the Independent Reconfiguration Panel review of the Health for north east London programme; consolidation of specialist services has resulted in improvements in outcomes for stroke patients and for complex vascular surgery patients; integrated care is progressing; the clinically-led cluster-wide Urgent Care Board is in place and a demonstrable reduction in reliance on acute hospital care has been seen.

QIPP initiatives are projected to deliver net savings across Barking and Dagenham PCT of £12.8m in 11/12 with a full year effect in 2012/13 of £14.4m, and additional in year savings are being made to ensure financial stability and deliver best value for money for services commissioned.

Outer north east London PCT boards and Clinical Commissioning Groups are working towards full delegation by April 2012, so that the CCGs will have a full year of shadow operation before abolition of the PCTs to ensure a seamless handover to new commissioners.

Barking and Dagenham CCG has developed the following strategic goals for 2012/13-2014/15:

- Reduce variation in performance across providers
- Develop an urgent care strategy that supports the public in using primary care services for urgent care needs, reducing inappropriate use of A and E
- Deliver high quality and equitable primary care from fit for purpose estate representing value for money

These strategic goals have been informed by engagement with the Health and Wellbeing Board and align with local strategies.

The Barking and Dagenham strategic goals support the common goals across outer north east London which are to:

- Address the health needs and health inequalities of our population by prevention of ill health and promotion of wellbeing
- Improve the quality of health services, standards of care and outcomes for local residents across all health services, hospital, primary and community services
- Deliver strategic and transformational change needed to ensure high quality and sustainable services into the future, through acute reconfiguration (consolidation of specialist services), through shifting services from hospital to the community, through
integration of services across primary, secondary and social care and ensuring the community and primary care infrastructure is in place to enable this

- Ensure financial stability and deliver best value for money for services commissioned
- Ensure a seamless handover to new commissioners.

A Health and Well Being strategy for the borough was published in 2010. The overarching aim of the strategy is to improve life expectancy and quality of life for local residents and ensure that they can look forward to the same life span as Londoners living in more affluent areas.

The priorities of the Health & Wellbeing Strategy are articulated in 2.2 based on the JSNA 2010. The shadow Health and Wellbeing Board has established a Health and Wellbeing Strategy Group chaired by the Joint Director of Public Health. During the period January 2012 to May 2012 the group will oversee the refresh the JSNA 2011 and develop a preparatory health and wellbeing strategy for 2012/14 and also to ensure the final product has taken full account of local circumstances and views, and is fit for purpose.

CCG development

Two GP pathfinders were approved in Barking and Dagenham which are in the process of merging to form a single Barking and Dagenham Clinical Commissioning Group (CCG). The new Board will be in place in January 2012. The CCG has communication and engagement mechanisms in place for all local practices and are active members of the Health and Wellbeing Board. Clinical forums are in place for CCGs to progress clinical commissioning with providers and CCGs have started a dialogue with public and patients through a discussion event on the CSP. The cluster is supporting CCGs to take on the responsibilities for equality duties.

2. Case for change – population needs, quality issues and finances

Population The current total population of Barking and Dagenham, Havering, Redbridge and Waltham Forest is estimated to be nearly 900,000 people with an increase of about 40,000 people (5.8%) expected over the next five years. As the population increases it is predicted to become more ethnically diverse overall with significant increases in the number of people aged under 19 years and those aged over 80 years – indicating an increase in the need for maternity services, health visiting services, school nursing services and care of elderly.

The population profile of each borough within outer north east London differs, Havering has greater proportion of older people and Barking and Dagenham a higher proportion of younger people. Redbridge has the highest proportions black and minority ethnic people in outer north east London. Barking and Dagenham has the highest projected growth with Waltham Forest having the lowest. There are also differences between the boroughs in terms of health inequalities and outcomes. Life expectancy varies across outer north east London with a difference up 10.7 years between the ward within outer north east London with the highest male life expectancy in Redbridge and that with the lowest in Barking and Dagenham.

The diseases and conditions that are most important for action in outer north east London are cancer, cardiovascular disease including coronary heart disease and circulatory disease, COPD (chronic obstructive pulmonary disease) and diabetes. Smoking and obesity are serious problems that impact on the health outcomes of the population of outer north east
London. Tuberculosis (TB) and HIV are the two communicable diseases of greatest concern in London.

**Quality** The key challenges for the ONEL CCGs are to improve the quality and experience of acute hospital care and primary care, to address the variation that exists across the sector with some excellent care being provided locally alongside services that have been identified as falling behind in providing the standard of care that patients should be able to expect particularly through the recent CQC review of services at BHRUT.

A consistent and systematic approach to improving quality in all commissioned services was established during 2011/12 with an agreed governance structure. The three key approaches to managing quality are CQUINs (Commissioning for Quality and Innovation performance framework), joint clinical audit and assurance frameworks. Regular quality review meetings with all providers and assurance frameworks for maternity and A and E services at BHRUT are in place to address areas of concern. The primary care strategy will address the issues of variation in primary care.

**Finances** In order to achieve a position of recurrent balance for each of the PCTs and to contribute to the NHS-wide efficiency savings, NHS ONEL needs to make savings of £56m in 2012/13.

The ONEL cluster already has the lowest operating costs in London with a budget 7% lower on average than the rest of the capital. Given the low unit costs the clinical commissioning groups will need to innovate if they are to provide their share of NHS savings whilst commissioning high quality services.

3. **Responding to the case for change – priorities and opportunities**

The priority areas that have been identified have a number of interdependencies.

1. **Commission safe, sustainable, high quality services for the local population**
   Improving the quality and ensuring the safety of acute hospital, primary care, community, mental health and specialist services is of the highest priority for outer north east London.

2. **Integrate care**
   Enabling improvements in care provided to individuals resulting in a better experience, improved outcomes and productivity.

3. **Redesign urgent and emergency care services**
   Ensuring patients and the public having access to convenient, high quality, timely and cost effective urgent and emergency care services and know how to access these services effectively.

4. **Staying healthy**
   Taking action to reduce the need for healthcare and to optimise the health of the local population needs to underpin and be integrated into all of these priority areas.

5. **Increasing productivity**
   Increasing productivity; high quality services are also productive services; productivity measures can improve outcomes and patient experiences.
CCG priorities

The CCG will be commissioning services in line with these priorities and has identified areas within these that are particularly important for the local population including the development of services at Barking Community Hospital.

A programme of opportunities has been developed which will enable progress to be made towards this priority areas. The opportunities are summarised in the main body of the CSP and an overview of each is available in the implementation appendix. Additional project documentation sits behind these to support planning and implementation. The opportunities include redesign and service improvement schemes, de-commissioning activities as well as investments in services.

Enablers

A number of key enablers that will underpin delivery of these opportunities and strategic goals are described in the CSP including working in partnership particularly working with local authorities on reablement. There are a number of incentives and contractual levers available to commissioners to influence providers, information management and technology, workforce and estates.

Impact of the CSP

The impact of the CSP needs to be considered in conjunction with other key events and changes including for example the London Olympics in 2012; its impact on services during the games and the opportunities for a health legacy for east London. The proposed merger of Barts and the London, Whipps Cross and Newham Hospitals will potentially change the provider landscape.

The overall impact of the commissioning strategy will be to improve patients experience and outcomes by improving the quality of services and targeting services appropriately. The strategy aims to achieve financial stability and sustainability for the whole health economy, recognising that the impact on acute providers in particular will be to reduce activity and therefore income. Overall the reduction in hospital activity should lead to reductions in the acute bed base. The implementation of the changes will play a key role in enabling improvements in quality and outcomes and improving sustainability.

Implementation

The implementation programme for the CSP can be found in the detail of the opportunities that have been developed. The CCGs will now take forward decisions on the different kinds of opportunities including agreeing redesign schemes, considering de-commissioning options and business cases for investment as they undertake the budget setting process for 2012/13.
Commissioning Strategy Plan

This document sets out the Commissioning Strategy Plan (CSP) for Barking and Dagenham for the 3 years 2012/13 to 2014/15. It is aligned with the NHS ONEL CSP for the same period.

1 Vision statement

To ensure that sustainable, safe and high quality local health services are provided to the residents of Barking and Dagenham through clinically led commissioning.

2 Strategic Goals

Barking and Dagenham Clinical Commissioning Group (CCG) has reviewed the strategic goals set out by NHS ONEL in 2011/12 as part of the process of developing the CSP for 2012/13-2014/15.

2.1 Progress made against strategic goals set in 2011

Improve the quality of health services

Although significant quality concerns still remain in outer north east London for acute hospital services in particular, improvements have been made to systems to monitor and address quality issues. Work has been undertaken to bring together the serious incident reporting, patient experience, claims and complaints process to provide another dimension to monitoring quality. Following the CQC review of services at BHRUT an improvement programme is in place for maternity services and emergency care.

Patients are benefiting from specific improvements to services, some examples follow:

- There has been significant improvement in the cancer pathway in BHRUT. The trust is now meeting all the cancer waiting time targets
- Across outer north east London an Enhanced Recovery Network has been established with involvement of acute and primary care clinicians. Admitting patients on the day of surgery is now the norm and there have been reductions in length of hospital stay following knee replacement and colorectal surgery. The full extent of the improvements in length of stay will be available at the end of the year.
- Clinical audits have been undertaken by acute consultants in BHRUT and Whipps Cross and GPs to agree and formulate care pathways particularly in urgent care but also in Whipps Cross in elective care and maternity/paediatrics (antenatal screening).
- Progress has been made in Barking and Dagenham in improving public health outcomes for breastfeeding and childhood immunisations, which have historically been areas of poor performance.
Deliver strategic and transformational change

Progress has been made on the following essential components of system change in outer north east London:

- Independent Reconfiguration Panel review of the Health for north east London programme. These plans are integral to securing safe and sustainable emergency and maternity services in north east London and will enable consolidation of the clinical workforce to give better outcomes for patients.
- Consolidation of specialist services has resulted in improvements in outcomes for stroke patients and for complex vascular surgery patients.
- Integrated care is progressing throughout outer north east London with implementation of integrated care management – further information on this is provided in Appendix 1.
- The Urgent Care Board is in place to ensure that the changes required to urgent and emergency care can be taken forward collaboratively across clinical commissioning groups
- A reduction in the reliance on acute hospital care can be demonstrated through shifts of activity from hospitals to the community, reductions in activity (first outpatient appointments) and reductions in lengths of stay in hospital through improved discharge arrangements.

Ensure financial stability and deliver best value for money for services commissioned

The latest QIPP projection for the current financial year assumes a saving of £12.8m for Barking and Dagenham with a full year effect in 2012/13 of the schemes in the region of £14.4m. Key components of the QIPP plan that have contributed these savings are: medicines management, improved utilisation of the Independent Sector Treatment Centre contract, contract negotiations for clinical services and reducing certain procedures. The procedures that have been limited are those that give minimal clinical benefit to the patient and those that have been nationally agreed to be cosmetic in nature. Some of these have been diminished in community settings and some in hospital. More details are available at: http://www.onel.nhs.uk/for-health-professionals/polce.htm

Further information on QIPP achievements can be found in section 6 below. Additional potential in year savings have also been identified.

Ensure a seamless handover to new commissioners

In July 2011 the PCT board established GP pathfinder clinical commissioning committees in each PCT as sub-committees of the Board with delegated financial responsibilities as well as fulfilling the statutory functions of the professional executive committee. The board and CCGs are working towards full delegation by April 2012, so that the CCGs have a full year of shadow operation before abolition of the PCTs. The CCG has a detailed development plan in place to support delivery of this aim with a number of key milestones and delivery is on track.
2.2 **Strategic goals for 2012/13-2014/15**

The Local Authority, the NHS and other statutory and voluntary sector partners are working together to bring about changes, so that people are healthier, live longer, and are more satisfied with the area they live in. A Health and Well Being strategy for the borough was published in 2010. The overarching aim of the strategy is to improve life expectancy for local residents and ensure that they can look forward to the same life span as Londoners living in more affluent areas. The Strategy has ten priorities for action:

1. Reducing the levels of smoking
2. Increasing participating in physical activity
3. Promoting healthy eating
4. Providing a broader range of support for depression
5. Improving sexual health
6. Ensuring residents get the benefit of immunisation and screening programmes
7. Promoting health and well being at work
8. Reducing levels of harmful drinking
9. Ensuring the best possible care at end of life
10. Reducing levels of domestic violence

The full strategy is available online: [Barking and Dagenham Partnership Health and Wellbeing Strategy 2010/11/2012/13](#)

The strategic goals agreed by Barking and Dagenham CCG are to:

- Reduce variation in performance across providers
- Develop an urgent care strategy that supports the public in using primary care services for urgent care needs, reducing inappropriate use of A and E
- Deliver high quality and equitable primary care from fit for purpose estate representing value for money

These support the common ONEL wide goals:

- Address the health needs and health inequalities of our population by prevention of ill health and promotion of wellbeing
- Improve the quality of health services, standards of care and outcomes for local residents across all health services, hospital, primary and community services
- Deliver strategic and transformational change needed to ensure high quality and sustainable services into the future, through acute reconfiguration (consolidation of specialist services), through shifting services from hospital to the community, through integration of services across primary, secondary and social care and ensuring the community and primary care infrastructure is in place to enable this
- Ensure financial stability and deliver best value for money for services commissioned
- Ensure a seamless handover to new commissioners.
3.1 The commissioning framework

The approach to commissioning health services across outer north east London is set out in the commissioning cycle shown diagrammatically below with the following key stages:

1. Assess needs: through a systematic process, understanding of the health and health care needs of the PCT’s resident population.
2. Describe services and gap analysis: reviewing the services currently provided and based on needs, defining the gaps (or over provision).
3. Deciding priorities: given a list of desirable actions, using available evidence of cost effectiveness and based on robust and defensible ethical framework, prioritise areas for purchase.
4. Risk management: understanding the key health and health care risks facing the PCT’s and deciding on a strategy to manage it.
5. Strategic options: bring together all the available information into a single strategic commissioning plan that outlines how the PCT will deliver its core objectives (including those of the Strategic Health Authority and Department of Health).
6. Contract implementation: put those strategic plans into action through contracting.
7. Provider development: (including care pathway redesign and demand management): support provider improvements or introduce new providers to deliver the services required (including setting up demand management systems and designing new care pathways). This includes supporting providers in decommissioning of services where appropriate.
8. Managing provider performance: monitor and manage the performance of providers against their contracts, especially against KPIs

This approach provides the framework for the cluster team to work with clinical commissioners on developing and implementing the CSP. The commissioning cycle aligns with NHS London Strategic Planning Principles 2012/13-2014/15 which also underpins the ONEL approach to developing the CSP.
3.2 The changing commissioning landscape

The schematic below sets out changes to commissioner responsibilities and the relationship between those responsibilities in future.

Services to be commissioned by Clinical Commissioning Groups

In 2011/12 CCGs across ONEL agreed to assume delegated responsibility for some of the commissioning budget through a phased approach aligned with delivery of the QIPP plan. CCGs are now leading the 2012/13 commissioning strategy planning process in preparation for 100% delegation of budgets that they will be responsible for and shadow running from April 2012. CCGs are leading the development of commissioning intentions, plans and contract negotiations and decisions for all commissioning responsibilities related to local acute and community services.

Services to be commissioned by the NHS Commissioning Board

The NHS Commissioning Board will be responsible for the commissioning of specialist services and for the direct commissioning of primary care, offender health, military health and public health.

Plans for military health focus on taking a tailored and more efficient approach to meeting the needs of this population group (which includes current personnel, reservists and family members) through the London NHS Armed Forces Network.

Mental health is a key priority which is reflected more generally in local health needs assessments.
Specialist Commissioning

In 2011/12 London Specialist Commissioning Group (LSCG) is commissioning £865m of services of which £753m is for London PCTs and £113m for PCTs outside London. As preparation for national convergence, it has been proposed that the portfolio of the SCG will increase to take on the whole Specialised Services National Definition Set by April 2013.

The experience of transfer of services in 2011/12 has shown that transfer can introduce risk into the system. This can be through identifying services individually which have previously been covered in block contracts and by lack of clarity about identifying precise activity to be transferred. Even where services are well understood, they are often counted in different ways by different providers and have been contracted for with different assumptions. The SCG aims to reduce the risk to London Clusters as much as possible by transferring services in two tranches with the easy to identify services in the first tranche, leaving an additional year to clarify and fully understand the services in the second tranche.

Detailed specialised services commissioning plans are available as are plans for smooth transition of commissioning responsibilities to the NHS Commissioning Board by April 2013.

3.3 Governance

In 2010 the NHS White Paper, Equity and Excellence: Liberating the NHS heralded fundamental change in the healthcare system and, at the beginning of 2011, the introduction of the Health and Social Care Bill (the Bill) set a pathway for legislative change. Subject to the Bill progressing, PCTs will be abolished as of April 2013, with commissioning responsibilities being transferred to new bodies, including CCG’s.

The diagram below shows the governance structure established in outer north east London, supporting work towards full delegation by April 2012, so that the CCGs have a full year of shadow operation before abolition of the PCTs.

During this period of full delegation the PCTs will retain statutory accountability and the governance arrangements will need to provide assurance to the boards in this regard.
Each CCG comprises members elected by constituent practices with responsibilities for ongoing communication and engagement with practices on key local issues. They are supported in this by the cluster communications team as well as receiving regular GP newsletters.

CCGs have also agreed local leadership arrangements in respect of key areas for collaborative working – for example on the Urgent Care Board – which ensures local clinical commissioning views are to the fore in the development of cluster-wide strategic development.

**Barking and Dagenham governance arrangements**

The Barking and Dagenham Clinical Commissioning Committee is a sub-committee of the ONEL Board which meets every two months.

The two GP pathfinders are in the process of merging to form a single CCG and a new board will be in place in January 2012.

Joint working with the Local Authority is being progressed through the shadow Health and Wellbeing Board and governance arrangements are being established to support joint commissioning arrangements, which are in the early stages of being implemented.

The existing governance arrangements for LSCG will operate for 2012/13 with allocations to PCTs, and the SCG operating as a joint committee of the 31 London PCTs. During 2012/13 the transitional arrangements to set up the NHS Commissioning Board (NHS CB) will take place with the NHS CB anticipated to be operating in shadow form from October 2012. NHS ONEL is represented on the LSCG at Executive Director level.
3.4 CSP development

The CCG board meets with all practices every quarter and supports a protected learning time educational event every month.

The CCG have engaged with their local practices in developing the CSP through the protected learning time events.

3.5 Engagement

Local providers

Clinical Forums have been established to create the mechanism for CCG clinical directors to work with provider clinicians to agree and oversee delivery of QIPP plans. There is a clinical forum with each of the key providers, BHRUT and North East London Foundation Trust that enable the escalation of QIPP plan delivery issues at an early stage; the development of collaborative approaches to meeting local health economy challenges and ensuring ongoing alignment of plans and contracting arrangements.

Patients and the public

CCGs have agreed an overall approach to ensuring patients and the public are involved in the development of their plans building on successful work with local LINKs and other groups and involvement of patients in cluster wide service reconfiguration through the People’s Platform (a cluster-wide engagement group). Through this structure the CCG aims to:

- Engage meaningfully with patients, carers and their communities in everything they do, especially commissioning decisions, and act upon this input.
- Effectively engage with and gather insight from patients and public, including hard-to-reach groups, as reflected in the decision making process of the emerging CCG.
- Engaging patients and the public in commissioning decisions. This includes elements of governance.
- Making robust, informed (including by the users of services) decisions, and ensuring that the right things get done about (1) resources (including cost), (2) quality of services and (3) the balancing of demand and supply.
- Also ensuring that the emerging CCG continuously improves.
- Work with patients to make most effective use of health services in the borough and to promote behaviour beneficial to public health.

To ensure early engagement in strategic direction setting for the CSP a joint patient engagement event was held on 14 November. Led by CCG leads and externally facilitated, this was a positive start to an ongoing dialogue between the CCGs and local people.

There were discussions at the event on the following topics: how to provide the best patient experience; urgent care and emergency services; integrated care; preventing ill health and staying healthy.

Four themes emerged from discussions about what is most crucial for the NHS to get right in order to ensure patients have a good experience: improving communication, making it as
easy as possible to access care, ensuring continuity of care across the patient journey and treating people as individuals with dignity and respect.

It is clear that the priorities set out in section 5 below reflect many of these concerns, as do the opportunities identified - particularly work that is underway to improve access to urgent care such as the Single Point of Access (SPA) 111 programme and the focus on providing more integrated care. The work that is underway to improve quality, described in section 4 and 5 below does address the issues of dignity and respect, particularly through the patient experience strategy however it is clear from this event that this work needs to be prioritised as does the emphasis on good communications. Further opportunities to engage patients and the public in the specific workstreams set out in the CSP including the urgent care board and integrated case management will be considered.

A full report from the event is available on request.

The borough based discussion at this event identified the following priorities for action in Barking and Dagenham: maternity services, integrated care, medicines management, A&E services. The group felt that quality of care is the most important aspect of healthcare and deserves particular attention. The group felt that more needed to be done to tackle and in particular to prevent obesity and to collaborate more with local government.

**Health and Wellbeing Board**

Barking and Dagenham local authority has been involved in the development of the CSP. The shadow Health and Wellbeing Board facilitated a workshop in August which explored how the PCT and Local Authority could align their planning to the commissioning cycles. A further meeting was held in October to review strategic priorities and improvement opportunities for 2012/13 with the draft CSP presented to the November Health and Wellbeing Board for comment.

Governance arrangements to support working between the NHS and the local authority include LB Barking and Dagenham representatives on the Clinical Commissioning Committee and CCG members engaged in the development of the JSNA and represented on the Barking and Dagenham shadow Health and Wellbeing Board.

**Other stakeholders**

The process for developing the CSP has been shared with other key stakeholders including MPs and local professional committees.

**3.6 Equality and Diversity**

CCGs will take on responsibilities for engagement and equalities; and this will also be scrutinised as part of the Care Quality Commission (CQC) registration process. The PCTs and cluster retain overall responsibility up until April 2013 and need to demonstrate that there are appropriate governance arrangements in place to meet equality duties. The model for doing this is through the NHS national Equality Delivery System (EDS). Organisations are scheduled to fully implement the EDS by April 2012.

Further work on this is being driven through the well-established local Equality Partnership Group, which is made up of leads from the cluster and local trusts. The work will be
overseen by the governance arrangements proposed by NHS London and refined locally – so an Equality Delivery System Working Group in turn reports to the Equality Delivery System Reporting Group. It is the latter group that will advise the Executive and provide reports to the Boards (via the lead director – i.e. director of corporate affairs) on performance of the overall health economy in meeting the EDS requirements. NHS London has advised that this model meets requirements.

The overall Equalities Analysis for the CSP appears as part of the implementation summary appendix 4 which provides an overview of equalities impacts and proposed approached to mitigation of any negative impacts. Further work will be undertaken to develop ongoing systematic processes for assessing equalities impacts across each opportunity and related delivery project using the tools developed by the cluster.
4 Case for Change

4.1 Population demographics

4.1.1 Overview of our population and their health needs

This section provides a summary of the population of outer north east London, enabling comparisons to be drawn between the Barking and Dagenham profile and those of the other boroughs as well as for some issues with the rest of London. Locally owned administrative data suggest that the population of Barking and Dagenham is between 182,276 (LBBD) and 185,176 (nkm), 2% higher than estimated by the GLA. A summary of the key findings for Barking and Dagenham are as follows:

a) Between 2010 and 2016:
   • the projected population is set to increase by 12.5% to 199,509. BAME ethnic groups are projected to constitute 35.5% of the population, equivalent to a 4.7% increase from 2010. As a result of this increase, the Black African ethnic group composition of the borough is likely to rise to 13.5% of the total population.
   • 48.8% of children and young people aged 0-19 years are projected to be from the BAME groups by 2016, an increase of 6.8% from 2010. 19.2% of these are likely to be from the Black ethnic group.
   • The 80 and over age group is projected to rise to 7,656, an increase of 3.8% from 2010.

b) Between 2003 and 2005 obesity was estimated to range from 21.1% to 27.4%

c) Cancer remains the leading cause of early death in Barking and Dagenham

Compared with the rest of the cluster Barking and Dagenham has:

   • The highest predicted population growth rate
   • A greater proportion of population living in deprived areas (along with Waltham Forest)
   • Statistically significantly higher rate of deaths attributable to smoking
   • Lower life expectancy, highest premature mortality rates
   • Statistically significantly higher rates of mortality from lung cancer and COPD
   • Fastest increasing trend of HIV prevalence

Compared with London and England averages, Barking and Dagenham:

   • Has second highest rate of deaths attributable to smoking in London
   • Has statistically significantly higher rates of all age all cause mortality
   • Has statistically significantly higher prevalence of diabetes
   • Saw the highest rates of emergency hospital admissions with a primary diagnosis of diabetic ketoacidosis and coma in 2007/08

Outer north east London overview

Outer north east London covers the four local authorities and PCTs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, comprising a total of 76 electoral wards. Current total population is estimated to be nearly 900,000 people with an increase of about 40,000 people (5.8%) expected over the next five years. As the population increases it is predicted to become more ethnically diverse overall with significant increases in the number of people aged under 19 years and those aged over 80 years – indicating an
increase in the need for maternity services, health visiting services, school nursing services and care of elderly.

There are significant differences in the population compositions of the 4 outer north east London boroughs with Barking and Dagenham having the highest proportion of young people and a low proportion of older people (age 65 years and over). In contrast, Havering has the highest proportion of older residents and the lowest proportion of young people living within the borough. More black and ethnic minority people live in Redbridge than any of the remaining boroughs. Barking and Dagenham has the highest projected population growth with Waltham Forest having the lowest.

There are also differences between the boroughs in terms of health inequalities and outcomes. Around a quarter of ONEL’s population live in the most deprived areas of England, with many more of Barking and Dagenham and Waltham Forest’s residents living in areas of deprivation than those of Havering and Redbridge. Barking and Dagenham and Waltham Forest both have significantly higher rates of all age, all cause mortality compared to England and London. Redbridge and Havering have significantly lower rates. Life expectancy varies across outer north east London with a difference up 10.7 years between the ward within outer north east London with the highest male life expectancy (Clayhall in Redbridge) and that with the lowest (River in Barking and Dagenham).

4.1.2 Processes for assessing population needs

Since April 2008 every PCT and local authority is required to work together on assessing needs for health and social care under the Local Government and Public Involvement in Health Act 2007. In ONEL each of the Directors of Public Health lead the process of developing JSNAs with their respective local authorities and presenting them to their shadow Health and Well-being Boards. An overview of the JSNAs has been created to inform the Commissioning Strategy Plan, identifying common population-based themes across ONEL and cluster wide commissioning opportunities which aim to optimise population health and health outcomes. The JSNA also identifies areas where quality and outcomes are not meeting best practice, leading to action to improve services as described below in the section on quality.

Full details of the local population including analysis against equality groups can be found in the JSNAs and Annual Public Health Reports. These documents are all available online: Barking and Dagenham Joint Strategic Needs Assessment 2011

With the annual public health reports available through the NHS ONEL website.

4.1.3 Population size and predicted changes

According to the 2001 Census the population of ONEL was 845,168. The 2010 GLA population estimates indicate that this has increased by 5.5% to 891,519 people. Of the 2010 population, 49% (437,252) were male and 51% (454,266) were female. Populations by PCT range from 175,649 in Barking and Dagenham to 256,843 in Redbridge. The population estimates for each PCT according to specific age group are illustrated in figure 1 below.
The population pyramid below (Fig.2) compares the age structure of Barking and Dagenham to that of ONEL as a whole and it is notable that ONEL has higher proportions of older people (aged 45+) compared to Barking and Dagenham which has much higher proportions of children and young people aged 0-19 years. The proportion of children aged 0-4 years in particular, is significantly higher in Barking and Dagenham than in ONEL as a whole.
The age profile also reflect that there are slightly more women in the Barking and Dagenham population who fall into the age bracket 25 – 44, compared to ONEL as a whole.

**ONEL Population Projections**

The resident population of ONEL is projected to increase to 960,757 by 2016, an increase of 5.8% from 2011. During this period, the Black, Asian and minority ethnic (BAME) groups are projected to constitute 35.8%, an increase of 2.7% from 2011. Individual ethnic groups constituting around 5% of the population are; Indian 7.0%; Black African 6.9%; Pakistani 6.0% and Black Caribbean at 4.8%. The age group 0-19 years is projected to increase to 255,963 by 2016, an increase of 6.9% from 2011. BAME ethnic groups are projected to constitute 50.4% of this age group by 2016. The 80 and over age group is projected to increase to 41,190 by 2016, an increase of 8.2% from 2011. The white population is projected to decrease by 2.7%, constituting 64.4% of ONEL population by 2016.

According to GLA population projections, the overall population in ONEL is predicted to increase by around 18% between 2010 and 2031 meaning that there will be an extra 165,551 people living in the sector. This is a higher percentage increase compared to the London projection of around 14%.
Figure 4 below illustrates the percentage change in the population by selected age group for ONEL and London. The biggest percentage increase is expected in the 65-74 age group in both ONEL and London as a whole of around 38% which is likely to pose an impact on health care demand and an increase in demand for long term care. The over 75 population in ONEL is projected to increase at a slower rate compared to London whilst the younger population (aged 0-14 years) is expected to increase at a faster rate than in London.

Figure 5 shows the percentage change in the Barking and Dagenham population between 2010 and 2031 by selected age group. Noticeably the 0-14 population is projected to increase at the fastest rate in Barking and Dagenham.
Ethnic population of ONEL

GLA have released population estimates and projections based on the 2001 Census for ethnic groups across London boroughs. It should be noted however that membership of an ethnic group is something that is subjectively meaningful to the person concerned. Ethnic group questions ask individuals which group they see themselves belonging to and this means that information may vary due to changes in the way people may define themselves.

According to the 2010 estimates 32.8% of the ONEL population is of a BAME group and 67.2% of the population is of white ethnicity. Compared to London as a whole, the ONEL sector has a slightly lower proportion of BAME groups. In London it is estimated that 34.6% of the population is of BAME and 65.4% are of white ethnicity.

Figure 6 outlines the percentage of the ONEL and London populations according to ethnic category. Generally, compared to London the ONEL sector has similar proportions of the population within each ethnic group. However ONEL does have a higher proportion of those of Pakistani ethnicity at 5.7% compared to 2.5% in London.

The breakdown of the population by ethnicity and specified age group for ONEL shows that in the younger population of 0-14 years there are higher proportions of Black and Asian ethnic groups compared to other ages. This is likely to be explained by the increasing migration pattern which has been experienced in more recent years.

Figure 6
Ethnic population by PCT

Across the 4 ONEL PCTs there is some variation present in the proportions of people from BAME groups. The highest proportion occurs in Redbridge at 48.9% and lowest in Havering at 7.6%. Figure 7 shows the percentage break down of ethnicity by ethnic category and PCT.

Figure 7

Havering PCT is markedly characterised by a population of white ethnicity and very few of BAME groups. On the contrary Redbridge has a population which is almost 50% BAME groups, the highest proportion of those being Indian (17.1%). Barking and Dagenham also has a high BAME population of 30%, with over one third of these (11%) being of Black African ethnicity.

Ethnic population projections

Between 2010 and 2031 the proportion of the BAME population in ONEL is expected to increase from 32.8% to 40.3%, this is an increase of around 120,000 people. All PCTs in ONEL are projected to experience an increase in the proportion of their population classifying themselves as BAME with Redbridge consistently having the greatest percentage (rising from 49.3% in 2010 to 59.8% in 2031). See figure 8 for the trend in estimates of BAME populations as a percentage of the total population for ONEL as a whole and the ONEL PCTs.
Births
Fertility rates in Barking and Dagenham have remained higher than the national average and above the Outer North East London (ONEL) trend. The decrease in total fertility rates in Barking and Dagenham in 2009 was not sustained in 2010. The age distribution of the population of the borough is also changing. The proportion of the total population of the borough made up of women aged 15 to 44 years is estimated to increase by 9.3% between 2008 and 2020, compared to a decrease of 2.4% in England¹.

Between 2005 and 2010 the number of live births in ONEL has increased from 12,732 to 15,831 (a percentage increase of 24%). Waltham Forest has consistently had the highest number of live births compared to all other PCTs in the ONEL sector, as illustrated in the figure 9.

Figure 9

Maternity demand in Outer North East London has continued to grow over the last five years. The number of births to Barking and Dagenham residents has increased by 35% between 2004 and 2010 (2751 births in 2004, 3729 in 2010). Births to Barking and Dagenham residents have increased at a faster rate than those to residents of the neighbouring boroughs (Figure 10).

**Figure 10: Number of births to residents of the four Outer North East London boroughs, increase from 2004 to 2010**

<table>
<thead>
<tr>
<th>Borough</th>
<th>Births 2004</th>
<th>Births 2010</th>
<th>% increase 2004 - 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking &amp; Dagenham</td>
<td>2751</td>
<td>3729</td>
<td>35.5</td>
</tr>
<tr>
<td>Havering</td>
<td>2559</td>
<td>2817</td>
<td>10.0</td>
</tr>
<tr>
<td>Redbridge</td>
<td>3483</td>
<td>4462</td>
<td>28.1</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>3957</td>
<td>4823</td>
<td>21.9</td>
</tr>
</tbody>
</table>


The increase in the number of babies born to mothers resident in Barking and Dagenham is a result of babies being born to women who were born outside the UK. The number of babies born to women born outside the UK increased by 75% in 2009 compared with 2004, while the number born to women born within the UK is virtually unchanged. The proportion of the total number of babies born to mothers born outside the UK that were born to mothers born in Asia and Africa has changed little, although the actual numbers have increased by around 75%. The numbers and proportion of babies born to mothers born in the various European countries have changed substantially, and in 2009 these babies comprised nearly 30% of the births to mothers born outside the UK.

**Figure 11: Country of birth of mother, Babies born to Barking and Dagenham residents, 2004 and 2009**

<table>
<thead>
<tr>
<th>Country of birth of mother</th>
<th>2004 number (%)</th>
<th>2009 number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total births</td>
<td>2751</td>
<td>3624</td>
</tr>
<tr>
<td>Mothers born within UK</td>
<td>1591 (58.8)</td>
<td>1585 (43.7)</td>
</tr>
<tr>
<td>Mothers born outside UK</td>
<td>1160 (42.2)</td>
<td>2039 (56.3)</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

Clearly the number of births is an important factor in planning maternity services. Detailed modelling of future births and capacity required in north east London has been carried out as part of the Health for north east London programme and can be found online in the decision-making business case on the Health for north east London website.

The changing demographic as well as the background increases in deprivation and poverty contribute to the need to planning for a more complex and diverse maternal caseload e.g. morbid obesity, haemoglobinopathies, HIV and other conditions. It is also crucial that maternity ante-natal and post-natal pathways are well established and link coherently between service providers to support the migration of women during, and after pregnancy.
4.1.4  Health inequalities and wider determinants of health

Deprivation

The index of multiple deprivations (IMD 2010) is a measure of multiple deprivations at a small area level. In general, those who live in areas of high deprivation suffer the most from poor health and wellbeing. IMD 2010 consists of seven domains of deprivation: income, employment, health and disability, education skills and training, barriers to housing and services, living environment and crime.

The deprivation scores at a Local Authority (LA) level show that across ONEL, three LA’s have fallen in the national rankings and are now more deprived compared to the rest of the country. Barking and Dagenham has remained ranked at 22, which places it in the top 7% most deprived boroughs in England. Waltham Forest is the 15th most deprived LA in the country and has fallen 12 places in the rankings (in 2007 was ranked 27th nationally). Figure 12 shows the national IMD ranks for 2007 and 2010 along with the change in ranking for ONEL.

Overall, in comparison to IMD 2007, has been an increase in the number of areas which now sit within the most deprived quintile (quintile 1).

Figure 13 illustrates the population distribution of ONEL as a whole by national quintile, and highlights the inequalities that exist within the sector between. Quintile 1 representing highly deprived areas and 5 the more affluent.

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>National Rank 2007</th>
<th>National Rank 2010</th>
<th>Change in rank from 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>22</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Havering</td>
<td>200</td>
<td>177</td>
<td>-23</td>
</tr>
<tr>
<td>Redbridge</td>
<td>143</td>
<td>134</td>
<td>-9</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>27</td>
<td>15</td>
<td>-12</td>
</tr>
</tbody>
</table>

Figure 13: Percentage of ONEL population by national quintile, IMD 2010
(Source: Communities and Local Government and ONS Population Estimates)
In Barking and Dagenham, there are no LSOA's which are ranked within the 40% least deprived areas in the country (quintile 5) for the overall Index of Multiple Deprivation.

92.6% of LSOA's in Barking and Dagenham sit within the 40% most deprived areas nationally and this was also similar in 2007. In Gascoigne ward, the number of deprived LSOAs has decreased from 4 to 2. However the LSOA that covers parts of the Harts Lane Estate is now among the 10% most deprived in the country.  

Over 50% of the Barking and Dagenham population lives in the 20% most deprived areas within the country. This swells to over 90% of the population when quintile 2 is added. In contrast to this, 55% of the Havering population lives in the 40% least deprived areas in the country (quintiles 4 and 5).

Poor health is an important aspect of deprivation that limits an individual’s ability to participate fully in society. The IMD 2010 health and deprivation domain measures morbidity, disability, premature mortality and the impairment of quality of life by poor health. It takes into consideration both physical and mental health but not aspects of behaviour or environment which may be predictive of future health deprivations.

There have been some changes in the IMD 2010 in terms of the number of local LSOAs falling within the national health and deprivation quintiles. For example, there has been a decrease in the number of Barking and Dagenham LSOAs in quintile 1 (areas with poor health), an increase in quintile 3 and two areas fall into quintile 4 (areas with better health) where previously there were none.

This is summarised in table 1 and table 2 below.

Table 1: Number and Percentage of Barking and Dagenham LSOAs in National Quintiles for Health Deprivation and Disability Domain, IMD 2007 and IMD 2010 (Source: Communities and Local Government)

<table>
<thead>
<tr>
<th>National Quintile</th>
<th>2010 No.</th>
<th>2010 %</th>
<th>2007 No.</th>
<th>2007 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintile 1</td>
<td>17</td>
<td>16</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>Quintile 2</td>
<td>66</td>
<td>61</td>
<td>60</td>
<td>55</td>
</tr>
<tr>
<td>Quintile 3</td>
<td>24</td>
<td>22</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Quintile 4</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>109</td>
<td>100</td>
<td>109</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 15 below compares the population distribution by quintile in Barking and Dagenham for the overall Index of Multiple Deprivation score with the Health Domain. There are approximately 63,000 less people in quintile 1 (poor health) when compared to the overall number of people within the high deprivation quintile of the Index of Multiple Deprivation.
Using the ONS population estimates for LSOA’s, Table 2 also shows a decrease in the number of people who are living with poor health (quintile 1).

Table 2: Barking and Dagenham Population by National Quintile for Health and Deprivation and Disability Domain, IMD 2007 and IMD 2010 (Source: Communities and Local Government and ONS Population Estimates)

<table>
<thead>
<tr>
<th>National Quintile</th>
<th>2010 No.</th>
<th>2010 %</th>
<th>2007 No.</th>
<th>2007 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintile 1</td>
<td>27,572</td>
<td>15.7</td>
<td>51,542</td>
<td>30.9</td>
</tr>
<tr>
<td>Quintile 2</td>
<td>104,888</td>
<td>59.7</td>
<td>90,578</td>
<td>54.3</td>
</tr>
<tr>
<td>Quintile 3</td>
<td>39,700</td>
<td>22.6</td>
<td>24,818</td>
<td>14.9</td>
</tr>
<tr>
<td>Quintile 4</td>
<td>3,443</td>
<td>2.0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>175,603</td>
<td>100</td>
<td>166,938</td>
<td>100</td>
</tr>
</tbody>
</table>

Child poverty indicators are a specific indicator of poverty and linked to a separate government agenda and there is a big push for health to engage more in this. Table 3 (London Poverty Profile\(^2\)), compares different measures or indicators associated with poverty across London Boroughs. Barking and Dagenham is amongst the worst four boroughs in London for some measures such as mortgage repossessions, benefits, unemployment, low pay, affordable housing and some of the indicators for education. Additionally there is a concentration of disadvantage generally across east London.

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Smoking

Smoking is the single biggest cause of death in England accounting for between 1 in 6 and 1 in 10 of all deaths. It also accounts for about half of the inequality in death rates between spearhead and non-spearhead areas and remains the biggest single cause of preventable mortality and morbidity in the world (Association of Public Health Observatories APHO, 2009). Smoking related deaths are also a powerful proxy measure of overall health and a predictor of healthcare demand.

The APHO have carried out analysis on the rate of deaths that are attributable to smoking. Figures for London are presented in the chart below.

The rate of deaths attributable to smoking in 2007-2009 in Barking and Dagenham was 289 per 100,000. This is statistically significantly different from the England average of 216 per 100,000. As illustrated below the rate of deaths attributable to smoking across London and
reveals that Barking and Dagenham has the second highest rate which is statistically significantly higher than the rest of ONEL.

Figure 16: Rate of deaths attributable to smoking in Barking and Dagenham compared to London and national averages. (2007-2009)


**Obesity**

Obesity is rapidly becoming the developed world's biggest health problem, with over 9,000 deaths a year in England being caused by obesity alone. According to data from the National Audit Office, being obese can take up to nine years off a life whilst contributing to the development of a range of health-related problems, including diabetes, heart disease, stroke, osteoarthritis, high blood pressure, infertility and depression. Furthermore, obesity contributes (in combination with a lack of exercise) to one-third of cancers of the colon, breast, kidney and stomach (NHS Direct, 2008). Between 2003 and 2005 obesity in Barking and Dagenham was estimated to range from 21.1% to 27.4%.

Childhood obesity remains a significant challenge in the borough and highlights the importance of prevention as well as treatment in the care pathways, for example promotion and support for breastfeeding (table 4 below)

Table 4: Barking and Dagenham breastfeeding performance 2010/11 performance and YTD 2011/12

<table>
<thead>
<tr>
<th></th>
<th>2009/10 OT</th>
<th>2010/11 Q1</th>
<th>2010/11 Q2</th>
<th>2010/11 Q3</th>
<th>2010/11 Q4</th>
<th>2011/12 Q1</th>
<th>2011/12 Q2</th>
<th>Target 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence</strong></td>
<td>86.9%</td>
<td>80.5%</td>
<td>77.9%</td>
<td>83.9%</td>
<td>76.0%</td>
<td>90.2%</td>
<td>94.4%</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
<td>57.7%</td>
<td>56.7%</td>
<td>45.0%</td>
<td>44.2%</td>
<td>47.1%</td>
<td>50.9%</td>
<td>50.8%</td>
<td>57.8%</td>
</tr>
</tbody>
</table>

*Comparison data to the 3 ONEL partner PCTs and to London and England averages is available.*
The results of the National Child Measurement Programme 2010/11, show that the percentage of obese children at reception and Year 6 is above the England and London average.

The CCG will need to work with partners to develop a coherent obesity management.

**Figure 17**

**Table 4**

<table>
<thead>
<tr>
<th>2010/11 Data by PCT</th>
<th>Obese 2010/11</th>
<th>Number of children measured</th>
<th>Participation rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reception</td>
<td>Year 6</td>
<td>Prevalence</td>
</tr>
<tr>
<td>Barking &amp; Dagenham PCT</td>
<td>13.8%</td>
<td>24.2%</td>
<td>2,957</td>
</tr>
<tr>
<td>Greenwich Teaching PCT</td>
<td>12.4%</td>
<td>24.9%</td>
<td>2,959</td>
</tr>
<tr>
<td>Havering PCT</td>
<td>10.8%</td>
<td>19.3%</td>
<td>2,459</td>
</tr>
<tr>
<td>Redbridge PCT</td>
<td>12.2%</td>
<td>23.2%</td>
<td>3,530</td>
</tr>
<tr>
<td>Waltham Forest PCT</td>
<td>9.8%</td>
<td>20.3%</td>
<td>3,111</td>
</tr>
<tr>
<td>London SHA</td>
<td>11.1%</td>
<td>21.9%</td>
<td>84,319</td>
</tr>
<tr>
<td>England</td>
<td>9.4%</td>
<td>19.0%</td>
<td>541,255</td>
</tr>
</tbody>
</table>
Life Expectancy
Life expectancy is a frequently used indicator of the overall health of a population; a longer life expectancy is generally a reflection of better health. Reducing the differences in life expectancy between populations between different parts of England is one of the aims of the Government’s policy to reduce health inequalities.

All Age All Cause Mortality (AAACM)
Nationally, the rate of AAACM has been steadily decreasing over time which has been mirrored across ONEL PCTs. The 2006/08 rates reveal that Redbridge and Havering have statistically significantly lower AAACM compared to England and London, whilst Barking and Dagenham and Waltham Forest have statistically significantly higher rates.

Figure 18

![Chart showing directly standardised rate of mortality from all causes in ONEL PCT, all persons all ages: 2006/08](chart.png)

ONEL has variations between PCTs and significantly between wards of differing life expectancy for men and women. During 2006/08 the male life expectancy in ONEL was highest in Redbridge at 79 years, followed by Havering at 78.5 years, then Waltham Forest with 76.5 and Barking and Dagenham at 76.4 years. However, when comparing wards across ONEL, there is significant variation – for example, male life expectancy average for 2003/07 in Clayhall at 82.9 years compared to River at 72.2 years for the same period, a difference of 10.7 years.

There are similar variances amongst ward level life expectancy for women. The highest female life expectancy for 2003/07 was in the Havering ward of Mawneys at 85.9 years, whilst the lowest was in Barking and Dagenham’s River ward at 77.3 years, a difference of 8.6 years. The male life expectancy in ONEL has been following an increasing trend since 1991/93 with a few minor fluctuations in most PCTs. Life expectancy in Redbridge and Havering has consistently been higher than the average for London and England as a whole. Whilst the life expectancy for Waltham Forest and Barking and Dagenham has been consistently lower and is increasing at a slower rate (as shown in the chart below).

During 2006/08 the female life expectancy in ONEL was highest in Redbridge at 82.6 years, closely followed by Havering with 82.5, then in Waltham Forest with 81.2 and Barking and Dagenham at 80.6 years.
Nationally, the female life expectancy is considerably higher compared to males with a difference of 4.1 years. This is also the case regionally and across the ONEL sector with the biggest difference between males and females being in Waltham Forest where there is a gap of 4.7 years.

The female trend is slightly more sporadic compared to the male trend however it is following an increasing trend in line with the England and London averages. The London average however is now slightly higher than Redbridge as illustrated in Figure 20.

Life expectancy figures relate to the rates of premature mortality and deprivation within the sector, e.g. Barking and Dagenham has the highest premature mortality rates and the highest proportion of its population living in the 20% most deprived areas in the country.
Causes of deaths

Analysis of causes of deaths and comparisons with London and England mortality rates help to identify the diseases and conditions that are most important for action in outer north east London; namely cancer, cardiovascular disease including coronary heart disease and circulatory disease, COPD (chronic obstructive pulmonary disease) and diabetes.

Tuberculosis (TB) although a rarer disease is a serious problem for London which now has the highest TB rate of any capital city in Western Europe.

Between 2006 and 2008 there were 21,155 registered deaths in ONEL, of which 11,142 (53%) were female deaths and 10,013 (47%) were male deaths.

- Death from cancer is the biggest cause of mortality in Barking and Dagenham and Havering
- Death from circulatory diseases is the biggest cause of mortality in Redbridge and Waltham Forest.
- Barking and Dagenham has statistically significantly higher rates of mortality from lung cancer and COPD
- Waltham Forest has statistically significantly higher rates of mortality from diabetes.

The table below outlines the directly standardised rate of mortality per 100,000 population by PCT and cause of death along with statistical significance compared to the England rates. Information available on how each of these diseases impact on outer north east London is set out below.

Figure 21: Directly standardised rate of mortality per 100,000 population (all persons, all ages) by cause of death and PCT, 2006/08

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Barking and Dagenham</th>
<th>Havering</th>
<th>Redbridge</th>
<th>Waltham Forest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DSR Sig</td>
<td>DSR Sig</td>
<td>DSR Sig</td>
<td>DSR Sig</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>101.0</td>
<td>68.0</td>
<td>68.2</td>
<td>103.4</td>
</tr>
<tr>
<td>Stroke</td>
<td>46.6</td>
<td>40.7</td>
<td>39.6</td>
<td>47.9</td>
</tr>
<tr>
<td>All Circulatory</td>
<td>203.0</td>
<td>171.0</td>
<td>205.8</td>
<td>205.3</td>
</tr>
<tr>
<td>Bladder Cancer</td>
<td>4.2</td>
<td>5.4</td>
<td>5.0</td>
<td>4.1</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>30.1</td>
<td>25.7</td>
<td>29.7</td>
<td>23.5</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>18.6</td>
<td>15.8</td>
<td>13.0</td>
<td>18.1</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>55.9</td>
<td>38.4</td>
<td>30.6</td>
<td>35.3</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>23.8</td>
<td>25.3</td>
<td>19.8</td>
<td>18.2</td>
</tr>
<tr>
<td>Stomach Cancer</td>
<td>7.1</td>
<td>5.4</td>
<td>3.8</td>
<td>8.2</td>
</tr>
<tr>
<td>All Cancer</td>
<td>201.9</td>
<td>180.1</td>
<td>166.7</td>
<td>175.7</td>
</tr>
<tr>
<td>COPD</td>
<td>41.5</td>
<td>29.8</td>
<td>18.0</td>
<td>28.5</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>38.6</td>
<td>36.1</td>
<td>29.9</td>
<td>38.9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8.3</td>
<td>5.0</td>
<td>5.6</td>
<td>9.0</td>
</tr>
<tr>
<td>Infectious and Parasitic</td>
<td>9.0</td>
<td>4.5</td>
<td>9.8</td>
<td>13.9</td>
</tr>
<tr>
<td>Suicide and Undetermined Injury</td>
<td>7.1</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Accidents</td>
<td>15.4</td>
<td>14.5</td>
<td>11.8</td>
<td>16.0</td>
</tr>
</tbody>
</table>

* Statistically significantly better than England
* No statistically significant difference
* Statistically significantly worse than England
There has also been a decline (figure 22) in the rate of infant mortality, that is, babies dying within the first year of life. The difference between the local rate and the London rate is small, however the downwards trend is greater in London than in Barking and Dagenham. So despite the increase in life expectancy and decrease in infant mortality, the health inequalities gap continues to widen.

Diagram: Figure 22 – Trends in infant mortality

1990 to 2009 (source: London Health Observatory)
Cancer mortality

Poor one year survival rates from breast, colorectal and lung cancers are found in outer north east London, as shown below.

**Fig 23: Colorectal Cancer ONEL Survival Rates (2006-08)**

![Colorectal Cancer ONEL Survival Rates (2006-08)](image)

**Fig.24: Breast Cancer ONEL Survival Rates Compared to London (2006-08)**

![Breast Cancer ONEL Survival Rates Compared to London (2006-08)](image)

**Fig 25: Lung Cancer ONEL Survival Rates (2006-08) (Source: NCHOD)**

![Lung Cancer ONEL Survival Rates (2006-08)](image)
Long term Conditions

The management of long term conditions accounts for 70% of health care spend, 70% of inpatient bed days, 50% of GP appointments and 64% of outpatients and A and E patients nationally. ONEL has a wide variation between boroughs of the rate and number of people living with a diagnosed long-term condition (LTC) as figure 26 illustrates.

Figure 26

Prevalence of Coronary Heart Disease (CHD)

CHD occurs when the hearts blood supply is blocked or interrupted by a build up of fatty substances in the coronary arteries. Figures from QOF 2008/09 detail that 25,668 ONEL patients were recorded on the CHD register as being diagnosed with CHD. This accounts for 2.7% of the ONEL GP population compared to the London average of 2.2% and the national average of 3.5%. Modelling by the Association of Public Health Observatories (APHO) suggests that there should be 9,970 additional CHD patients that do not currently appear on the GP registers in ONEL.

In ONEL the number of people on GP practice disease registers was greatest in Havering with a prevalence of 3.2% Waltham Forest had the lowest with 2.2% (figure 27).

Figure 27
Table 4 shows the estimated prevalence of CHD (diagnosed and undiagnosed) in ONEL and by individual PCT compared to the observed prevalence from the local QOF register. The data show that 28% of people with CHD in ONEL are not included on the QOF registers. This has possible implications with undiagnosed and unmanaged CHD resulting in an increased risk of premature death or disability due to a heart attack.

**Recorded and expected prevalence of CHD in ONEL by PCT**

<table>
<thead>
<tr>
<th>PCT</th>
<th>Recorded (QOF)</th>
<th>Modelled (APHO)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Prevalence</td>
<td>Number</td>
</tr>
<tr>
<td>B and D</td>
<td>4,523</td>
<td>2.5%</td>
<td>6,687</td>
</tr>
<tr>
<td>Havering</td>
<td>7,989</td>
<td>3.2%</td>
<td>10,580</td>
</tr>
<tr>
<td>Redbridge</td>
<td>7,286</td>
<td>2.8%</td>
<td>8,783</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>5,870</td>
<td>3.1%</td>
<td>9,588</td>
</tr>
<tr>
<td>ONEL</td>
<td>25,668</td>
<td>2.7%</td>
<td>35,638</td>
</tr>
</tbody>
</table>

(Source: QOF 2008/09 and APHO 2009)

**Prevalence of Diabetes**

The number of people with diagnosed Type 2 diabetes is increasing each year especially in deprived communities. The Quality and Outcomes Framework (QOF) provides information on the registrations for diabetes. The most recent QOF data refers to 2008/09 and shows that the national prevalence of diabetes in patients aged 17+ was 5.1%.

In ONEL there were 42,355 patients aged 17+ who were recorded as having diabetes, this gives a prevalence slightly higher than the national average at 5.7%. This prevalence is also higher than the average for London at 5.0%.

The chart below shows the prevalence of diabetes across London which ranges from 3.0% in Richmond and Twickenham to 6.9% in Newham. Redbridge has the fifth highest prevalence in London at 6.3%.

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3 Diabetes National Audit data for 2009-10 available for analysis
The 95% confidence intervals demonstrate that Redbridge, Barking and Dagenham and Waltham Forest all have prevalences which are statistically significantly higher than the national and regional averages.

Table 5 below outlines the actual number and prevalence of patients aged 17+ recorded as having diabetes for each PCT in ONEL.

**Table 5: Number and recorded prevalence of diabetes (patients aged 17+) by PCT, 2008/09**

<table>
<thead>
<tr>
<th>PCT</th>
<th>Number</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>7,821</td>
<td>5.9%</td>
</tr>
<tr>
<td>Havering</td>
<td>9,945</td>
<td>5.0%</td>
</tr>
<tr>
<td>Redbridge</td>
<td>12,982</td>
<td>6.3%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>11,607</td>
<td>5.6%</td>
</tr>
<tr>
<td>ONEL</td>
<td>42,355</td>
<td>5.7%</td>
</tr>
<tr>
<td>London</td>
<td>xx</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Sector level analysis of the QOF diabetes data shows that the highest prevalence occurs in North East London, the highest being in the Inner North East London sector at 6.0%, closely followed by Outer North East London with 5.7%. The two South West London sectors have the lowest recorded prevalence of diabetes.
Emergency hospital admissions – diabetic ketoacidosis and coma

In ONEL during 2007/08 there were 264 emergency admissions with a primary diagnosis of diabetic ketoacidosis and coma (ICD 10 E10 – E14).

The rate of emergency admission per 100,000 population across London ranges from 10.2 in Brent to 53.6 in Barking and Dagenham. As illustrated below, 95% confidence intervals demonstrate that the rate for Barking and Dagenham is statistically significantly higher compared to the national and regional averages as well as the other ONEL PCTs.

Figure 29

Highest mortality caused by diabetes is Waltham Forest at 9 per 100,000 compared to Haringey at 11 per 100,000 and Sutton at 4 per 100,000.

Care Processes

The National Diabetes Audit (2009-10) identifies the percentage number of people registered with diabetes who received the 9, NICE recommended, care processes of diabetes care (measure: weight, blood pressure, HbA1c, urine albumin creatinine ratio, serum creatinine, serum cholesterol; assess: eyes, feet, smoking – ‘bundle of care’). Nationally, people diagnosed with Type 1 and 2 diabetes are increasingly receiving the bundle of care. However, across ONEL, Havering, B and D and Redbridge are below the national average of 52.9% with Waltham Forest above at around 54.5% coverage.

Prevalence of COPD

The symptoms of COPD can appear to be similar to those of asthma. However, whereas asthma can be controlled with treatment, COPD causes permanent damage to the lungs. The prevalence of COPD in ONEL is 1.1% which equates to 10,393 patients. The prevalence across London is highest in Havering at 1.5%; figure 30 shows the QOF recorded prevalence of COPD for 2008/09 for all London PCT’s.
Prevalence of Mental Health

The prevalence of detected mental health is captured through the QOF disease registers and refers to people with schizophrenia, bipolar disorder, and other psychoses. The 20010/11 data shows that there were 1,324 people on the register in Barking and Dagenham. This equates to a prevalence of 0.7%. This is the third lowest prevalence in London. Overall London has a prevalence of 1.0% and England 0.8%.

It is possible that there are low rates of psychotic illnesses in Barking and Dagenham but the more likely reason is that there is a marked under-diagnosis and low rates of capture onto the mental health register.

A specific Child and Adolescent Mental Health (CAMHS) Needs Profile was undertaken in 2011/12 to inform the commissioning of CAMHS across ONEL. Barking and Dagenham faces significant challenges with high levels across the majority of risk factors linked to poor mental health in children, e.g. poverty, low parental education and high rates of worklessness.

An estimated 3,442 children aged 5 to 16yrs in Barking and Dagenham are living with a mental health disorder. Young offenders have higher rates of mental ill health than the general youth population and between 260 and 860 young people coming into contact with the youth offending service will have a mental health need.

Similarly looked after children have higher rates of mental ill health and an estimated 154 out of the 410 caseload in 2011 will have mental health needs.

This review is being used to inform the commissioning of CAMHS services moving forward.

TB and HIV

TB and HIV are both of concern for ONEL, particularly when compared with London and England averages.
TB Notifications: persons all ages

Tuberculosis (TB) is a bacterial infection which primarily affects the lungs but can also spread to different parts of the body including the bones and nervous system.

Globally TB remains a major public health problem – it is estimated that one third of the world’s population is infected with latent TB. Sub-Saharan Africa, Asia, Eastern Europe, Russia and Central America are all known to have high rates of TB (NHS Choices). Tuberculosis is notifiable under the Public Health Acts and Infectious Disease Regulations.

In ONEL in 2008 there were 318 notifications of TB, accounting for 12% of all notifications in London.

As shown in figure 31, the highest incidence rate in ONEL occurred in Redbridge at 60.8 per 100,000 population, this rate was statistically significantly higher than the England and London averages in addition to the rest of the ONEL sector. This may be related to the number of people from ethnic minorities compared to some of the other areas in London.

Figure 31

Table 6 shows the absolute number of notifications and directly standardised incidence rate per 100,000 population for each ONEL PCT during 2008.
The number of TB notifications in 2008 is the highest it has been over the last six years, since 2003 the number has increased by 22% from 261 to 318.

The trend of directly standardised rates for each PCT is illustrated in figure 32.

**Figure 32**

![Trend of TB incidence, directly standardised rate per 100,000 population, 2003 - 2008](source: NCHOD)

Interestingly in 2007, all four PCTs experienced a decrease in the incidence rate of TB; however this has again increased for 2008.
Human Immunodeficiency Virus (HIV) is one of the most important communicable diseases in the UK. It is associated with serious morbidity, high costs of treatment and care, significant mortality and high numbers of years of life lost.

There are substantial geographic variations in the prevalence of diagnosed HIV as illustrated in the map below, with higher prevalence occurring in London.

The 2008 data reveals that there were 1,713 people aged 15-59 years in ONEL who were living with a diagnosed HIV infection, giving a prevalence of 3.1 per 1,000 population. Table 6 outlines the number and prevalence of HIV infections for 2008 by PCT.

**Table 6: Prevalence of diagnosed HIV infection in ONEL: 2008**

<table>
<thead>
<tr>
<th>PCT</th>
<th>Number</th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>475</td>
<td>4.6</td>
</tr>
<tr>
<td>Havering</td>
<td>162</td>
<td>1.2</td>
</tr>
<tr>
<td>Redbridge</td>
<td>427</td>
<td>2.7</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>649</td>
<td>4.5</td>
</tr>
<tr>
<td>ONEL</td>
<td>1,713</td>
<td>3.1</td>
</tr>
<tr>
<td>London</td>
<td>25,319</td>
<td>4.9</td>
</tr>
</tbody>
</table>

**HIV Trend**

The trend of HIV prevalence has gradually increased since 2002 in all ONEL PCTs, however the trend in Barking and Dagenham as increased at a faster rate compared to other areas as illustrated below. The HIV vertical transmission rate for B&D is higher than London average.

**Figure 33**
Prevalence of HIV has been on the increase across London and within outer north east London. With the exception of Havering, HIV prevalence rates in outer north east London PCTs are significantly higher than England. Unlike other areas, prevalence in ONEL is highest among heterosexuals, particularly Black Africans, followed by men who have sex with men.

Late diagnosis of HIV leads to poorer outcomes and higher cost of treatment. All the ONEL PCTs have higher rates of late HIV diagnoses compared to London and England.

4.1.5 Public health strategic response

Responding to the strategic needs assessment of the population of Barking and Dagenham and outer north east London:

The intelligence summarised above has been considered against the recommendations in the 'Marmot Review' of health inequalities and the London Mayor’s Health Inequalities Strategy. The Mayor wants to be assured that the trajectories for indicators such as increasing life expectancy, reducing low birth weight babies, infant mortality, reducing obesity and premature death from cardiovascular disease and cancer are all going in the right direction. Public health teams and local government colleagues have a strong track record in collaborative working and intend to continue to work closely to address local needs.

The strategic response required from outer north east London to the population needs and key elements of action needed in relation to health services is summarised below.

An early start to good health

- Improving maternity services, antenatal screening programmes and supporting breastfeeding – this needs improvements in terms of increasing volume, improving services and promoting breastfeeding as an integral part of all prenatal, antenatal and postnatal staff involvement.
- Improving childhood immunisation rates through improved data administration pathways in primary care, social marketing based invitations from primary care to parents, structured training for health and non-health staff and practice level performance monitoring.
- Having adequate numbers of health visitors and school nurses to enable our children to have a healthy start in life and sustaining it with full implementation of the Healthy Child Programme.
- Reducing childhood obesity by increasing the levels of physical activity and promoting healthy eating, improving pathways for prevention and management of obesity
- Ensuring that attention is paid to the health needs of the most vulnerable children particularly looked after children and disabled children.

Reducing inequalities and increasing life expectancy by tackling the big causes of morbidity and mortality

- Tackling smoking as the most significant contributor to improving health inequalities and mortality rates
- Identifying and intervening with those people at risk of CVD and diabetes
- Improving prevention and management of obesity as a major cause of diabetes, cancer and CVD
• Improving prevention, screening rates and early diagnosis of cancer
• Improving detection and management of COPD.

**Staying healthy in adult life – keeping people healthier for longer**

• Promoting good sexual health, ensuring the services commissioned in outer north east London provide access to long acting contraceptives, promotion of safe sex and chlamydia checks, education about protection against HIV and quick diagnosis.
• Working to reduce harmful alcohol consumption and impact on emergency services
• Supporting people and their carers to manage mental ill health, including dementia and depression
• Supporting people to manage their long term conditions particularly through integrated care as described elsewhere in this document
• Preventing falls among the elderly

Within each of these strategic areas health services need to work to reduce inequalities by working with different communities and socio-economic groups to maximise the health opportunities available to them. Working closely with local authorities via the Health and Wellbeing Boards is critical not only to engage with the population in this way but also to influence the wider determinants of health.

**4.1.6 Public health commissioning approach**

The approach being taken by public health teams in outer north east London towards the commissioning of services is set out below:

• Getting best value for services commissioned
• Increasing the role of Health and Wellbeing Boards in understanding and overseeing the public health actions in ONEL
• Standardising and stabilising services across outer north east London
• Ensuring population needs are met – identifying gaps in services including specific gaps set out below.
• Putting in place a coherent strategy to screening services

Working with GPs to support their key role in primary and secondary prevention

At the end of January 2012 we will be advised by the Department of Health on the shadow public health grant for Barking and Dagenham. On receipt of this information during February 2012 NHS ONEL PCTs and the Council will discuss and agree the public health investments and disinvestments for 2012/13 financial year for those services covered by the that public health commissioning responsibilities that will transferring to the Council over the next 12 months.

**4.1.7 Service gaps**

The following service gaps have been identified for outer north east London as being particularly relevant for Barking and Dagenham:

• Stop Smoking Services and Tobacco Control
• Weight management services
• Community based sickle cell and haemoglobinopathy services
• Falls service
Business cases to support decision-making about services gaps will be considered by CCGs.

Stop Smoking and Tobacco Control
For many years a high smoking rate in the borough has been identified as one of the main threats to the health of the population. The 2011 Joint Strategic Needs Assessment identifies 25 specific recommendations for reducing smoking prevalence and reducing the impact of smoking. These include recommendations related to:

- Pregnancy – ensuring full implementation of National Institute for Health and Clinical Excellence (NICE) PH26 guidance. This includes training midwifery and other staff and monitoring the management of all pregnant women who smoke.
- Improving tobacco control – via collaborative work on illegal cigarette sales.
- Monitoring and improving the quality of the contract with the Community Stop Smoking Providers to better reflect the extent of the problem in Barking and Dagenham. This includes ensuring provision of stop smoking advice at much more diverse locations and by many more staff groups via cascade training.
- Patients with smoking induced or exacerbated long term conditions (for example COPD, Heart Disease and Diabetes) should have tailored services so that access to stop smoking advice is easy and minimally inconveniences the patient.

All contracts with all providers should consider a commitment to decreasing smoking levels within the borough.

4 Quality position

4.2.1 Overview of quality challenges and response
The key challenges in ONEL are to improve the quality and experience of acute hospital care and primary care, to address the variation that exists across the sector with some excellent care being provided locally alongside services that have been identified as falling behind in providing the standard of care that patients should be able to expect.

The cluster uses information from a range of sources including the patient survey, the JSNAs, hospital data and clinical audit to identify areas where quality and outcomes are not meeting best practice. Analysis of these routine sources of information triggers focused work including clinical audits on specific areas of concern. The information available on quality and outcomes combined with the outcome of reviews and investigations by regulators including the CQC informs the action taken to improving quality.

A consistent and systematic approach to improving quality in all commissioned services was established during 2011/12 with an agreed governance structure. The three key approaches to managing quality are CQUINs (Commissioning for Quality and Innovation performance framework), joint clinical audit and assurance frameworks. Regular quality review meetings with all providers and assurance frameworks for maternity and A and E services at BHRUT are in place to address areas of concern.
4.2.2 Patient experience

Patients in outer north east London tend to have on average a worse experience when trying to access or use local health services than elsewhere in the country, across primary and secondary care.

Primary care

The Ipsos MORI GP/patient survey results for 2010/11 show some examples of excellent patient experience in GP practices across outer north east London but also identifies that there need to be improvements in accessing primary care services and in the consultation provided by doctors and nurses. The main areas requiring improvement as identified by this survey are:

- Ease of getting an appointment with a practice nurse
- Ease of speaking to a doctor on the phone
- Out of hours GP service (ratings were higher in Havering)
- Impression of waiting time at the surgery (ratings were higher in Havering)
- Consultation with a doctor (ratings were higher in Redbridge)
- Consultation with a practice nurse (ratings were higher in Havering)

Acute hospital care

Satisfaction rates with hospital services are low in ONEL. The national CQC-commissioned patient survey showed that for the past year patients attending (BHRUT) reported a poorer experience than other trusts in the following areas – where each include a set of specific questions:

Outpatients Details on which trust scored worse are as below:

- Getting an appointment
- Seeing a doctor during the appointment
- Patients who may have needed to see a nurse or other clinician
- What happened during patients appointments at the outpatient department
- Tests and treatment for patients who received tests or treatment during their appointment
- Overall views and experience

Inpatients Details on which trust scored worse are as below:

- The emergency/A and E department
- Waiting to get to a bed on a ward
- Doctors
- Nurses
- Care and treatment
- Leaving hospital
- Overall views and experience
**Maternity** (worse for 5 out of 5 themes for BHRUT):

- Care during pregnancy - antenatal care
- Labour and birth
- Staff during labour and birth
- Care in hospital after the birth – postnatal care
- Feeding the baby during the first few days

**Mental health**

**Community based care:**

In 2010 a national survey was carried out to find out about the experience of service users when receiving care and treatment from mental health care providers. The three themes which the North East London Foundation Trust (NELFT) scored worse than other trusts were:

- **Care plan** - for being able to understand what was in their care plan and for their care plan covering what to do in a crisis
- **Day to day living** - For someone in mental health services asking about any physical health needs they may have and receiving enough support from mental health services in getting help. Also for receiving any help in finding or keeping accommodation
- **Overall** - receiving good overall care from mental health services in the last 12 months and for mental health services involving family or someone else close to them as much as they would like

**What service users said about care in hospital** (worse for four out of 12 themes)

The national survey was used to find out about the experience of service users when receiving care and treatment from mental health care providers. At the start of 2009, a questionnaire was sent to people who had recently had an inpatient stay for acute mental health problems. NELFT scored worse than other trusts in the following four themes:

- **Physical Health Checks** - for having medical tests about physical health
- **Rights** - for being made aware of how to make a complaint if they had one and for feeling that they were treated fairly during their stay
- **Leaving hospital** - for having a contact number for someone from their local mental health services to phone out of office hours and for being given information about how to get help in a crisis before leaving hospital
- **Overall** - for how good the overall care was that they received

National surveys of community services are not available however local information on patient experience will be considered in taking forward the patient experience strategy described below.
4.2.3 CQC reviews and performance

CQC Reviews

The report of the Care Quality Commission’s (CQC) investigation into the quality of care provided at Barking, Havering and Redbridge University Hospitals NHS Trust set out a range of quality and safety priorities which the trust must urgently address, with the support of local commissioners and partners.

Improvements in the management, culture and working practices at the trust were identified, but the CQC said more needs to be done, particularly in relation to maternity services. NHS ONEL and the trust, working with other hospitals across north east London, have already implemented a new maternity plan that is keeping the numbers of women delivering at the hospital within safe limits on very busy days. More however needs to be done to increase the capacity of maternity services and choice for pregnant women locally. Implementation of the Health for north east London changes to maternity and A & E services will ensure longer term sustainability of these services as quality improves. This will have an impact on services in Barking and Dagenham where commissioners wish to promote choice and ensure sufficient capacity in provision; the procurement of a midwifery led birthing unit at Barking Hospital will offer a further opportunity to support choice in maternity.

The report on the Care Quality Commission’s (CQC) and Ofsted visit on Children’s Services in Waltham Forest, reviewed safeguarding provision and services for Looked After Children across health and social care. The CCG will seek to review the recommendations in the context of local services and implement findings where appropriate.

Performance

In addition to the targeted reviews carried out by the CQC, routinely collected performance data also highlights need for change in outer north east London in the following areas:

- Improving emergency care across outer north east London remains a key challenge. None of the three sites within the cluster are consistently delivering the five new headline measures set out by the Department of Health. The Queens Hospital site is also consistently failing to meet the proxy standard of 95% of patients seen within 4 hours for type 1 attendances. During winter and at the time of pressure surge the challenge of maintaining an adequate level of service is still not assured.

- Maintaining the flow through acute hospitals is vital to improving and sustaining emergency care performance. Although over the last year improvements have been made there are still too many people spending too long in hospital after they have been assessed as medically fit for discharge but need to be moved to a more appropriate setting. The Cluster stretch target of 1% is still not met at either BHRUT or Whipps Cross.

- The community health service infrastructure has been developed in outer north east London, supported by some excellent focused work by GPs but referral rates for hospital services, and non elective activity remains higher than commissioning plans. The level of acute over-performance must be addressed to maintain financial balance and ensure that patients are getting the care they need in the right location.
Performance management during transition

To ensure that there is no deterioration in the transition year as the new Public Health Services are being formed, plans are in place to ensure that NHS ONEL will be held to account for performance at borough level. There will need to be close working with local public health teams, local authorities and any emerging public health service within London and the cluster.

Similarly, as CCGs move towards full authorisation, NHS ONEL will work with CCGs on how to monitor and affect performance of a single, shared provider. NHS ONEL is already working with the pathfinders in the Urgent Care Board to look at urgent care strategy and performance reporting.

4.2.4 Clinical sustainability

The biggest risks to sustaining clinical services in outer north east London relate to the primary care workforce and the distribution and retention of the emergency and maternity workforce.

Health for north east London

The implementation of the Health for north east London programme is critical to ensuring that emergency and maternity services can be provided safely over the medium to long term. Once the immediate improvements required to quality at BHRUT have been demonstrated, services can be reconfigured to provide a sustainable base for the local population. A and E services will be consolidated, supported by the implementation of the outer north east London model of urgent care, to ensure that senior clinical cover is available for all those needing emergency care.

The implementation of the maternity campus model of care including development of new midwifery-led units will give more choice for local women of normalised, midwifery-led care and allow specialist obstetric care to be consolidated leading to better levels of senior clinical cover for more complicated and higher-risk deliveries.

More information on the requirements for the maternity and urgent care workforce changes needed to support Health for north east London can be found in the maternity workforce strategy and urgent care workforce scoping report.

Primary care workforce

The primary care workforce is changing. Workforce needs modernisation to include succession planning for GPs, enhanced roles for practice nurses, health care assistants and practice managers taking on a larger portfolio of business management. A workforce plan to support the primary care strategy will be put in place that will focus on recruitment and retention issues of ONEL to retain professional staff once trained.

The workforce plan will also address primary care practitioner succession planning which is important in ONEL that has a high proportion of GPs aged 61 years old and over. Succession planning should be a priority for single handed practices where the GP is aged 60 years or over. In particular, PCTs need to start discussions where the contractor owns their premises to identify their future intentions and options of the local population.
Promoting self care, partnership working with allied health professionals, using telephone triage and the use of email are all methods that can be used to address the workforce issues.

4.2.5   Responding to quality and performance issues

A systematic approach to improving quality has been the centre of attention for the cluster board, with the establishment of a consistent and systematic approach to improving quality in all commissioned services in 2011/12 by undertaking the following:

1. Quality improvement became the centre of contract management and review process. Regular quality review meetings are now in place with acute, community and mental health service providers.

2. Wherever possible clinical effectiveness, cost effectiveness and patient experience are brought together to give a holistic view of the quality of the services under scrutiny/consideration.

3. An effective governance structure was established to ensure that the board has its fingers on the pulse. The following diagram summarises this.
Patient experience strategy

There are some great services in outer north east London but as noted above many fall short of patients’ expectations and many more could still be better. The cluster is working with CCGs to bring together the best methods used to involve patients and the public in the design, shaping and monitoring of local healthcare services.

The draft 2011-2013 Patient Experience Strategy for NHS Outer North East London sets out a framework for how patient experience will be captured and used. As well as defining overall aims for the next three years, it includes specific objectives. A detailed action plan of how these objectives will be measured and evaluated is being developed. The outcome of this endeavour should be:

- Patient experience feedback received becomes integral to development of services that meet the needs of the local population
- Patients and public from all sections of the community see local commissioners listening to their views and acting on them.

CCGs response to patient survey

The outcome of the patient survey is one of the key drivers for the Primary Care Strategy. This strategy will undergo a 3 months consultation before being finalised in March 2012, and can be found in Appendix 2. CCGs are particularly keen to understand better what the components of a truly good consultation are from a patient perspective. CCGs want to do much more to work with public health and other colleagues to understand the needs of different community groups better and develop better information for patients. This includes producing information on how to make best use of health services for all newly registered patients and generally working with patients to help them better manage and optimise their own health.

Contracting mechanisms to improve quality

Patient survey data is used to inform contract management and to drive improvements through the wider commissioning cycle through the development of the patient engagement strategy. NHS ONEL is working closely with providers to develop real time data on patient experience. Quality improvements are driven through the following CQUINs:

Acute providers:

- Improve patient experience
- Assessment of risk for venous thrombolism
- Reduce pressure ulcers
- Reduce harm related falls
- Enhanced recovery programme for eight elective surgery procedures-we expect to see significant reduction in length of stay of certain planned operations.
- Reduce catheter related bacteraemia
- To be seen by a senior clinician/consultant within 12 hours of emergency admission
- Reduce cardiac arrests outside critical care areas.

Mental health:

- To improve the physical health and medicines reconciliation of patients with mental health problems
• Understanding and improving patient reported measures of care
• Recovery

Community services:
• Improving end of life care
• Reducing pressure ulcers
• Ensuring patients have full understanding if their condition and how to manage it.
• Assess if patients in community rehabilitation have achieved their goal on discharge
• Reduce the incidence of falls that result in harm – this will be measured by the reduction in numbers of admissions for hip fractures in older people.

Safeguarding
A significant cross-cutting theme for all services is safeguarding for children and adults. Under the NHS reforms statutory duties to safeguard children and adults will transfer to CCGs.

NHS ONEL takes a cross generational approach to safeguarding children, young people and adults. This is delivered through a single integrated team that provides strategic leadership for safeguarding across ONEL’s health economy. The roles provide leadership, quality assurance, training, supervision and specialist clinical advice on safeguarding to the PCT and the provider health economy.

To enable closer working across the generations NHS ONEL is currently developing a single safeguarding strategy for 2012 to 2013. The Safeguarding team will present progress against the strategy work plan to NHS ONEL Quality and Safety Committee on a Quarterly basis. NHS ONEL has a high level of commitment to safeguarding children and adults and is an active member of the Local Authorities Boards.

Overarching development areas for 2012-2013 are to:

1. develop the NHS ONEL Safeguarding strategy to reflect new strategic priorities and in particular to respond to the changes in legislation, statutory guidance, health service structures and partnership priorities.
2. manage the safe transition of safeguarding children and adults work into new community structures; building clinical engagement at operational and strategic levels supporting commissioning consortia in preparation for future statutory safeguarding responsibilities.
3. support health providers undergoing restructuring to ensure that safeguarding arrangements are maintained through transitions, particularly those around transferring Community Services.
4. improve the quality monitoring of care homes and how the care of these most vulnerable adults is assured.
4.3 Financial position

4.3.1 Overview

The current financial environment across the NHS and wider public sector is very challenging. The 2010/11 Operating Plan process outlined the requirement for £20bn efficiencies over the planning cycle. NHS Outer North East London has an important role to play in delivering a share of these efficiencies.

An estimate of the ONEL (Commissioner and Provider) share of this target is in the region of £340m.

ONEL already has the lowest unit costs across London; if the rest of London could match ONEL spend per weighted capitation it would generate savings in excess of £900m across the capital. Given the low unit costs the clinical commissioning groups will need to continue to innovate if they are to provide their share of NHS savings whilst maintaining quality services.

It is estimated that savings of £56m across ONEL will be required in financial year 2012/13, to deliver an £8m surplus (0.5% turnover). A full financial analysis is provided in section 8.

4.3.2 Programme budgeting

Programme budgeting will inform an analysis of the financial position and plans for prioritisation of investments and savings.

Barking and Dagenham PCTs highest spend areas, excluding programme 23 (Other), are £194 per head per year on Mental Health, £131 on Circulation and £116 on Maternity. Barking and Dagenham PCT has no outlier outcomes, but in the areas: Vision, Trauma and Injuries, Maternity, the PCT has outliers on spend. This means that the borough has outcomes within acceptable limits for all services when looked at as a whole. However, it has a significantly low spend and slightly below average performance in vision services and has significantly high spend and slightly below average performance in maternity services. CCGs have received this information and will use it to inform discussions with providers about achieving best value for money as well as in considering priorities for investment and savings.

4.3.3 LSCG - first cut operating budget planning assumptions

London Specialist Commissioning Group (SCG) has a track record of delivering challenging financial settlements and for 2011/12 agreed a budget 0.9% lower than 2010/11. Currently the SCG is on target to deliver this budget. Each service has developed robust savings plans which have largely offset the cost of demand growth, which is above that of other health services. This growth arises from two sources, demographic (268,000 or 3% by 2015), and epidemiological (e.g. 10% for PIC, 6% for HIV and 4% for haemophilia from 2007/8 – 2009/10).

In the recent exercise to determine what the budget for specialised services for London’s residents will be for the NHS CB, it has been estimated that London spends between £1.8 and £1.9bn on specialised services. This will mean an additional transfer of commissioning
value in the region of circa £800m from London PCTs to the NHS CB. This is because London PCTs currently commission a significant number of specialised services themselves such as cardiology and many children’s services. In preparation for the NHS CB, the plan is to transfer specialised services commissioning to SCGs over the next two years consistently across the country. The proposed phased transfer arrangements are about managing the risk associated with large transfers of activity and finance.

A first cut operating budget has been developed for 2012/13, delivering £19.4m savings on the current portfolio of services. This has been approved by the SCG Board as a basis for negotiation with PCTs/Clusters and providers. The first cut Operating Budget for the SCG for 2012/13 is based on a budget for 2011/12 that was 0.9% less than the previous year.

The first cut budget is an early indication for planning purposes and will be subject to change as a result of the National Operating Framework in December as well as changes to PbR. The strategy set out in this CSP will need to be supported by key financial/service decisions in December and January to deliver a balanced budget in March 2012.

4.3.4 Finance and activity informatics

During 2011/12 ONEL has improved its reporting of practice based finance and information including having rolled out the Health analytics system developed in NHS Redbridge across the sector. This has enabled CCGs to improve their understanding of activity performed and empowered them to take action to make changes where necessary. An example of these changes is the 13% reduction in GP referrals in Barking and Dagenham for the first seven months of 2011/12 compared to the same period last year as shown in figure 35.

Figure 35

![NHS Barking & Dagenham GP referrals 2010/11 to 2011/12 YTD](source:UNIFY2)

The improved reporting of information has also supported the CCG to reduce its prescribing expenditure. Figure 36 demonstrates this improvement, which shows that cumulative expenditure is £468Km lower than in the same period this year.
Figure 36

NHS Barking & Dagenham GP Prescribing Expenditure 2010/11 to 2011/12
YTD

£2,150,000
£2,100,000
£2,050,000
£2,000,000
£1,950,000
£1,900,000
£1,850,000
£1,800,000
£1,750,000
£1,700,000

April May June July August September October
5. Priorities

5.1 Summary of CCG priorities

To deliver the strategic objectives and vision developed by the CCGs and to respond to the challenges set out above (case for change), the following areas have been prioritised for action across CCGs in outer north east London. These priority areas are neither new nor disconnected from each other. Existing plans are being implemented and strengthened to ensure progress and to understand and benefit from the interdependencies.

1. Commission safe, sustainable, high quality services for the local population
   Improving the quality and ensuring the safety of acute hospital, primary care, community, mental health and specialist services is of the highest priority for outer north east London. This includes ensuring sufficient provision of services for maternity, children and for the BME populations.

2. Integrate care
   Enabling improvements in care provided to individuals resulting in a better experience, improved outcomes and productivity.

3. Redesign urgent and emergency care services
   Ensuring patients and the public having access to convenient, high quality, timely and cost effective urgent and emergency care services and know how to access these services effectively.

4. Staying healthy
   Taking action to reduce the need for healthcare and to optimise the health of the local population needs to underpin and be integrated into all of these priority areas.

5. Increasing productivity
   Increasing productivity; high quality services are also productive services; productivity

An additional specific priority for Barking and Dagenham is the development of Barking Community Hospital including the opening of midwifery led unit.

CCGs and NHS ONEL will need to ensure that the work to date to effect a smooth transition to new commissioning arrangements continues. The development of the CSP has enabled CCGs to grasp the strategic commissioning leadership role and the work over the coming months to set an operating plan and budgets and negotiate contracts will ensure they are well placed to take on delegated authority.
5.2 Rationale for selecting priorities

CCGs have agreed the priorities for 2012/13 – 2014/15 at borough level workshops. Their local reviews have been informed and based on:

- The local context and case for change (as set out in section 4). In particular their views have been shaped by the quality agenda and the need to find sustainable solutions given the nature of the financial challenge.
- The Urgent Care Programme (led by the cluster wide Urgent Care Board over the last 12 months) and the recent Joint Clinical Audits at both local acute hospitals (which looked at frail elderly, cardiac and paediatric emergency pathways and identified significant opportunities for improvement going forward).
- The developments that have taken place in integrated care management over the last 12 months
- Consideration of the national outcomes framework domains - reducing mortality, long term conditions, helping people recover from illness or injury (acute episodes), patient safety and patient experience and the six London-wide actions required to improve the health and healthcare in London and the Mayor of London Health Inequalities Strategy.
- Bench marking analysis (McKinsey review; spend and outcome data)
- The King’s Fund Transforming our healthcare system, with its focus on the significance of developing primary care and the way in which in relates to the wider healthcare system.
- The work of the pan-London care pathway clinical working groups and the London Specialised Commissioning Group priorities.

The key priorities have subsequently been endorsed at the joint meeting of PCT Boards on 17 November 2011.


6 Opportunities

6.1 Review of current opportunities and impact

Across ONEL, CCGs are on track to deliver £45m of QIPP opportunity savings in 2011/12 (against a plan of £48m). Overspends on acute contracts (particularly emergency admissions and continuing care budgets) have reduced the overall financial benefit to £33m. The resulting gap is being managed through the return of £8m top slice and £4m of additional in-year savings initiatives.

The table below summarises the financial impact by QIPP opportunity category:

<table>
<thead>
<tr>
<th>QIPP category</th>
<th>Forecast Outturn 11/12 £m</th>
<th>Forecast Outturn 11/12 £m</th>
<th>Forecast Outturn 11/12 £m</th>
<th>Forecast Outturn 11/12 £m</th>
<th>Forecast Outturn 11/12 £m Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Barking and Dagenham</td>
<td>Havering</td>
<td>Redbridge</td>
<td>Waltham Forest</td>
<td></td>
</tr>
<tr>
<td>Productivity</td>
<td>1.5</td>
<td>2.3</td>
<td>2.1</td>
<td>3.1</td>
<td>9.0</td>
</tr>
<tr>
<td>Integrated care</td>
<td>3.1</td>
<td>5.1</td>
<td>2.3</td>
<td>2.6</td>
<td>13.0</td>
</tr>
<tr>
<td>Decommissioning ineffective procedures</td>
<td>3.9</td>
<td>1.4</td>
<td>0.7</td>
<td>3.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Running costs</td>
<td>3.0</td>
<td>0.1</td>
<td>0.0</td>
<td>3.1</td>
<td>6.2</td>
</tr>
<tr>
<td>Clinical overheads</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>1.7</td>
<td>2.1</td>
</tr>
<tr>
<td>Reducing drug spend</td>
<td>1.3</td>
<td>1.0</td>
<td>2.0</td>
<td>2.0</td>
<td>5.5</td>
</tr>
<tr>
<td>Total savings</td>
<td>12.8</td>
<td>9.8</td>
<td>7.5</td>
<td>15.4</td>
<td>44.8</td>
</tr>
</tbody>
</table>

Successes in 2011/12 have included:

- Productivity gains on mental health and community contracts £8m
- Integrated care (Planned care) – maximised utilisation on independent sector contract (averaging 93% compared with planned level of 85%) £3.4m, and successful negotiation of new contract saving the cluster £7m pa plus potential pathway guarantee gain of an additional £2.5m
- Decommissioning ineffective procedures – roll out of new policy saving an additional £1.3m
- Reducing drug spend - on track to meet the £6m savings target set for 2011/12
Ensuring delivery

During 2011/12 a number of actions were taken to support QIPP delivery, including the establishment of a Programme Management Office and a team of dedicated project managers.

QIPP performance dashboard produced by the Programme Management Office (PMO) have been used by CCGs, the cluster Executive, Finance and Performance Committee and the Boards, to monitor and manage performance.

6.2 Opportunities - summary

This section sets out the opportunities CCGs intend to implement in order to address their priorities.

They build on the 2011/12 productivity programme and the developmental work that has taken place over the last 12 months. Implementation plans for quality; integrated care and urgent and emergency services as a result are significantly further refined on those presented last year.

Barking and Dagenham CCG has identified clinical leads for the key QIPP workstreams who report to the Clinical Commissioning Committee. The CCG is working collaboratively with neighbouring CCGs through the BHRUT Clinical Forum to oversee delivery of the QIPP programme across the local health economy.

The table in Appendix 4 summarises the opportunities and their QIPP categorisation. They have been grouped by priority but there are clearly a number of priority interfaces. Each opportunity identified in the table is supported by an implementation plan which sets out:

- Sponsor and project lead
- The case for change
- Overall description
- Key times
- Project governance and Enablers
- Outcomes and measures
- Engagement and patient choice
- Costs/resources
- Impact on providers
- Risks and mitigation

The section below gives an outline of the key aspects of the detailed implementation plans.
6.3 Opportunities – overview

**Priority 1: Commission safe, sustainable, high quality services for the local population**

**Maternity Services**

Sustainable maternity services must be secured for the growing population. This will be achieved by driving up quality and choice of maternity services and consolidating obstetric-led services.

The importance of improving the quality of maternity services and the action being taken to address concerns at BHRUT in particular has been covered elsewhere in this document. Immediate improvements are being made, supported by the commissioning of alongside (at Queen’s) and standalone (at Barking Community Hospital) midwifery-led units which will facilitate greater choice for women and greater access to normalised, midwifery led deliveries as well as helping to manage maternity demand and capacity in outer north east London. The implementation of the Health for north east London changes will ensure these improvements are sustained into the future.

Improving services and promoting breastfeeding as an integral part of the pre-conception antenatal and postnatal pathway will require an integrated approach, for example developing breastfeeding support services through Family Support Workers and Children’s Centres.

**Children and young people services**

The Children and Young Peoples Plan is the delivery plan for improving outcomes for children and young people. A Children’s Health Group, reporting to the Children’s Trust and Health and Wellbeing Board will be responsible for refreshing the plan and monitoring it’s delivery.

NHS ONEL is implementing the Health Visitors Call to Action programme (expansion and new role of health visiting), reflecting the learning from the NHS London early implementer sites for the Family Nurse Partnership. A children’s community nursing plan has been developed which is focused on the realisation of the ‘call to action’ milestones.

Improvements to universal child health services will have an impact on children and young people as will the improvements to maternity service on newborns. Full implementation of the Healthy Child Programme will ensure a sustained focus on improving outcomes for children and there are opportunities for greater input from primary care and front line workers, including in the Local Authority and schools.

The changing demographics will placed an increased demand on universal services and specialist services such as speech therapy for children with complex needs. A strategic review of child and adolescent mental health services is being undertaken across ONEL and this will inform the development to service specifications for 2012/12 that deliver improved outcomes for children and young people. The CAMHS review also includes a review of health input into Youth Offending Services, in response to the CQC review of Youth Offending Services in 2011/12.
Commissioning weight management interventions for children and young people is another priority area for service commissioning to ensure access to tier 2, 3 and 4 service models.

The PCT and Local Authority are developing joint commissioning arrangements to improve the physical and mental health and well being of children and young people by improving the range of services for children with disabilities and complex health needs and their families (Aiming High). This includes access to services for short breaks.

Specific opportunities to achieve higher quality standards in acute surgical and medical care were identified by the Health for north east London Clinical Working Groups, and further opportunities to improve the paediatric emergency and urgent care pathways have been identified in the urgent care workstream.

The highest rate of A&E attendance not followed by admission, in Barking and Dagenham is for 0-4 year olds. The Barking and Dagenham practice rates are similar to Waltham Forest and lower than Redbridge and have fallen between 2007/08 and 2008/09. A clinical audit of emergency admissions at BHRUT has identified paediatrics as a priority for pathway review in 2012/13. And urgent care pathways for paediatrics will be reviewed as part of the urgent care QIPP workstream.

**Family Nurse Partnership (FNP)**

The government commitment to early life and improving the outcomes for vulnerable children is reflected in the 2011/12 NHS Operating Framework. This sets out the requirement to sustain and expand the FNP programme. The programme is currently being tested in Barking and Dagenham and Waltham Forest with support and leadership from the Department of Health and Department of Education.

The FNP complements and supports the expansion and transformation of health visiting, providing a new model of practice that can revitalise and enhance universal health visiting locally, contributing to staff retention and motivation. NHS ONEL is working with FNP sites to integrate FNP within universal services by sharing the learning and testing new practice and service models on the ground.

**Cancer services**

Improving Outcomes: A Strategy for Cancer published in January 2011 is the first of a proposed series of national improving outcomes strategies. It refreshes and updates the *Cancer Reform Strategy (DH 2007)* but does not fully replace it. It has 4 key strands:

1. Prevention and early diagnosis
2. Quality of life and patient experience
3. Better treatment
4. Reducing inequalities

Over the years there has been year on year improvement in cancer mortality and cancer incidence across outer north east London. During 2011/12 an awareness campaign was carried out on cancer symptoms. Cervical and breast screening rates have improved but there is room for further improvement. The bowel screening programme has been rolled out but its uptake needs to be improved. BHRUT has significantly improved the cancer waiting times and Whipps Cross is addressing similar cancer waiting time issues. However, within outer north east London there are significant inequalities related to incidence of cancers and...
cancer related death. In addition the one year survival rate for cancer is amongst the worst in England and in London.

There is a London wide focus on improving outcomes. Integrated cancer systems are being formed to ensure patients are able to access the best treatment in a seamless way. Providers in east and north central London are coming together to create the integrated cancer system for our population. The cancer networks have been charged with the responsibility to facilitate this.

The Mayor’s Health and Wellbeing Strategy has identified early diagnosis of cancer as a key priority for London. This is also a key priority for outer north east London as the one year survival rate of the local population is amongst the worst in the country. There are numerous reasons for this e.g. delay in patients seeing their GP, delay in GP recognising the symptoms and making urgent referral for treatment, delay in patient pathway in the hospital.

To improve the situation in outer north east London the following actions will be prioritised:
1. Each Clinical Commissioning Group should appoint a Primary Care Cancer lead to ensure that GPs have up to date knowledge of cancer guidelines for referral and diagnosis.
2. Provide GPs direct access to the following diagnostics:
   - MRI for suspected brain cancer
   - Non obstetric ultrasound for suspected ovarian cancer
   - Flexible sigmoidoscopy/colonscopy
   - Chest X ray
3. Raise awareness of cancer symptoms among our population
4. Ensure our trusts implement Improving Outcomes guidance and improve care pathways
5. Improve palliative care services
The North East London Cardiovascular and Stroke Network has produced a series of commissioning recommendations for 2012/13 for consideration by commissioners. In summary these are as follows:

**Stroke**

The pan London model of care is now in place. Early supported discharge services and community stroke rehabilitation services need to be developed which will greatly reduce the need for stroke unit and inpatient rehabilitation beds.

**Cardiac**

The Pan London cardiovascular model of care needs to be implemented, the main opportunities that the CCGs wish to progress are developing community cardiology pathways to ensure the effective pathway is in place for patients. Community diagnostics also needs to be reconfigured to provide optimal quality and cost effectiveness.

Work also needs to be undertaken to ensure heart failure services comply with NICE 2010 heart failure guidelines, the NICE 2011 quality standards and BCS recommendations. Services will be assessed against the acute standards for cardiac care as recommended by the British Cardiovascular Society (BCS).

From a specialist commissioning perspective the consultation is now concluded on Paediatric Congenital Cardiac Services (PCCS) with the next stage of the process in development. The implementation of changes might take place in 2012/13.

**Vascular**

The reconfiguration of complex vascular services as per the Health for north east London model are complete. However there are issues over the compliance of BHRUT to the interventional radiology quality standards, the Royal College of Surgeons guidelines and the total volume of patients. It was assumed in the modelling that BHRUT would increase activity by 50% via increased Essex activity and some increase in ONEL activity. This is now in doubt due to the East of England intentions to centralise all complex vascular work with in the East of England boundary; this raises issues over the long term viability of BHRUT as a complex vascular centre. Work will continue to resolve these issues. This is noted in the provider impact section below.

From a specialist commissioning perspective the outcome of the service reviews and consultations may impact in 2012/13 in particular, PCCS as set out above, Aortic Aneurysm (Cardiovascular review) and tertiary paediatrics.

**Local Need for Stroke and Cardiovascular Interventions**

Whilst The North East London Stroke and Cardiovascular Network has identified deficits in secondary and tertiary care services in Cardiovascular disease the Barking and Dagenham JSNA identified some specific early interventions. These include:

- prevention and early detection with an understanding of the cost benefit of good primary care disease management in reduction of unnecessary hospital admissions. This includes comprehensive, proactive case finding to identify those at medium or high risk and those with single abnormal measures (for example high blood pressure or high cholesterol)
- Ensuring that there is adequate provision of lifestyle interventions such as exercise, sensible drinking, smoking cessation and weight management; and consider the
creation of a complete package of lifestyle intervention rather than a “piecemeal” approach.
- actively identify and managing atrial fibrillation using primary care Risk Assessment and Stroke Prevention Tools.

**Mental health**

The CCGs are working collaboratively to take forward key priorities in mental health work and to share learning across ONEL. Each borough has agreed to take forward a programme of work on behalf of all boroughs and there is good engagement from GPs within the commissioning process for this client group. The key CSP priorities were identified at a Mental Health priority setting event in July 2011 involving NHS London. This has subsequently been confirmed and agreed with NELFT as the main mental health provider and key stakeholders. The key areas for QIPP are:

- **Acute Mental Health Pathways** - review how people get into the system of inpatient care and how they can be better managed within the community. This follows work by the National Development Unit for Mental Health and papers published both by the Audit Commission and NHS Confederation.

- **Review and progression of the implementation of the National Dementia Strategy** – with a specific focus on moving resources from the acute sector provider to mental health services and developing more effective memory clinics across ONEL PCTs. This follows the publication of the London wide Commissioning Pack for Dementia, including the economic case for transformation.

- **Develop the London wide Models of Care for Mental Health** which were published in 2011 – using the recovery model and enhanced primary care support to sustain clients within shared care with GP practices as the cornerstone of provision. It also means reviewing why patients end up in A and E and experience crisis and moving both resource and the focus of support into primary care. A pilot project has started in Waltham Forest focusing on the active management of long term mental health conditions in primary care with anticipated improvements in quality and outcomes and reduction of secondary care usage as a result. The results of this will enable further modelling of impact with the plan to roll out across all boroughs.

- **Strengthen the connection between physical health and mental health in terms of depression and anxiety pathways.** The focus for this is to review over the next year how IAPT's and depression and anxiety pathways are operating.

- **Review CAMHs services across ONEL.** This will identify the risks and current provision working with local authorities for a comprehensive CAMHs service and provide CCGs with options for change. This will be a major piece of work and will lead to a clear framework to follow over the next 3 years.

In addition:

- The impact of the introduction of PBR will be assessed.

- Discussions with specialist commissioning are taking place on Perinatal psychiatry (There is a proposal to agree a simplified and standardised pricing framework for forensic services at East London FT for inclusion in the 2012/13 contract);
Low/Medium Secure Mental Health - Case management has been introduced for low/medium secure MH over the last year and will be further extended in 2012/13.

Learning Disabilities

The Learning Disabilities Partnership Board oversees delivery of the commissioning plan for learning disabilities and a Clinical Lead has been identified to provide leadership to the delivery of the health action plan. The Self Assessment Framework for 10/11 showed improved performance in health and disease prevention compared to 09/10 and the SAF Action plan is being updated to sustain and improve performance moving forward. Discussions have been initiated with the Local Authority regarding lead commissioner arrangements for learning disability services.

Some adults with more severe learning disabilities require regular and ongoing access to specialist services. The specification for the specialist Community Learning Disabilities Team has been revised to deliver an integrated service to users and will be monitored to ensure delivery.

All adults with learning disabilities are entitled to equitable access to mainstream health services. This means that all services, primary care, out of hospital and acute make the required reasonable adjustments to allow fair access to services by people with an LD. The requirements for mainstream services’ provision for people with LD will be explicitly set out in contracts and performance managed. This is a requirement arising from the LD SAF action plan.

Asperger’s Syndrome

It is a statutory responsibility of the PCT and Local Authority to implement “Fulfilling and rewarding lives: the adult strategy for autism in England [2010]. It is recognised locally that there is a need to improve access to diagnosis and develop a consistent care pathway for adults with autism.

Adults with Asperger’s Syndrome require improved recognition and diagnosis at primary and specialist care levels. Adults with severe autism and learning disability will continue to be managed by the specialist learning disabilities services with an emphasis on, wherever possible, having less reliance on out of area placements for such patients.

At present, patients with suspected Asperger’s Syndrome are often assessed on a spot purchase basis by out of area hospitals such as the South London and Maudsley NHS Trust (SLAM). Clinical pathways are being reviewed to ensure that there is local access to the local specialist mental health provider for diagnostic services for adults who do not have learning disabilities.

All mainstream health services are required to demonstrate that they are making reasonable adjustments for adults with Asperger’s Syndrome.

Burns – specialist commissioning

The Burns review Case for Change has been endorsed and approval given to proceed to Phase 2 of the review, by the SCGs of London, South East Coast, East of England and South Central. The process will take forward the development of a detailed model of care for
the long term configuration of specialised burns services across the London and South East Burns Network area. This may result in a procurement exercise to be started in 2012/13.

**Service gaps**

Service gaps have been identified for haemoglobinopathy services, of particular importance for people with sickle cell/thalassaemia. Business cases for commissioning services will be considered by the CCGS.

**Priority 2: Integrate care**

**Integrated care management (ICM)**

Integrated care management was identified as a key priority for 2011/12 in Barking and Dagenham. It addresses specific patient needs in a case managed approach. It enables improvements in the care provided to individuals with long term conditions or high users of services. Integrated care is supported by a multidisciplinary system across health and social care. It focuses on population health and uses risk stratification to provide evidence-based care on a pro-active and planned basis.

Significant progress to implement ICM has been made over the last 12 months. It is seen as a key driver to delivering system quality and productivity challenges over the next four years. A full supporting pack for integrated care management programme can be found at Appendix 1.

PCTs and subsequently CCGs have identified other opportunities which we are now aligning with the ICM programme. These include:

- focus on the care of patients with COPD - this has included the implementation of a Year in the Life which is an ONEL cluster wide HEIC project focussed on increasing the uptake of screening, pro-active management of COPD patients, benchmarking clinical practice and implementing tailor-made primary care.
- piloting of personalised health budgets in Barking and Dagenham and Havering
- Integration of Frail elderly pathway - older people represent the biggest users of all health and social care services and as such present a real opportunity to improve care and outcomes and making better use of available resources.

**Falls prevention**

In 2011/12 falls prevention services were reviewed across three boroughs in partnership with the local authorities. These have focussed on developing the scope of this work and in 2012/13 will move into implementation. The falls prevention services will identify and diagnose falls risk factors, provide rehabilitation to improve mobility and identify slip and trip hazards and provide equipment and home adaptations to minimise these risks. The service will focus on people with poor balance, gait or mobility problems due to degenerative joint disease, motor disorders, stroke, multiple medications, visual impairment, impaired cognition and postural hypotension. In Barking and Dagenham, reablement monies are being invested in the expansion of the falls service.

**End of Life Care**

The End of Life Care Strategy promotes high quality care for all adults at the end of life and reports that nationally 58% of all deaths occur in hospital, which isn't the preferred choice for
most people. To improve this, it is recommended that there is an integrated health and social care planning approach and the development of a co-ordinated seamless care pathway which identifies patients and their preferences, assesses their needs, develops an agreed care plan and delivers that care where patients’ want it, in their last days of life (Liverpool Care Pathway). In addition, it is fundamental that the needs of patients’ carers are also met during the patient’s illness and after their death because “How people die remains in the memory of those who live on”. In order to achieve this, the care people want needs to be commissioned, co-ordination of care across needs to be achieved and the workforce needs to be trained to provide end of life care.

The most recent figures available for deaths at home (all causes) in England are for 2007/8 at 19.9%, comparing with 18.2% for London. In Outer North East London, Redbridge had the lowest percentage of deaths at home at 16%, followed by Waltham Forest at 16.4%, Barking and Dagenham at 18.2% and Havering at 18.2% and we want to see these figures improve to at least the national average.

**Planned Care**

A planned care strategy will be developed taking into account the implementation of Health for north east London recommendations around separation of planned and emergency surgery. The award of a new PbR contract for the North East London Treatment Centre will be of benefit to commissioners in 2012/13.

**Out of hospital care**

Ensuring out of hospital services are both aligned and available to deliver integrated care is key to the success of the approach and to supporting the improvements required in urgent and emergency care. The primary care strategy described below is a central component of work in this area, and will include the development of polyclinic services at King George Hospital as well as at other sites in north east London. The development of community services is integral to this work.

**King George Hospital vision**

A commissioning strategy for the King George Hospital site will be put in place to best meet the needs of local residents as well as reviewing the opportunities to provide more specialist services from a wider population at this site. The strategy will underpin the Health for north east London changes by incorporating the development of the 24/7 urgent care centre on the site.

**Priority 3: Improve urgent and emergency care services**

Urgent and emergency care is one of the key priorities for all CCGs. In line with *The guidance for commissioning integrated urgent and emergency care a whole system approach*, (Dr Agnelo Fernandes August 2011) our focus continues to be on engaging stakeholders from across the health and social care system in developing integrated approaches to commissioning coherent 24/7 urgent care services with greater consistency, improved quality and safety, improved patient experience, greater integration and better value. Services need to be developed around the needs of the patients that use them. The system needs to support easy and appropriate access to the right level of service and provide responsive services for children, frail older people and those with mental health needs that integrate effectively with primary, community and other services designed to keep people well and out of hospital.
The CCG supports a model of care that places the GP practice as the first port of call for urgent care and will focus on pathway redesign that enables repatriation of patients with primary care conditions back to general practice.

There are key links between our urgent and emergency care work stream and work on long term conditions, Integrated case management our developing approach to integrated care for frail older people and a number of mental health projects focused on interplay between physical and mental health care.

The implementation of Health for north east London and the reduction from 6 to 5 A and E sites in north east London will secure a sustainable emergency service configuration that will allow greater levels of senior clinical cover and more effective use of scarce resources. The changes will be supported by the implementation of the cluster wide urgent care model.

The recent clinical audits of frail elderly, paediatric and cardiac admissions showed opportunities for improvements to pathway design and reductions in admissions.

To ensure involvement of key stakeholders in a whole system approach and to drive the implementation and delivery of this strategy CCGs agreed the establishment of the Urgent Care Board which had its inaugural meeting in April 2011. The Board has achieved good clinical engagement and is chaired by a GP with membership from acute providers, community providers, ONEL representatives from Planning and Delivery and Performance, GP leads, LAS, PELC and local authorities as appropriate. The Board has agreed the strategic priorities for urgent care which include early agreement by GPs of a consistent model for urgent care across the Cluster. Commissioning strategy plan workshops were held with CCGs in September-October 2011. The diagram overleaf summarises the principles, model and key enablers for delivery.
No confusion of what to do, who to call or where to go
- 999 immediate life threatening conditions
- NHS 111
- Electronic DoS

A joined up and co-ordinated urgent and emergency health care system
- Integrated Case Management
- Cluster rapid response model
- Primary Care Discharge Facilitation Team

Consistent, responsive and high quality service
- Model for urgent care
- Non-elective pathway development
Model for Urgent Care

A wider review of the Polyclinics and Walk in Centres is underway across the cluster to ensure that the development of the cluster wide model for urgent care is reflected in the future provision of these services.

Priority 4: Staying Healthy

The following opportunities have been identified to deliver against the staying healthy priorities. Some of these opportunities will also deliver productivity savings within existing contracts as well as improving quality and prevention of ill health. Other areas will require investment.

- London TB plan
- Smoking cessation
- Obesity/weight management
- Screening and health checks
- Child health
- Sexual health
- Alcohol harm reduction

The opportunities identified above support the priority area of staying healthy, by ensuring that services are commissioned appropriately to support healthy choices, to screen for disease and to raise awareness. Strategic commissioning needs to incorporate preventative measures even if the benefits will not be felt within the time period of the strategy as is the case with some of the key public health interventions such as smoking cessation, childhood obesity and breastfeeding promotion.

The approach being taken by public health teams in outer north east London towards the commissioning of services is set out below:

- Getting best value for services commissioned
- Standardising and stabilising services across outer north east London
- Ensuring population needs are met – identifying gaps in services including specific gaps set out below.
- Putting in place a coherent strategy for screening services
- Working with GPs to support their key role in primary and secondary prevention

Priority 5: Increasing productivity

The opportunities described above contribute to the cluster productivity programme. Building on the successes to date, ONEL have continued to develop an overall commissioner productivity programme. In addition to these, the programme includes the continuation of opportunities through:

- Productivity gains through contractual levers (including specialist commissioning)
- Decommissioning ineffective procedures
- Decommissioning on non core services
- Shift services to lower cost settings - Work will continue across primary care, community and hospital services to shift outpatient activity and procedures from hospital to more convenient and cost effective settings of care in the community. CCGs are keen to progress with this programme of work
• Medicines management
• Community services - Community Health Services across the sector are now provided by NELFT through NELCS (North East London Community Services) following the successful transfer of ONEL CS to NELFT on October 1, 2011. This presents commissioners with an opportunity to maximise efficiencies and realise pathway re-design across the sector taking into account the variance in needs between the CCCs (aligned to ICM programme and required supporting community infrastructure).
• Individualised care placements - there are opportunities to commission better quality services which deliver better value for money for people who meet the eligibility for continuing health care in outer north east London. The main mechanisms that commissioners will use to achieve improvements will be to develop a procurement framework for home care, move from block contracts to more flexible purchasing arrangements for care homes, review high cost placements, develop a collaborative commissioning approach across outer north east London to community equipment services and seek internal efficiency savings from improved payment processes.
• Estates and infrastructure savings through better utilisation aligned to Health for north east London.

During 2011/12 the development of a Primary Care Strategy was also prioritised. (This is attached at Appendix 2)

The delivery of the Strategy and ownership by ONEL GPs and Clinical Commissioning Groups will help address the challenges and opportunities presented in reshaping the local NHS. The six recommendations are focused on what ONEL and GPs need to plan and deliver together.

• To have a clear focus for the primary care system around addressing the improvements in health outcomes and overall quality. This would include supporting continuing improvement in the quality and productivity of primary care services, ensuring universal quality standards of service delivery.
• To establish ONEL integrated care networks of practices to collaborate with other health care providers on population based services. This will provide an improved patient experience with a co-ordinated pathway of care.
• To support networks of GPs in the transition from sub-standard primary care premises into fewer but better facilities providing a community based hub for patients.
• To have a Unified Operating Model for the contracting of primary care services. This will encourage universal population coverage of health care, fairness, equity and transparency in the way general practice services are commissioned and assurance of value for money.
• To have a workforce plan that supports succession planning and enhanced role of GPs, practice managers and other allied practice staff. This will need to consider links to all health professionals in the integrated care model including pharmacists and community staff.
• To maximise the role of IMT to ensure practices are able to access high quality information relating to their patients in order to improve quality and value for money.
There will be a borough specific primary care improvement plan (PIP) to support the development of Clinical Commissioning Groups in ONEL. This will assist in firstly, the delivery of the vision for primary care set out in this Strategy and secondly, the authorisation process for CCGs. It is expected that this will include the direction for the future of key local health centres including the East Dagenham Community Hospital. Following stakeholder and patient representative consultation, the Strategy will be published for implementation in April 2012.
7 Enablers

7.1 Working in partnership

The commissioning strategy can only be delivered through effective working with key partners and stakeholders. Effective partnership working with local authorities is particularly important when addressing the staying healthy agenda and in shifting the focus of activity from the hospital to the community. The establishment of the Health and Wellbeing Boards will support partnership working as the clinical commissioners take up full responsibility for health budgets and the reablement mechanisms will allow resources to be aligned. Commissioners and providers will need to work together to realise the aims of the commissioning strategy and to understand and manage the impact of the strategy.

NHS funding of £2.3M will be transferred to the local authority under a Section 256 Agreement (NHS Act 2006) in 2012/13 to carry out activities with health benefits. This will provide opportunities to support innovative ways of providing social care to improve health and social care outcomes, reducing cost pressures across both health and social care.

7.2 Incentives and contractual levers

GP commissioning incentives
In July the PCT Board committed, within the Clinical Commissioning Groups Delivery Agreements, to continue Practice Based Commissioning (PBC) incentive funding.

The agreements set out how ONEL emerging CCGs have been allocated a budget the equivalent of £2 per head of registered population. The purpose of the funds is to support and incentivise GPs at a local practice level to achieve QIPP delivery and CCG financial balance. A CCG may use up to 10% to support the additional costs of Professional Executive Committees (PEC).

Each emerging CCG has agreed with its constituent members the most effective use of this budget and designed incentive schemes to support and encourage practice engagement.

Contract mechanisms
Current contractual levers include:

- Improvement planning
  Service development and improvement plans for providers are incorporated into contracts.

- AQP
  The use of Any Qualified Provider gives commissioners an opportunity to introduce competition into the market which can be helpful to address any limitations identified locally relating to quality of services, access or choice. As any new providers need to be commissioned in addition to existing providers initially, there is a potential for additional costs to arise in the first year of any such strategy. Any savings will need to be found by subsequent decommissioning once a new provider is in place.

- Key Performance Indicators
  Local key performance indicators are introduced to contracts in addition to the national KPIs.
Clinical audits
Clinical audits can be useful in contract negotiation and monitoring. Audits undertaken in outer north east London this year identified a clear need to review and introduce new pathways of care which will shift services to a lower cost model and/or shift to a more integrated approach. An outcome of the clinical audits will be to put service transformation programmes in place with trusts aligned in particular to the Integrated Care programme. These will be developed through the clinical forums. There is an intention to agree annual clinical audit programmes as part of contract negotiations to build on service and quality improvements. To ensure the full benefit of this work is realised there are plans to put in place an in year programme of reviews of service specification and KPIs against transformation programmes. This will ensure that progress made is embedded in contractual terms.

In addition to the existing levers described above there have been early indications that a new national contractual framework will be developed along the lines of an integrated care contract model with acute, community and mental health contracts using a single contract model. This model will promote providers working together to improve patient pathways. Commissioners and providers will agree service transformation projects to be delivered within fixed prices.

7.3 Information
NHS ONEL has been working with Information for Commissioners (IFC), a workstream of the Commissioning Development programme, to ensure the information needs of the Commissioning Board and CCGs are identified and supported. In order for effective commissioning there needs to be accurate and comprehensive information and effective ways of managing and sharing this data. An initial assessment of information needs was carried out to determine the core business roles that must be performed, the activities necessary to perform those roles and, at a high level, the information required to carry out those activities. This assessment will provide a basis for discussion that will ultimately lead to the development of solutions focused on the needs of the CCGs.

The current informatics system, provided by Health Analytics, was developed from a need to enable clinical commissioners and managers to monitor and evaluate all available patient related data in one place. The reporting of commissioning performance provides an understanding of current and predicted future healthcare needs, the ability to identify opportunities for improving patient care, details on primary, secondary and community care utilisation and cost and quality reports on pathways of care.

Since the roll out of this informatics system, it has advanced to become a tool to support decisions and will connect the GPs and the CCGs. Recent developments include:

- Additional financial data, enabling the monitoring of cost and spend across pathways
- The ability to track the delivery of improvement initiatives over time
- At the request of primary care commissioning, a health checks module has been developed that enables automatic identifying of patients, capturing of health checks completed, automated payment in real time and ensures ONEL meets its national commitments
- A number of templates have been developed and rolled out across ONEL to improve data quality
The support provided by NHS ONEL will enable practices to meet the 2012/13 operating plan requirement for all patients to have a Summary Care Record by March 2013. It will also allow practices to realise the local benefits and improved patient experiences delivered by the provided information systems.

Our approach to gathering the information requirements of CCGs is to work closely with clinical and commissioning stakeholders to understand their concerns and priorities. This is an ongoing process that has occurred through Informatics Steering Group meetings and GP engagement events, such as GP workshops, borough wide engagement events and Protective Learning Time (PTI) events. ONEL has also planned for a capital expenditure programme to improve GP connecting.

Realising CCG Information Requirements:

Through GP engagement we can share best practices and develop the future from the grassroots up. Looking ahead, NHS ONEL will seek to derive a priorities roadmap for requirements and solutions to support the needs of CCGs.

7.4 Workforce

The changes proposed as part of the implementation of Health for north east London will form the basis of workforce changes and development over the coming period and these will proceed at pace following the Secretary of State’s decision to approve the IRP recommendations. NHS ONEL will support the development of a system-wide perspective for future workforce requirements engaging with GPs to understand their views on workforce development, developing system-wide workforce plans for the changed service and implementing workforce assurance processes as part of performance management.

A national system of workforce assurance is being developed which will provide a tool for assuring that the composition of the workforce can deliver cost effective, safe and high quality care. The tool will be integrated into the performance management systems of the cluster for 2012/13. This will enable a standardised approach linking workforce to quality and safety and enable the cluster to consider potential risks in a structured, logical and data driven manner. Through this we will be able to triangulate organisational performance (workforce, activity and finance) via selected metrics.

Commissioning Transition

A programme of work will be undertaken to support the workforce aspects of the transition to clinical commissioning including mapping staff to successor organisations, a programme of communications and engagement and management of personal futures. Workforce models for commissioning support will be developed in collaboration with other Clusters in north and east London, the transfer of the Public Health function will be facilitated and resources aligned to support the development of CCGs.

The wider transition programme will ensure that activities associated with workforce planning, education commissioning and workforce assurance are transferred to the
appropriate receiving organisation and that organisational knowledge and memory are preserved in the run up to PCT dissolution in March 2013.

7.5 Estate

Having the right estate in place from which to deliver services now and in the future is an essential enabler of the CSP. In outer north east London there are a variety of estates issues to address, from statutory compliance and backlog maintenance to space utilisation and environmental efficiency. These have been managed through individual Estates Strategies and will continue to be managed through the emerging NHS ONEL Primary Care Strategy. There are a number of opportunities to make better use of the existing estate and plans to benefit from these opportunities will be aligned with the commissioning strategy.

Estates Transition

Recent guidance from DH has spelt out the future for some PCT estate across the country. Further guidance is awaited. In NHS ONEL cluster 13 sites will be transferred to North East London Foundation Trust (NELFT), which we understand, is due to proceed in 2012. For the remaining fifty nine sites that are owned or leased by the PCT, at the time of writing it is only possible to provide an outline for an estates transition beyond the demise of the PCT in 2013.

For the sites that are not transferring to NELFT in 2012 a site and service analysis has revealed which premises are surplus to requirements. This is either through those sites that are currently vacant or through better space utilisation, which has freed up various sites. Currently the Cluster has identified approximately six sites that could be either partly or completely disposed of.

It is anticipated over the coming years that a large proportion of the receipts from these sites will help fund the Health for north east London (H4NEL) proposals (this could be in the region of £10m or more, subject to the final capital cost of H4NEL), although some of the receipts may be available to help fund the PCTs capital programme.

Whilst a variety of minor project work will take place at sites across the Cluster mainly to address statutory compliance, backlog maintenance, space utilisation and environmental efficiency, there are a handful of large projects, worthy of mention. These include the East Dagenham Health Centre. A business cases is being developed for this. These projects will be funded through a variety of means including receipts from site disposals, DH allocations and through third party financing arrangements.

To help guide the development of these and other projects and disposals the emerging Primary Care Strategy will set a vision and framework for estates planning and investment. This vision is fleshed out through various objectives and development principles. Implementation of the Primary Care Strategy will rest with various key stakeholders such as Clinical Commissioning Groups, local healthcare practitioners (including doctors, pharmacists and opticians), local authorities.
8 Delivery impact

This section sets out the main impact the CSP will have on patients, commissioner finances and providers. There are other important events and changes that inform the context in which the CSP has been produced. These are set out in brief below:

Acute reconfiguration

A and E and maternity services in north east London will be reconfigured, following the outcome of the Independent Reconfiguration Panel review of the Health for north east London programme. Services will be consolidated from 6 sites across inner and outer north east London to five, enabling better use of the workforce and resulting in better clinical outcomes. The outcome of the review is available at www.irp.org.uk. The supporting evidence for decision-making on the reconfiguration including the impact on activity and finances is available at www.healthfornel.nhs.uk. The main impact will be for BHRUT, with A and E and maternity services moving from King George Hospital.

Olympics

Health services have plans in place to manage business continuity during the Olympic and Paralympic Games working with partners to ensure services will be delivered during this period. At borough level multi-agency partnerships are in place to gain maximum benefit for local residents from the health legacy of the Olympics.

Merger

The proposed merger of Barts and the London, Whipps Cross and Newham Hospitals will potentially change the provider landscape. Commissioners have worked closely with the merger team on the development of the Full Business Case. Commissioners are fully engaged in the assurance process that will be followed for decision-making.

Other commissioning/provider changes

- Complex vascular surgery – potential impact on BHRUT of East of England commissioning strategy for vascular services, could potentially reduce activity there.

- London modernising pathology programme. This has been on the agenda at the provider clinical forums; the current status of the programme is described in the November position statement.

8.1 Patient impact/outcomes

The detailed implementation plans in appendix 3 set out the impact on patients and/or the local population. The overall impact of the commissioning strategy will be to improve patients’ experience and outcomes. This will be achieved by improving the quality of services, ensuring better access to services and continuing to bring services out of hospital closer to people’s homes. The impact of the CSP will be measured across the range of outcome, performance and quality measures.
8.2 Financial impact

It is estimated that savings of £56m across ONEL will be required in financial year 2012/13, to deliver an £8m surplus (0.5% turnover).

Table 1 below details the 12/13 financial position by PCT.

<table>
<thead>
<tr>
<th></th>
<th>NHS BD</th>
<th>NHS H</th>
<th>NHS R</th>
<th>NHS WF</th>
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To be delivered by:

- 11/12 QIPP full year effect 1,587 3,060 1,849 1,262 7,758
- 11/12 unplanned savings 3,787 3,414 3,127 3,121 13,449
- 12/13 New schemes required 9,155 8,408 8,176 9,260 34,999

This analysis relies upon a number of assumptions which are further explored below.

8.2.1 Planning assumptions

Forecast Outturn

The latest current year forecast (2011/12) assumes that each PCT will report breakeven at year end, with the exception of NHSR who will generate a £4m surplus.

The forecast year-end position for 2011/12 has a significant impact on the 2012/13 budget planning process.

The forecast position is based on all known information as at month 6, should there be any change in assumptions between now and budget agreement in March these will be factored into the 2012/13 plan.
Non-recurrent support

The current year planned position relies upon an element of non-recurrent support, including using under-spends carried forward from previous years, and planned inter-sector support. The requirement for this support is similar within each PCT but the source is varied.

Whilst it is not unusual to rely upon an element of non-recurrent support every year, for planning purposes, it is prudent to assume no non-recurrent support in the 2012/13 budget.

Furthermore, given that this is the last year before the Primary Care Trusts are abolished and responsibility transfers to clinical commissioners the planning assumption is that all four organisations are in recurrent balance.

The planned position, therefore, assumes that there will not be a requirement for further inter-sector support in 2012/13.

Growth in funding

Each PCT will receive a year on year increase to its baseline funding. Baseline funding growth across London is assumed at 2.38%. However a reduced level will be given to those PCTs that are currently deemed to be funded above the target levels. In ONEL it is estimated that NHS Barking and Dagenham and NHS Waltham Forest will receive reduced growth payments.

As an aggregate, ONEL sector is currently funded below its “funding target”. The majority of London is currently funded significantly over its funding target as detailed in following table.

<table>
<thead>
<tr>
<th>PCT Summary</th>
<th>11/12 Recurrent Allocation</th>
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<th>1/12 DFT Assumed</th>
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<td>NCL</td>
<td>2,390,485</td>
<td>6.45</td>
<td>154,182</td>
</tr>
<tr>
<td>NWL</td>
<td>3,401,354</td>
<td>9.51</td>
<td>323,568</td>
</tr>
<tr>
<td>Barking and Dagenham PCT</td>
<td>318,975</td>
<td>0.60</td>
<td>1,902</td>
</tr>
<tr>
<td>Havering PCT</td>
<td>397,724</td>
<td>-1.60</td>
<td>-6,467</td>
</tr>
<tr>
<td>Redbridge PCT</td>
<td>391,027</td>
<td>-2.90</td>
<td>-11,678</td>
</tr>
<tr>
<td>Waltham Forest PCT</td>
<td>416,735</td>
<td>2.50</td>
<td>10,164</td>
</tr>
<tr>
<td>ONEL</td>
<td>1,524,461</td>
<td>-0.40</td>
<td>-6,079</td>
</tr>
<tr>
<td>SEL</td>
<td>2,924,401</td>
<td>3.59</td>
<td>104,915</td>
</tr>
<tr>
<td>SWL</td>
<td>2,207,213</td>
<td>6.42</td>
<td>141,674</td>
</tr>
<tr>
<td>London</td>
<td>13,971,181</td>
<td>6.20</td>
<td>866,607</td>
</tr>
</tbody>
</table>

There is, therefore, a possibility that funding arrangements will change to allow for a more equitable split across London; this will be known once the new formulae allocation is announced on 1 December. However, for the purposes of the CSP the assumption is no change to current allocations and, therefore, growth in funding will be in line with the rest of the country.

Reserves

This year the sector is likely to use all of its contingency reserve and its 2% top-slice. Both of these reserves will need to be reinstated in 2012/13 and this accounts for a significant cost
pressure in the next year. However, this is a non-recurrent cost pressure which is why the savings requirement reduces in future years.

The NHS Operating Plan requires PCTs to only use 2% of their funds for non recurrent spend, which has to be authorised by NHS London; this equates to £32m in ONEL.

It has been assumed that 1% of the top-slice will be used to fund non-recurrent expenditure in year subject to NHSL approval. The financial planning assumption is that the remaining balance will be held by NHSL as a sector contingency reserve.

This is in addition to the 0.5% contingency held by individual PCTs which accounts for a further £8m.

**Price Inflation**

Price inflation takes account of the latest assumptions regarding year on year price increases. This includes a 0.5% increase in Primary Care, pay increase of 1%, and before further savings are applied it has been assumed that prescribing will require a 5% uplift to counter both activity and price increases.

**Volume Inflation**

Volume increases take account of the latest assumptions regarding the effects of population and non demographic growth.

Population growth is applied to activity based contracting areas and is based upon the GLA / ONS projections. This varies for each PCT and is outlined below. The difference between growth in population between Barking and Dagenham and Waltham Forest is over 1% which equates to approximately £4m p.a. additional cost pressure to Barking and Dagenham.

<table>
<thead>
<tr>
<th>CODE</th>
<th>Organisation</th>
<th>Demographic growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>5C2</td>
<td>Barking and Dagenham</td>
<td>1.66%</td>
</tr>
<tr>
<td>5A4</td>
<td>Havering</td>
<td>0.90%</td>
</tr>
<tr>
<td>5NA</td>
<td>Redbridge</td>
<td>1.23%</td>
</tr>
<tr>
<td>5NC</td>
<td>Waltham Forest</td>
<td>0.43%</td>
</tr>
<tr>
<td>ONEL</td>
<td></td>
<td>1.06%</td>
</tr>
</tbody>
</table>

Historically, growth in activity has outstripped demographic projections due to improved access to services, advances in medical science, better recording/pricing of activity in secondary care etc.

A non-demographic growth assumption has, therefore, been made of 1.9% increase (0.9% additional growth in activity and 1% increase in prices above tariff). This is consistent with our previous medium term financial assumptions and historic growth.
The table below shows a comparison of the historic activity trend with the current growth rates in the CSP model.

<table>
<thead>
<tr>
<th></th>
<th>ONEL (sector wide) combined (all) activity data from SEM</th>
<th>Historical Growth</th>
<th>CSP Activity Growth %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006/07</td>
<td>2007/08</td>
<td>2008/09</td>
</tr>
<tr>
<td></td>
<td>432,128</td>
<td>452,746</td>
<td>478,808</td>
</tr>
<tr>
<td></td>
<td>68,900</td>
<td>95,646</td>
<td>99,792</td>
</tr>
<tr>
<td></td>
<td>105,377</td>
<td>106,847</td>
<td>104,857</td>
</tr>
<tr>
<td></td>
<td>854,503</td>
<td>827,421</td>
<td>886,885</td>
</tr>
<tr>
<td>Total</td>
<td>1,340,639</td>
<td>1,381,638</td>
<td>1,472,516</td>
</tr>
</tbody>
</table>

At summary level the data suggests that historic growth rates for A and E and outpatients are in line with our planning assumptions, but the projections for Day cases and Electives and Non Elective vary.

However there are a number of factors that need to be considered, in particular, the Day Case and Elective figures are skewed for non recurring 18 weeks activity and the Non Elective is impacted by the unprecedented growth in 11/12 emergency admissions.

- Day Case and Elective – for the 5 year period the sector annual growth is 4.89% but in the last 2 years this has only been 1.5% suggesting that a steady state has been reached and that the planning assumption will be adequate.

- Non Elective – for the 5 year period the sector annual growth is 2.88% however for the first four years this is only 1.6% - the significant rise in 2011/12 is currently under review and discussion.

**Investments**

A number of potential investments have been identified. Business cases for each of these are required and will need to be reviewed as part of the CSP process, and reported to the boards through budget setting.

The current planning assumption is that these investments will not exceed £6m across the sector. This figure may need to be adjusted downwards depending upon the success of identifying further QIPP savings to fund.

In addition the QIPP plan assumes a level of investment - £11.5m 2012/13, £9.8m 2013/14 and £5.6m 2014/15.

**Re-ablement**

PCTs have developed local plans in conjunction with the Local Authorities to target services and systems to facilitate improved hospital discharge care and to prevent avoidable hospital readmissions, in line with the focus on integrated care.

It is assumed in 12/13 that the level of re-ablement funding included within the baseline has doubled. Discussions are ongoing with local authorities regarding the sustainability of this funding source and whether any additional investment should be self financing.
Efficiencies

The PCTs can also benefit from some price related efficiencies. “Efficiencies gain acute” takes account of the 1.5% price decrease expected in 2012/13, which is nationally agreed. (The 1.5% efficiency is made up of 4% efficiency savings with 2.5% inflation)

“Efficiencies gain non acute” relates to a 1.5% price decrease which will need to be negotiated with providers again on the assumption that they can generate at least a 4% efficiency.

8.2.2 Savings requirement

An initial £56m financial gap has been reduced by through the application of the full year impact of 2011/12 saving initiatives which totals £21m.

The 2012/13 additional saving requirement, £35m is shown below as a percentage of total budget.

<table>
<thead>
<tr>
<th>PCT</th>
<th>Savings as of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS BD</td>
<td>2.68%</td>
</tr>
<tr>
<td>NHS H</td>
<td>2.04%</td>
</tr>
<tr>
<td>NHS R</td>
<td>1.90%</td>
</tr>
<tr>
<td>NHS WF</td>
<td>2.17%</td>
</tr>
<tr>
<td>ONEL</td>
<td>2.17%</td>
</tr>
</tbody>
</table>

Most of the assumptions used for planning purposes are national and therefore the financial challenge will be similar across the country. It should be noted provider trusts are required to find 4% efficiencies to “stand still” as part of the national tariff decrease in 2012.

The 2.17% is therefore manageable, but is dependent upon delivery of additional savings in final quarter of 2011/12. The financial strategy has been to bring on line as many schemes as is feasible in 11/12 to limit the financial risk in 12/13; many of the schemes rated as amber in the CSP are therefore likely to be green before the start of the new financial year.
The tables below provide an analysis of savings by QIPP category. The detail to support this analysis is given in appendix 3.

<table>
<thead>
<tr>
<th>QIPP category</th>
<th>Projected savings 11/12 QIPP FYE £m</th>
<th>Projected savings 11/12 Unplanned savings £m</th>
<th>Projected savings New schemes £m</th>
<th>Projected savings Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity</td>
<td>0.1</td>
<td>5.3</td>
<td>8.9</td>
<td>14.3</td>
</tr>
<tr>
<td>Integrated care</td>
<td>7.3</td>
<td>0.3</td>
<td>19.3</td>
<td>27.0</td>
</tr>
<tr>
<td>Decommissioning ineffective procedures</td>
<td>0.4</td>
<td>3.6</td>
<td>2.3</td>
<td>6.2</td>
</tr>
<tr>
<td>Running costs</td>
<td>0.0</td>
<td>3.5</td>
<td>0.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Clinical overheads</td>
<td>0.0</td>
<td>0.7</td>
<td>0.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Reducing drug spend</td>
<td>0.0</td>
<td>0.0</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Total savings</strong></td>
<td><strong>7.8</strong></td>
<td><strong>13.5</strong></td>
<td><strong>35.0</strong></td>
<td><strong>56.2</strong></td>
</tr>
</tbody>
</table>

The table below provides a breakdown of savings for 12/13 by CCG.

<table>
<thead>
<tr>
<th>QIPP category</th>
<th>Projected savings 12/13 Barking and Dagenham £m</th>
<th>Projected savings 12/13 Havering £m</th>
<th>Projected savings 12/13 Redbridge £m</th>
<th>Projected savings 12/13 Waltham Forest £m</th>
<th>Projected savings 12/13 Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity</td>
<td>3.8</td>
<td>3.6</td>
<td>3.3</td>
<td>3.6</td>
<td>14.3</td>
</tr>
<tr>
<td>Integrated care</td>
<td>7.0</td>
<td>7.6</td>
<td>5.8</td>
<td>6.6</td>
<td>27.0</td>
</tr>
<tr>
<td>Decommissioning ineffective procedures</td>
<td>2.2</td>
<td>1.3</td>
<td>1.5</td>
<td>1.3</td>
<td>6.2</td>
</tr>
<tr>
<td>Running costs</td>
<td>1.2</td>
<td>0.9</td>
<td>0.8</td>
<td>0.7</td>
<td>3.5</td>
</tr>
<tr>
<td>Clinical overheads</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Reducing drug spend</td>
<td>0.9</td>
<td>1.2</td>
<td>1.4</td>
<td>1.1</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Total savings</strong></td>
<td><strong>15.2</strong></td>
<td><strong>14.6</strong></td>
<td><strong>12.9</strong></td>
<td><strong>13.5</strong></td>
<td><strong>56.2</strong></td>
</tr>
</tbody>
</table>
The table below provides a breakdown of savings for 13/14 by CCG.

<table>
<thead>
<tr>
<th>QIPP category</th>
<th>Projected savings 13/14 Barking and Dagenham £m</th>
<th>Projected savings 13/14 Havering £m</th>
<th>Projected savings 13/14 Redbridge £m</th>
<th>Projected savings 13/14 Waltham Forest £m</th>
<th>Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity</td>
<td>0.8</td>
<td>0.6</td>
<td>0.3</td>
<td>0.4</td>
<td>2.1</td>
</tr>
<tr>
<td>Integrated care</td>
<td>2.9</td>
<td>3.2</td>
<td>3.1</td>
<td>3.1</td>
<td>12.3</td>
</tr>
<tr>
<td>Decommissioning ineffective procedures</td>
<td>0.1</td>
<td>0.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Running costs</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Clinical overheads</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Reducing drug spend</td>
<td>0.6</td>
<td>0.8</td>
<td>0.9</td>
<td>0.7</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total savings</strong></td>
<td><strong>4.4</strong></td>
<td><strong>5.3</strong></td>
<td><strong>4.3</strong></td>
<td><strong>4.2</strong></td>
<td><strong>18.2</strong></td>
</tr>
</tbody>
</table>

The table below provides a breakdown of savings for 14/15 by CCG.

<table>
<thead>
<tr>
<th>QIPP category</th>
<th>Projected savings 14/15 Barking and Dagenham £m</th>
<th>Projected savings 14/15 Havering £m</th>
<th>Projected savings 14/15 Redbridge £m</th>
<th>Projected savings 14/15 Waltham Forest £m</th>
<th>Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity</td>
<td>0.8</td>
<td>0.6</td>
<td>0.3</td>
<td>0.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Integrated care</td>
<td>2.2</td>
<td>2.5</td>
<td>2.4</td>
<td>2.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Decommissioning ineffective procedures</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Running costs</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Clinical overheads</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Reducing drug spend</td>
<td>0.6</td>
<td>0.8</td>
<td>0.9</td>
<td>0.7</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total savings</strong></td>
<td><strong>3.6</strong></td>
<td><strong>3.8</strong></td>
<td><strong>3.5</strong></td>
<td><strong>3.4</strong></td>
<td><strong>14.3</strong></td>
</tr>
</tbody>
</table>
In terms of new schemes, the main focus now will be on confirming and implementing detailed proposals in response to the significant opportunities identified through the joint clinical audits on emergency admissions (assumed saving of £13m).

### 8.2.3 Summary financial position

In the tables below the summary financial for each PCT is set out across the planning period.

The net QIPP figure is shown after investments; as previously discussed the QIPP requirement reduces in future years after the full impact of reinstating the 2% non recurrent reserve is accounted for in 12/13. This accounts for a £32m cost pressure next year.

<table>
<thead>
<tr>
<th>Barking and Dagenham</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income</td>
<td>340,935</td>
<td>343,692</td>
<td>351,479</td>
<td>362,516</td>
</tr>
<tr>
<td>Net QIPP</td>
<td>(351,624)</td>
<td>(354,686)</td>
<td>(355,518)</td>
<td>(364,113)</td>
</tr>
<tr>
<td>Surplus/(deficit)</td>
<td>9,579</td>
<td>9,139</td>
<td>4,393</td>
<td>3,606</td>
</tr>
<tr>
<td>Surplus/(deficit) % of RRL</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Havering</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income</td>
<td>417,303</td>
<td>421,552</td>
<td>437,217</td>
<td>452,570</td>
</tr>
<tr>
<td>Net QIPP</td>
<td>(425,964)</td>
<td>(432,870)</td>
<td>(441,135)</td>
<td>(453,436)</td>
</tr>
<tr>
<td>Surplus/(deficit)</td>
<td>6,536</td>
<td>8,475</td>
<td>5,295</td>
<td>3,756</td>
</tr>
<tr>
<td>Surplus/(deficit) % of RRL</td>
<td>0.0%</td>
<td>0.4%</td>
<td>1.1%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Redbridge</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income</td>
<td>418,366</td>
<td>426,384</td>
<td>433,819</td>
<td>445,543</td>
</tr>
<tr>
<td>Net QIPP</td>
<td>(423,594)</td>
<td>(433,244)</td>
<td>(436,252)</td>
<td>(446,254)</td>
</tr>
<tr>
<td>Surplus/(deficit)</td>
<td>7,494</td>
<td>8,182</td>
<td>4,341</td>
<td>3,538</td>
</tr>
<tr>
<td>Surplus/(deficit) % of RRL</td>
<td>1.0%</td>
<td>1.1%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Waltham Forest</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income</td>
<td>435,624</td>
<td>440,307</td>
<td>452,538</td>
<td>465,666</td>
</tr>
<tr>
<td>Net QIPP</td>
<td>(445,419)</td>
<td>(449,055)</td>
<td>(454,102)</td>
<td>(466,131)</td>
</tr>
<tr>
<td>Surplus/(deficit)</td>
<td>8,490</td>
<td>9,206</td>
<td>4,205</td>
<td>3,448</td>
</tr>
<tr>
<td>Surplus/(deficit) % of RRL</td>
<td>0.0%</td>
<td>0.6%</td>
<td>1.1%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ONEL Summary</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income</td>
<td>1,612,228</td>
<td>1,631,935</td>
<td>1,675,053</td>
<td>1,726,295</td>
</tr>
<tr>
<td>Net QIPP</td>
<td>(1,646,602)</td>
<td>(1,669,856)</td>
<td>(1,687,006)</td>
<td>(1,729,933)</td>
</tr>
<tr>
<td>Surplus/(deficit)</td>
<td>32,391</td>
<td>35,022</td>
<td>18,234</td>
<td>14,348</td>
</tr>
<tr>
<td>Surplus/(deficit) % of RRL</td>
<td>0.3%</td>
<td>0.5%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
8.3 Provider impact

Commissioners will work with local providers to find strategic sustainable solutions to support the direction of travel set out in the CSP.

The table below summarises the predicted value of Service Level Agreements with local providers for 2011/12 through to 2014/15:

<table>
<thead>
<tr>
<th>Provider</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>Increase / (Decrease)</th>
<th>Increase / (Decrease)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>BHRT</td>
<td>305,749</td>
<td>290,903</td>
<td>284,535</td>
<td>283,736</td>
<td>(22,013) (7%)</td>
<td>(7%)</td>
</tr>
<tr>
<td>WX</td>
<td>169,365</td>
<td>155,388</td>
<td>152,253</td>
<td>151,171</td>
<td>(18,194) (11%)</td>
<td>(11%)</td>
</tr>
</tbody>
</table>

The 2011/12 forecast outturn is predicated on over-performance of £8m for BHRUT and £4m for Whipps Cross.

The significant reduction in the expected value of Service Level agreements is driven by the QIPP program. The expected levels of activity by provider are shown in the two tables below:

<table>
<thead>
<tr>
<th>BHRT</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>Increase / (Decrease)</th>
<th>Increase / (Decrease)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Elective &amp; Day Case</td>
<td>41,085</td>
<td>41,561</td>
<td>42,407</td>
<td>43,271</td>
<td>2,186 (5%)</td>
<td>(5%)</td>
</tr>
<tr>
<td>Non Elective</td>
<td>70,281</td>
<td>61,277</td>
<td>56,585</td>
<td>53,343</td>
<td>(16,938) (24%)</td>
<td>(24%)</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>163,311</td>
<td>100,141</td>
<td>91,864</td>
<td>87,805</td>
<td>(75,506) (46%)</td>
<td>(46%)</td>
</tr>
<tr>
<td>OP 1sts</td>
<td>132,981</td>
<td>115,104</td>
<td>111,653</td>
<td>113,943</td>
<td>(19,038) (14%)</td>
<td>(14%)</td>
</tr>
<tr>
<td>OP Fups</td>
<td>276,039</td>
<td>238,312</td>
<td>231,558</td>
<td>236,288</td>
<td>(39,751) (14%)</td>
<td>(14%)</td>
</tr>
<tr>
<td>OP procedures</td>
<td>28,698</td>
<td>29,292</td>
<td>29,882</td>
<td>30,484</td>
<td>1,786 (6%)</td>
<td>(6%)</td>
</tr>
<tr>
<td>Critical Care</td>
<td>18,933</td>
<td>19,349</td>
<td>19,762</td>
<td>20,184</td>
<td>1,251 (7%)</td>
<td>(7%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WX</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>Increase / (Decrease)</th>
<th>Increase / (Decrease)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Elective &amp; Day Case</td>
<td>29,751</td>
<td>30,108</td>
<td>30,571</td>
<td>31,041</td>
<td>1,290 (4%)</td>
<td>(4%)</td>
</tr>
<tr>
<td>Non Elective</td>
<td>32,256</td>
<td>26,456</td>
<td>23,850</td>
<td>21,988</td>
<td>(10,268) (32%)</td>
<td>(32%)</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>85,211</td>
<td>78,343</td>
<td>73,619</td>
<td>71,279</td>
<td>(13,932) (16%)</td>
<td>(16%)</td>
</tr>
<tr>
<td>OP 1sts</td>
<td>78,066</td>
<td>69,231</td>
<td>70,288</td>
<td>71,362</td>
<td>(6,704) (9%)</td>
<td>(9%)</td>
</tr>
<tr>
<td>OP Fups</td>
<td>157,404</td>
<td>140,204</td>
<td>142,329</td>
<td>144,488</td>
<td>(12,916) (8%)</td>
<td>(8%)</td>
</tr>
<tr>
<td>OP procedures</td>
<td>20,373</td>
<td>20,715</td>
<td>21,051</td>
<td>21,392</td>
<td>1,019 (5%)</td>
<td>(5%)</td>
</tr>
<tr>
<td>Critical Care</td>
<td>5,775</td>
<td>5,863</td>
<td>5,951</td>
<td>6,039</td>
<td>264 (5%)</td>
<td>(5%)</td>
</tr>
</tbody>
</table>

The most significant financial risk is the achievement of the Non Elective activity reductions. The reductions are being driven by the outcomes of the joint clinical audits recently performed with both local providers. Providers and commissioners are currently working through the findings together to confirm the size of the opportunities.

The above tables show a big reduction in the volume of A and E activity that is expected to occur. This is not decommissioning, rather an expected shift of activity to Urgent Care Centres. The expectation is that this activity will be performed at 80% of the current PbR tariff price and therefore there is not a material financial exposure if this improved utilisation does not all occur in 2012/13.
As part of the SLA planning process the detailed numbers underpinning the tables above will be shared with all interested stakeholders including CCGs and our local providers. The strategy aims to achieve financial stability and sustainability for the whole health economy, recognising that the impact on acute providers in particular will be to reduce activity and therefore income.

The detailed impact of the CSP on providers is shown in the activity template.

**Impact on acute beds**

NHS ONEL has developed a methodology to predict the collective impact of the commissioning strategy on the acute hospital bed base. During December commissioners will work with providers to confirm the impact of both commissioner and provider productivity initiatives to establish a clear bed reduction programme in line with Health for north east London assumptions.
9 Sustainable commissioning

All constituent PCT are signatories to the NHS Sustainable Development Unit’s (SDU) Good Corporate Citizen Model. This provides an important context and road map to driving sustainability improvements at a PCT level. Importantly this starts with high-level sign up and finishes with an efficient and sustainable organisation. Sustainability is a broad term, and Trusts should be encouraged to consider the economic, social and environmental aspects of it.

A cluster-wide sustainability strategy is being prepared and will build upon progress made at a PCT level. Cluster-wide planning provides many advantages, not least the improved buying power and economies of scale it offers. As such it provides better returns on investment for many sustainability improvements, including smart metering, boiler upgrades or insulation upgrades. It also allows stronger negotiations with suppliers, such as waste contractors, office supplies or building contractors.

Recent project work associated with the Health for north east London considered the environmental or carbon footprint. The main environmental benefits were associated with a more efficient use of the acute setting allowing the downsizing/closure of other buildings. This economy of scale allows energy/utility savings. There was considered to be only a very minor negative impact on transport. So despite there being fewer centres of acute excellence, with the increased patient journey times this would create, a large part of the health pathway is still provided at a local level, either at GP practices or polyclinics, and thereby minimising the number of journeys to those centres of excellence.
10 Implementation

Processes and structures for ensuring delivery of plans are already embedded at local, provider health economy and cluster levels. This includes a cluster wide Programme Management Office which monitors implementation at each level and reports to the Board, Finance and Performance Committee and the QIPP Executive on progress. Officers within the Borough Teams also monitor CSP delivery from a borough perspective. The Finance and Performance Committee plays a key role in testing business cases and assuring delivery. Further in year “health checks” will be built into the process to ensure ongoing evaluation of the effectiveness of plans from the outset.

The Programme Management Office function is well embedded and provides regular monthly information on progress against QIPP schemes on cluster and CCG basis. It also provides various project support functions including a central library (including QIPP national workstream newsletters and other evidence of effectiveness in commissioning), templates and guidance for standardised approach to project and business case development. The PMO provides first level review and assurance of implementation plans and also supports performance management software and cascade training to project leads.

The opportunities set out above will each have supporting documentation, including strategy documents, project briefs, business cases (particularly in the case of areas requiring investments) and finance and activity information. For an opportunity to be implemented each CCG will need to expressly approve the plans and will require the appropriate supporting information to inform their decisions. Each opportunity will have a named clinical (CCG) sponsor.

Risks to implementation

Each of the opportunities identified in the CSP will have a risk management plan in place as part of the implementation structure, managed via the PMO. The risks to the financial plan are set out below.

The risks inherent in the current position that shows a financial gap of £35m are:

- The projected year-end position for 2011/12: changes to the 2011/12 outturn will have an impact on the required savings.
- 2012/13 Funding: PCTs will receive funding allocations as part of the Operating Framework at the beginning of December. The actual funding uplift may differ from the assumption used to date.
- Budgeting for a 0.5% surplus: this is an improvement on the current year (0.25%) but less than the 1% national target and will be subject to NHSL approval.
- Investments/ unavoidable cost pressures: £6m has been earmarked for new recurrent spend (as identified in the opportunities above), this may not be affordable dependent upon saving programmes that we identify; also further unavoidable cost pressures may become apparent during budget consultation process.

In addition to the risks against each opportunity, a strategic overview of key risks to delivery of the priority areas within the CSP and mitigations required are summarised in the table below.
<table>
<thead>
<tr>
<th>Priority area</th>
<th>Key strategic risk to delivery</th>
<th>Likelihood/Severity</th>
<th>Mitigation required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe sustainable high quality services</strong></td>
<td>Providers unable to secure quality improvements as rapidly as required</td>
<td>Likelihood: Medium Severity: High</td>
<td>Robust improvement programmes in place H4NEL programme in place to drive through the strategic transformation required to improve services</td>
</tr>
<tr>
<td><strong>Improving productivity</strong></td>
<td>Actions required to realise savings not supported by stakeholders</td>
<td>Likelihood: Medium Severity: High</td>
<td>Appropriate decision-making processes in place</td>
</tr>
<tr>
<td><strong>Integrated care</strong></td>
<td>Delay in delivering admissions avoidance targets</td>
<td>Likelihood: Low Severity: High</td>
<td>Programme management and leadership arrangements in place</td>
</tr>
<tr>
<td><strong>Urgent and emergency care</strong></td>
<td>Continued increase in emergency admissions and A and E attendances</td>
<td>Likelihood: High Severity: High</td>
<td>Full implementation of ICM and urgent care model Maximising opportunities identified through clinical audits, working jointly with acute providers</td>
</tr>
<tr>
<td><strong>Staying healthy</strong></td>
<td>Savings required in the short to medium term undermine investment required for longer term outcomes</td>
<td>Likelihood: High Severity: High</td>
<td>Strategic approach to public health commissioning to ensure efficiencies within existing contracts</td>
</tr>
</tbody>
</table>

The implementation programme team is being established under the very senior leadership of Heather Mullin underlining the level of priority the cluster places on taking the reconfiguration forward safely and effectively and as soon as appropriate to do so in the light of the Secretary of State’s decision. A key focus will be on refining assurance arrangements to enable safe implementation and on ensuring that the views of patients and the public are fundamentally embedded in all areas of implementation design and assurance.

A draft 2012/13 budget and associated Medium Term Financial Plan will be presented to the January boards. In advance of this, further engagement with CCGs and Health Wellbeing Boards will take place. QIPP saving schemes will be further explored to enable savings to occur as early as possible in the new financial year.

After January a number of outstanding funding and expenditure issues will remain. These should be resolved by March 2011, most notably Service Level Agreements with local providers for which there is a requirement to finalise by the end of February.

A final budget report will, therefore, be presented to the boards in March identifying any significant variations to assumptions made in this report and incorporating any changes agreed by the boards.
The CCGs and boards will also have opportunity to scrutinise the budget at an away-day planned the start of February and any agreed changes will be incorporated in the final budget.

Table below provides a summary of the main dates and meetings

<table>
<thead>
<tr>
<th>Month</th>
<th>Milestones</th>
<th>Forum</th>
</tr>
</thead>
<tbody>
<tr>
<td>November</td>
<td>CCC review of in year unplanned savings target</td>
<td>CCC Business meetings in first two weeks of November</td>
</tr>
<tr>
<td></td>
<td>CCC sign off CSP in principle</td>
<td>CCC Board meetings</td>
</tr>
<tr>
<td></td>
<td>Patient engagement event</td>
<td>Patient Groups</td>
</tr>
<tr>
<td></td>
<td>HWB sharing of CSP and high level financial assumptions</td>
<td>HWB Boards</td>
</tr>
<tr>
<td></td>
<td>Operating plan published</td>
<td>Finance and performance sub group</td>
</tr>
<tr>
<td></td>
<td>Review of CCG 11/12 Financial position</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CEO and Chair sign off</td>
<td></td>
</tr>
<tr>
<td>November/December</td>
<td>December CCC review of new opportunities, investment proposals and</td>
<td>CCC Board meetings</td>
</tr>
<tr>
<td></td>
<td>de-commissioning decisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ONEL CC review latest planning progress</td>
<td>ONEL CC meeting</td>
</tr>
<tr>
<td>December</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>External stakeholders planning event</td>
<td>TBD</td>
</tr>
<tr>
<td>January/February</td>
<td>CCC’s review draft budget</td>
<td>CCC Board meeting</td>
</tr>
<tr>
<td></td>
<td>ONEL CC review latest planning process</td>
<td>ONEL CC meeting</td>
</tr>
<tr>
<td></td>
<td>Board review draft budget/CCC leads present local CSP to ONEL Board</td>
<td>ONEL Board</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>NEDs/CCC Internal Finance stakeholder event</td>
<td>Board Strategy Session</td>
</tr>
<tr>
<td></td>
<td>Signoff of NHS Contracts</td>
<td>Contract process</td>
</tr>
<tr>
<td>March</td>
<td>Board/Sign off Final Budget/Medium Term Plan</td>
<td>Trust Board</td>
</tr>
<tr>
<td></td>
<td>HWB Final Budget for noting</td>
<td>HWB Boards</td>
</tr>
</tbody>
</table>
11 Appendices

Appendix 1 Integrated Care

Appendix 2 Primary Care Strategy

Appendix 3: Implementation: Opportunities summaries – including equalities analysis
References

i Armed Forces and military health position paper from NHSL

ii London Specialist Commissioning Group strategic commissioning intentions (NHSL)


v London Health Inequalities Strategy, Mayor of London 2010

vi Health for north east London, Maternity Workforce Strategy

vii Health for north east London Urgent care workforce scoping report


ix Cardiovascular and stroke commissioning recommendations

x ONEL Cluster 2012 Olympic and Paralympic Plan

xi North East London Modernising Pathology Programme November Position Statement

Cathy Geddes, SRO and Chair, NE London Modernising Pathology Programme, 17 November 2011

xii QIPP Performance Dashboards


xiv Comparative analysis of the resident population of the six Olympic host boroughs, 2011. Mayhew-Harper Associates,

xv The English indices of Deprivation, 2010.


You need to reference the JSNA and Health & Wellbeing strategy