Tower Hamlets Primary Care Trust

Trust Board meeting

There will be a meeting of the Tower Hamlets Primary Care Trust Board on January 18 2007 at 4pm

Aneurin Bevan House
81 – 91 Commercial Road
London E1 1RD

AGENDA

		Enclosure
1.	Welcome and introductions	
2.	Apologies	
3.	Declaration of interests	
4.	Minutes of the Board meeting held November 9 2006	A
5.	Matters arising from the minutes	
6.	Chief Executive's overview	

Items for Consideration/Decision

7.	Tower Hamlets Multi Agency Refugee Strategy To endorse the revised MAR Strategy and to note the actions required of the PCT	B
8.	Maternity Services Review To consider the Terms of Reference and progress of the review of Maternity Services in Tower Hamlets	C
9.	Tower Hamlets Primary Care Trust Commissioning Plans 2007/08 9.1 Commissioning Intentions 9.2 Draft Operating Plan 9.3 Delivering the 18 week patient pathway (to follow)	D
10.	NHS London Primary Care Trust Commissioning Regime To consider THPCT's response to the consultation on the draft Commissioning Regime	E
11.	Finance and Performance Report - Month 8 To consider this report introduced by the Director of Finance and Performance Management	F

Tower Hamlets Primary Care Trust
Mark Docherty
Executive Officer
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Telephone 020 8223 8964

12. Board Assurance Framework 2006/07 G
To consider the 2006/07 Framework

13. Connecting for Health update H
13.1 Child Health Interim Application replacement Business Case (to follow)
To receive this report from the Associate Director, Information Communications and Technology

Items for information

14. Long Term Conditions Annual Report I
To note

15. Tower Hamlets Multi Agency Pandemic Influenza Plan J
To consider and note the latest version of the Plan (to follow for Board members only)

16. Reports from the Committees of the Board K
Clinical Governance Annual Report

17. Chief Executive's Report L

18. Any other business

19. Date of next formal Board meeting March 8 2007

TRUST BOARD MEETING

Confirmed minutes of the Tower Hamlets Primary Care Trust Board held on
November 9 2006
The Aberfeldy Community Centre
Aberfeldy Street
London E14 0NU

Present:
Board members

Mr T Ahmed	Non Executive Director
Ms C Alexander	Director of Nursing and Therapies
Cllr Abdul Asad	Local Authority representative
Ms M Ford Hutchinson	Non Executive Director
Dr S Howell	Professional Executive Committee Co Chair
Ms D Jones	Non Executive Director
Ms N Khatun	Non Executive Director
Mr G King	Non Executive Director
Ms L Marks	Professional Executive Committee Co Chair
Mr S O'Brien	Chair
Dr D Russell	Medical Director
Mr S Saw	Director of Finance and Performance Management
Ms J St John	Non Executive Director
Ms E Trenchard Mabere	Acting Director of Public Health and Health Improvement
Mr A Uddin	Non Executive Director
Ms A Williams	Chief Executive

Apologies There were none.

In attendance
Mr M Benkharmaz Staffside Representative
Mr J Burden Director of Strategic Commissioning
Mr M Cusack Deputy Chief Executive
Mr A Ridley Director of Primary & Community Care Commissioning

Ms A Thompson Associate Director Integrated Governance

Mr M Docherty Trust Executive Officer (minutes)

Apologies Mr Butcher, Ms Howe, Ms Yates.

Welcome and introductions
Mr O'Brien welcomed members and members of the public to the November 2006 meeting of the Board.

Declaration of interests

Mr O'Brien reminded members that they should declare any financial and non financial interest they had in the items of business for consideration, identifying the relevant agenda item and nature of interest.

No interests were declared.

THPCTB/052/06 **Minutes of the Board meeting held September 14 2006**

These were agreed as a true and accurate record of the meeting.

THPCTB/053/06 **Matters arising from the minutes**

East London and the City Mental Health Trust – NHS Foundation Trust status application (THPCTB/047/06 refers)
Ms Williams informed the Board that the response discussed at the previous Board meeting had been submitted to the Chief Executive of the Mental Health Trust. Similar responses had been received from other partner organisations, and the decision had been taken to defer the application.

THPCTB/054/06 **Chief Executive's overview**

Ms Williams drew the Boards' attention to the Chief Executive Report included in the papers and made particular reference to the following items:

Fitness for Purpose – the draft letter following the Board to Board meeting had been received and commented on, and the final letter would be circulated once it had been issued. We were one of five PCTs in London to be given a green rating over all the assessment domains, and the PCT would be in Wave 2 of the Development Programme which was due to start in January 2007.

A number of PCT hosted events had taken place recently, bringing together both PCT staff and staff from other organisations/disciplines, including a Nursing Conference, an End of Life Care Event and an Urgent Care Network Board event.

A number of PCT staff had been invited to a meeting at Number 10 to discuss the progress of choice in Tower Hamlets with Tony Blair. It was a relaxed informal meeting where issues such as the length of time the process took, encouraging patients to proactively ask about choice and communicating choice to patients whose first language was not English were raised and hopefully these would be taken into consideration in the revisions that were being made to the choice agenda.

Items for consideration/decision

THPCTB/055/06 **North East London Pharmaceutical Committee**

Mr Ridley spoke to this item, advising the Board on developments since the Board had last considered this at its meeting in October 2005 when the decision to de recognise the North East London Pharmaceutical Committee had been taken, with the caveat that this would be suspended pending discussions between sector Directors of Primary Care and the Local Pharmaceutical Committee. The outstanding issues from October 2005 had now mostly been resolved. Mr Ridley recommended that the Primary Care Trust continue to recognise the Local Pharmaceutical Committee as the representative committee for local contractors.

The Chair invited Mr Hemant Patel (LPC Secretary) to comment on the report. Mr Patel welcomed the recommendation, and looked forward to progressing the development of good relations between the Primary Care Trust and the Local Pharmaceutical Committee.

The Board endorsed the recommendation in the report.

THPCTB/056/06 **Multi Agency Refugee Strategy**

This item was deferred to the January 2007 meeting.

THPCTB/057/06 **Healthcare Commission**

Annual Health Check 2005/06
Ms Thompson introduced this item, reviewing the outcome of the 2005/06 Health Check. The PCT had been rated fair in both use of resources and quality of services and an action plan had been developed to address those areas where the PCT had been rated as having underachieved or failed. The action plan would be monitored by the Risk Management Committee and any exceptions would be reported to the Board as appropriate.

Process and timetable 2006/07
The outline process for 2006/07 was noted, and a more detailed brief would be drafted when further guidance was issued.

The Board noted both reports and welcomed the action plan to be monitored by the Risk Management Committee.

THPCTB/058/06 **Annual Audit Letter 2005/06**

Ms Ford Hutchinson, as Chair of the Audit Committee, spoke to this item, presenting the Board with the Annual Audit Letter which had been reviewed by the Audit Committee. The Letter summarised the key issues arising from the work carried out by the Audit Commission in the course of the year and made a number of recommendations to the Board. An action plan addressing these would be considered by the Audit Committee at its meeting in January 2007.

Auditors Local Evaluation Report
The Audit Commission also undertook this report in 2005/06, which made scored judgements in the five key areas directly linked to the Code of Audit Practice:

- financial reporting
- financial management
- financial standing
- internal control

and

- value for money

The PCT had been rated as having achieved the required standard in four of the five areas, performing consistently above the standard for financial standing. However, for financial reporting the required standard had not been met, primarily due to the quality of working papers.

Mr Saw presented the Board with an action plan which addressed the improvement areas identified in the evaluation. This showed that all areas were being addressed

appropriately with the exception of the signing of Service Level Agreements. It was expected that this would be resolved in 2006/07. He also informed the Board that the action plan was being audited by Parkhill Audit and would be monitored by the Audit Committee with any exceptions being reported to the Board.

The Board received the Annual Audit Letter and the Auditors Local Evaluation report and agreed that the Audit Committee would be responsible for monitoring the associated action plans.

THPCTB/059/06 **Board Assurance Framework 2006/07**

Dr Russell spoke to this item, informing the Board that this was work in progress. A further iteration would be taken to the Risk Management Committee meeting in December for consideration. The Board requested that some thought was given to the presentation of information in the Framework, and that the process for updating the risk status and progress was strengthened with a view to receiving a more rounded report at its meeting in January 2007.

On an associated matter Dr Russell informed the Board that the February Informal Board meeting would include a Risk Management training session for Board members.

The Board received the Framework and noted that further work was required in its development.

THPCTB/060/06 **Single Equalities Scheme**

Ms St John as Chair of the Equality and Diversity Committee spoke to this item, reporting progress on the development of a Single Equalities Scheme as recommended by the Equality and Diversity Committee. The Scheme would give a framework for action across all equality strands, and in particular those that had positive duties associated with them (race, disability and gender). It was expected that the Scheme would be in place by the end of December, taking into account the outcome of consultations on specific aspects of the scheme. An associated action plan was also presented to the Board for consideration and it was noted that service specific plans should be in place by the end of March 2007.

In response to a question with regard to commissioned services the Board welcomed the inclusion of a compliance clause in all commissioning plans.

Ms St John informed the Board that as the Scheme was launched the Committee would be stood down. She would continue to attend the Planning Group sessions and make regular reports to the Board, demonstrating commitment not only to compliance but also moving toward mainstreaming equality and diversity through out the organisation.

The Board noted the progress made and thanked Ms St John and the Equality and Diversity Committee for delivering this piece of work.

THPCTB/061/06 **Finance and Performance Report – Month 6**

Mr Saw reported the Month 6 position, informing the Board that the PCT was currently meeting its statutory duty of financial balance and would be delivering a planned £700,000 surplus by year end, with no significant risks to note.

Mr Saw also drew the Board's attention to the non financial indicators of the report which detailed payroll and agency expenditure, workforce, staff turnover and sickness rates. It was noted that since April 2006 the PCT average sickness rate (2.4%) was consistently below the NHS average (4.5%).

Ms Thompson summarised the key performance indicators for the four elements of the quality rating in the Healthcare Commission Annual Health Check reporting good performance against "Getting the basics right" with high compliance score against core standards. There were some gaps in performance against existing targets and actions plans were being developed to address these. Progress against new targets was reported as mixed given that indicator constructions had yet to be updated for these targets and availability of data.

The Board received and noted the finance and performance report, and welcomed the addition of the non financial information recognising that some of the data should be considered as part of the bigger picture.

THPCTB/062/06 **Outline Commissioning Intentions 2007/08**

Dr Howell and Ms Marks gave a presentation, summarising discussions at the Professional Executive Committee and the Executive Team on the development of the commissioning intentions for 2007/08. The plan would take account of local health needs, national and local targets and financial planning assumptions. The presentation identified early key priorities for commissioning acute, mental health, and primary and community services and would be further developed by the Professional Executive Committee. More detailed proposals would be brought to the December Informal Board meeting for agreement before being submitted to NHS London at the end of December 2006.

The Board noted the early outline of the Commissioning Intentions.

Items for information

THPCTB/063/06 **Reports / minutes from sub committees of the Board**

The Board received the September 2006 Equalities and Diversity Committee minutes and the August 2006 Professional Executive Committee minutes for information.

THPCTB/064/06 **Nursing Strategy Annual Report**

Ms Alexander drew the Board's attention to this report, which highlighted progress made since the launch of the Nursing Strategy in October 2005. A significant amount of progress had been made in developing the nursing infrastructure and supporting the development of nursing staff in the last year and these provided a real opportunity to support the development of nursing services across community and primary care in the future.

The Board welcomed the Annual Report and commended the progress made this year.

THPCTB/065/06 **Chief Executive's report**

This was received for information.

THPCTB/066/06 **Any other Business**

There was none.

THPCTB/067/06 **Date of next formal Board meeting**

This was agreed as January 11 2007 (Post meeting note, this was subsequently agreed as January 18 2007).

……
Stephen O'Brien
Chair
January 18 2007

Tower Hamlets
Multi Agency Refugee Strategy
2006-09

Content: **Page**

1. Introduction

Tower Hamlets has a long history of welcoming refugees and asylum seekers. Under the 1951 UN Refugees Convention, the UK and other signatories are obliged to consider properly and positively any application for asylum made by a person who is fleeing persecution by the state. The UK Government's dispersal policy, introduced in 1999, led to large numbers of asylum seekers and refugees settling in Tower Hamlets.

The Tower Hamlets Refugee Forum was established in 1998 and is chaired by the Corporate Director of Social Services. It was set up by the Council to allow Tower Hamlets' statutory, voluntary, and faith organisations to work in partnership to support refugees more effectively. The forum identified a series of key actions, which would be likely to make a real difference to the lives of asylum seekers and refugees in Tower Hamlets.

Much has been learned since the publication of the Tower Hamlets MARS Action Plan (2001-2003) - not least that the integration of refugees and asylum seekers is a two-way process which benefits host communities, Tower Hamlets as a whole and the new communities settling into life here. Tower Hamlets' progress in integrating asylum seekers and refugees is looked upon as an example of good practice and this is something to be proud of. It is important to recognise that this is largely thanks to the good work carried out by organisations and volunteers at a grass roots level, committed to making Tower Hamlets as welcoming as possible with a better standard of living for everyone.

At the time of publication of the first Multi Agency Refugee Strategy (MARS) and Action Plan, a commitment was given to report on progress in implementing the Action Plan. This has proven to be a slow process. The Forum therefore, has decided to review the MARS in light of the recent changes both locally and nationally.

The importance of partnership working should not be underestimated. Partnerships such as the Tower Hamlets Refugee Forum and its member organisations, voluntary groups and the different Community Plan Action Groups (CPAGS) have played a key role in integration of services for refugees in Tower Hamlets.

The priority objectives in the Strategy are fairly broad and non-specific - in effect more principles than tasks. These objectives in particular prove challenging to report on - such wide aims call for continuous improvement and are difficult to fully complete. More importantly, these broader tasks are less obviously the responsibility of one department or organisation and consequently difficult to delegate. Where actions are more specific it is fairly easy to determine if they have been achieved or not. The purpose of the MARS Action Plan will be to ensure that SMART targets that contribute to the strategic objectives are explicit.

Some of the issues in the original Action Plan may no longer be deemed to be the most pressing. New issues will have arisen since the last MARS Action Plan was written and must be identified in our revised priorities for integration in the future. It is worth pointing out that refugee integration in Tower Hamlets is far from complete, although significant progress has been achieved in some key public services such as Health and Social Care and Education.

2. Definition of refugee and asylum seeker

The right to asylum in a country of safety is binding upon all national states who are signatories to the United Nations Geneva Convention of 1951. National legislation stems from this obligation and related legislation should not undermine that purpose of the convention.

Article 1 in the Convention defines a refugee as:

"A person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution"

The Convention also ensures equality of entitlement within the new country. It also defines a refugee's obligations to host governments.

Within the terms of the Convention, a nation state has the right to seek verification of the need to be accepted as a refugee. Those undergoing this verification process are called "asylum seekers".

Many who seek asylum are not by the strictest definition "persecuted" personally but are nevertheless very vulnerable because of the violent and discriminatory situation from which they come. These will be given protection categorised variously as:

- Humanitarian protection
- Indefinite Leave to Remain
- Exceptional Leave to Remain

In a Borough like Tower Hamlets there will be individuals and families who have come here under other immigration routes. However, in all other respects their experience and needs will be the same as refugees. For example many will have come through Family Reunion or through secondary migration from other European Union states.

3. Asylum Seekers and Refugee Data

Tower Hamlets is not unique in having difficulty in quantifying the number of refugees and asylum seekers resident in the borough, the population is fluid and few public authorities record immigration status. Research data is contradictory as different methodologies produce widely conflicting "guesstimates".

According to the Home Office figures whereby 2,080 asylum applications were received from Bangladeshis (1991 – 1999) and only 10 applicants were granted refugee status and 45 were granted Indefinite Leave to Remain (ILR), given that around 24% of the total Bangladeshi population of Britain is in Tower Hamlets, the number of Bangladeshi asylum seekers in Tower Hamlets is likely to be in the region of between 480-1000. It is also estimated that a large number of asylum seekers from Turkey, Pakistan, India and China also live in the borough.

There is no reliable data on refugees. In the study available[1] it was estimated that there are about 1,000 refugees from the Vietnamese community in Tower Hamlets. In a different estimate[2] 1,200 was quoted. The number of Somali refugees is more complex. It is estimated that 4,500 refugees from the Somali community are currently living in the borough[3]. Most community workers think the number could be a lot higher than this. However, it is unknown how many of those have been granted Indefinite Leave to Remain (ILR) or Exceptional Leave to Remain (ELR).

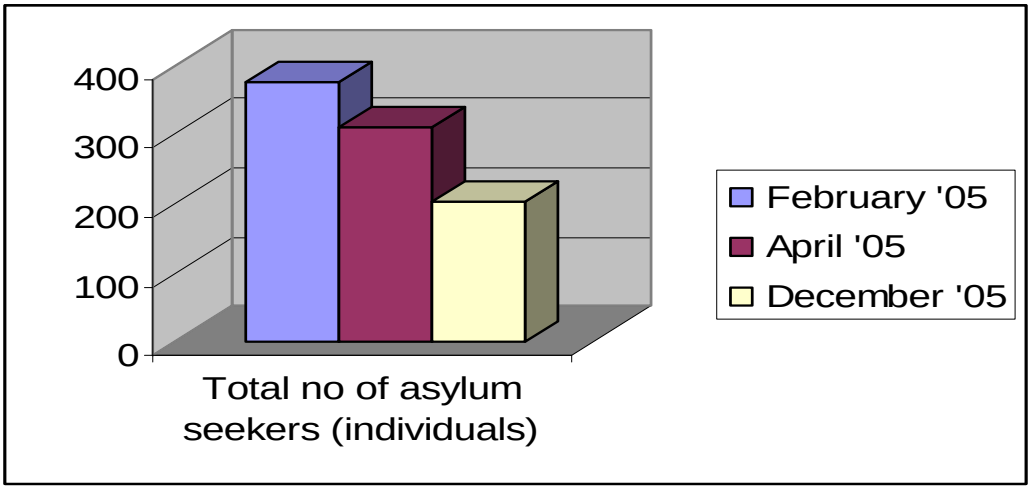
[1] Marianne Green, LSE September 2001
[2] The community of refugees from Vietnam (community group)
[3] Marianne Green, LSE September 2001

The figures we have show that in February 2005 Tower Hamlets had responsibility for 375 asylum seekers either as "interim cases" or unaccompanied minors. Forty seven of them were unaccompanied children, all between the ages of 16 and 17. This number declined over the year to a total of 201 (see the table below). However, it is not known how much of this reduction resulted from asylum seekers receiving refugee status, or ILR or ELR, and how much from people moving away from Tower Hamlets. In the same period, the number of asylum seeking individuals living in the borough receiving support from NASS also declined from 233 in February 2005 to 167 in December 2005[4]. The Asylum Social Work Team based in the Housing Directorate is currently supporting 9 families (made up of 16 children and 12 adults) and 14 single adults.

Tower Hamlets Asylum Seekers Data*

	Interim Supported Adults and Families					Unaccompanied Asylum Seeking Children			
	Total no of asylum seekers (individuals)	Single Adults	Total no. of families	No of adults in families	No of children in families	Young people 0-15	Young People 16-17	Young People 18+	Total No of Young People 0-18+
February '05	375	60	80	124	144	0	47	0	47
April '05	310	56	40	97	119	10	28	0	38
December '05	201	16	40	64	80	11	30	0	41

* Source: London Asylum Seekers Consortium (www.westminster.gov.uk)



[4] London Asylum Seekers Consortium: Asylum Support Trends, January 2006

Although these figures don't look high, it is important to not that they are a snapshot, and therefore do not indicate numbers coming in and out of the official Home Office definition of 'asylum seeker'. Neither do they include asylum seekers who are not on the Home Office records, i.e. those who are not officially registered by the Home Office as asylum seekers but who nevertheless came to this country with that intention, and those whose application has failed. While these latter may be illegally in Tower Hamlets, they may still be registered with a GP by virtue of having been asylum seekers previously. According to the most recent study available[5], in addition to the figures above it is estimated that about 30 asylum seekers live in Tower Hamlets who are supported by other boroughs. The figures above do not include Refugees, i.e. those whose application as an asylum seeker has been accepted who are then granted Refugee status, and figures are not available of people who entered Tower Hamlets with Limited Leave to Remain, e.g. on work permits, students, spouses on probation and so on.

There are 84 languages spoken in Tower Hamlets. These include 33 African languages. The majority of the BME population in Tower Hamlets are from Bangladesh, Somalia, China, Vietnam, Turkey and some Arabic speaking countries. Some of these are countries from which refugees and asylum seekers originate. The overall picture is of a community whose size is significant but equally is not overwhelming. It is a community whose needs are intense particularly in the early stages of settlement. They are also intrinsic to the historic and present day dynamic of the borough. They will also play a significant part in the future regeneration.

In addition to Asylum seekers and Refugees, there are now increasing numbers of new residents: from the 8 accession countries; undocumented workers; people having difficulties securing immigration papers for foreign born partners; trafficked people and so on. These present considerably more challenges but will have a real impact on community cohesion and service provision, especially given the developments projected for East London.

Refugee status is increasingly difficult to secure and people with genuine cases may fall foul of tight legal procedures in which case they make seek to find alternative routes to legality or become part of a clandestine population. There are increasing numbers of people who come to London with different or uncertain status while sharing many of the characteristics of the experience of refugees. Among these groups are victims of trafficking, failed asylum seekers unable to return to their countries, migrants who have fallen victim to exploitation, and people who have experienced unexpected difficulties in their new country. It is difficult to quantify these. However, concerns have been expressed by homelessness agencies and Praxis of an increasing take up of services by A10 citizens, undocumented workers with health problems and destitute asylum seekers.

Comment [D1]: from Vaughan Jones 24/4

According to the latest Home Office figures almost 1600 migrants arrive in Britain every day, and in 2004 alone an estimated 582,000 people came to Britain. The largest group of new residents (54,000) came from Bangladesh, India and Sri Lanka[6]. Figures from Tower Hamlets Primary Care Trust show that 1474 referrals were received in 2003, 2478 in 2004, 3528 in 2005, and 923 in the 1st quarter of 2006.

This strategy is intended to be inclusive in its approach and embraces all asylum seekers, people who have exceptional leave to remain in the UK, and those who have refugee status. Their presence provides challenges and opportunities to public and voluntary sector agencies, and this strategy has been developed to ensure the most effective outcomes are achieved by co-ordinating responses and establishing common aims and objectives.

Comment [D2]: Emdad – given the figures and comments above about people who aren't actually officially refugees, asylum seekers etc., does it then make sense to revert to the 'this is an inclusive strategy' point when it actually doesn't explicitly include the people you've just been talking about? Or has it been decided definitively that the strategy is only for people 'officially on the books'?

[5] Marianne Green, LSE September 2001
[6] ONS, 2006

4. Aim of the strategy:

The aim of the strategy is to ensure that asylum seekers/refugees in Tower Hamlets are received and supported in accordance with the principles of Human Rights for the good of the individual and the host community.

5. Principles:

The objectives of the strategy are based on the three fundamental principles:

i) To enable asylum seekers/refugees to gain access to the services to which they are entitled.

ii) To challenge disadvantage and discriminatory practices and empower refugees to overcome these barriers.

iii) To recognise and enhance the positive contribution that asylum seekers/refugees can make to the host community.

6. Refugee people's needs

The needs of refugees and asylum seekers are challenging and complex. "Refugee" is not a homogeneous category. Refugees are of diverse ethnicity, age, gender, marital status, sexuality, educational background, health, abilities and faith. Planning services for refugees takes place within a matrix which inter links with mainstream services. Refugees need equal access to mainstream services and for those services to be sensitive and responsive to the particularities of their needs.

Service area	Generic needs	Refugee specific needs
Housing:	• Access to information. • Emergency accommodation. • Transitional accommodation. • General needs accommodation. • Choice based lettings.	• information in community languages • accommodation that maintains existing support networks • additional welfare support needs
Education and Youth Service.	• To be healthy in body and mind. • To be free from harm and prejudice • To be able to enjoy school and achieve high standards. • To be able to make a positive contribution to society. • To be able to achieve economic well-being	• To have culture and experience recognised by the host community • To have access to community languages provision and interpreters when needed. • Parents to have access to support and advice about the UK education system. • Refugee children to be supported on entry to school and their progress tracked.
Social Care	• Appropriate care for vulnerable adults and children. • Support for parents, families and carers. • Promotion of independence and social inclusion. • Joined up services across health, social care, and other agencies.	• Access to information and services. • Appropriate care and support. • Culturally reflective resources • Integration with wider community services. • Appropriate counselling and other services to address issues of trauma and disrupted life experiences.
Health	• Access to primary, urgent and community health services, and Dentists for both preventative and curative care. • Access to local hospital services both elective	• Information in appropriate languages and advocacy support • Advocacy support is particularly important when refugees are accessing specialist services.

Comment [D3]: Sarah Gale

	and emergency care • Access to specialist services when necessary such as screening, sexual health and mental health services. • Access to outreach services in the community e.g. for immunisations • Research and teaching	• For illiterate patients information should be provided in formats/media other than written. • Providing culturally sensitive services based on understanding the needs of refugees
Training and employment	• Unemployment • Lack of training opportunities.	• Awareness of LBTH vacancies and training opportunities. • Information on different routes available to access employment or training with LBTH and other public sector employers.
Community Safety	• Harassment. • Accident. • Crime reduction.	• Bi-lingual information on crime reporting/reduction. • Contact with local police to inform/discuss issues affecting refugee groups/individuals. • Contact with local police to impart knowledge of U.K policing/law & support available.

7. Strategic Objectives and Action Plan

Based on the experience gained the Multi Agency Refugee Forum has identified some priority objectives for the future strategy. These objectives are based on the principles of equalities and inclusion, and partnership working, and are designed to fill any gaps that exist in the current service provision in the borough. These objectives are intended to benefit refugees at different stages of their lives in the borough. These stages are divided into three themes (1) New Arrivals, (2) Settlement and (3) Citizenship.

Theme 1	Overarching Objective	Champion
New Arrivals	To support new arrivals in Tower Hamlets to secure the help they need.	Vaughan Jones Praxis

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
1. To ensure that information and easy access to appropriate advice and where necessary services, is made available promptly.	Ensure is that information regarding accessing social care is readily available to children and families.	On going development	Ann Goldsmith Children's Services	
	Ensure is that information regarding accessing social care is readily available to users and carers.	On going development	John Goldup Adults Services	
	Ensuring that the Customer Contact Centre (CCC) / One Stop Shops offer an appropriate service including access to information via the internet.	On going development	Claire Symonds Chief Executive's	
	Undertake review of New Entrants Service – re-	June 2006	Tim Madelin Tower Hamlets	

Comment [D4]: This was changed based on suggestions made by Margot.

Comment [D5]: given by John Beverton, but responsible Officers are in CE's department

Comment [D6]: EH checked with Claire and amended as she advised

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	commission appropriate New Entrants service which takes into account the needs of refugees.		Primary Care Trust (THPCT)	
	Provide open access advice and outreach service.	Ongoing service	Vaughan Jones / Praxis NRS	
	Pilot provision of information to parents through Parent Information Point (PIP) sessions in schools, Children's Centres and community venues in partnership with Praxis.	July 2006 Review outcomes of pilot and expand if successful.	Sharon Sullivan Children's Services	
	Support Refugee Week (19th June to 25th June) through the provision of funding to Praxis and through the promotion of events on the Internet/Intranet.	Funding agreed and in budget plan. April 2006 Events planned and promoted. June 2006	Peter Nathan Equalities and Inclusion	
	Ensure Domestic Violence information is available to refugees.	Ongoing service	Phillipa Chipping Domestic Violence Team	
	Ensure that up to date information on drugs services reaches the refugee community.	Ongoing service	Gilly Cottew Drugs Action Team	

Comment [D9]: EMDAD – the 4 additions by Anjum Shabbir in this section are actions for other people – have they agreed that these actions should go in / are they already in their own Business Plans? ANJUM IS THEIR REP LIAISING WITH US- EH

Comment [D7]: From Anjum Shabbir 25/4

Comment [D8]: From Anjum Shabbir 25/4

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
2. To secure engagement in appropriate screening services for health related concerns.	Include refugee groups in patient and public involvement programme. Engage with refugee groups through specialist voluntary agencies. Communication Needs assessment required for refugees. At the point of assessment for social care, to ensure families are provided with health information in the locality where they are placed. Provide a Referral Service to appropriate health services. Ensure that refugee groups are facilitated to access substance misuse services through the provision of satellite services provided by New Residents' Support Scheme.	March 2007 March 2007 May 2006 Ongoing June 2006	Sarah Mudd BLT Tim Madelin Tower Hamlets Primary Care Trust (THPCT) Ann Goldsmith Social Services Vaughan Jones, PRAXIS Gilly Cottew Drugs Action Team.	
3. To ensure a place of safety and wellbeing.	Supply Crime prevention material (in different required languages) to identified refugee groups. Provide rigorous investigation	Review number of requests for material – October 2006 Monitor	Des McCarthy Metropolitan Police As above	

Comment [D10]: From Anjum Shabbir 26/4

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	into allegations of Hate crime against any refugee group/individual.	investigations (brought to attention of responsible person) – review October 2006		
	Make & maintain contact with identified refugee groups.	Review number of contacts – October 2006	Des McCarthy Metropolitan Police	
	Attendance & participation in refugee forums.	Ongoing – but review attendance October 2006	As above	
	Monitor the delivery of Hate Crime information material to refugee communities (in different languages required)	Ongoing-review quarterly	Anjum Shabbir – RHIAF	
	Provide option for training on race and hate crime for refugee organisations in Tower Hamlets that give advice.	Ongoing-review quartnerly	As above	
	Provide guidance for schools on meeting the needs of new arrivals.	Ensure that all EMA (Ethnic Minority Achievement) Co-ordinators are aware of procedures through briefings and training - March 2007	Jane Connolly Children's Services	

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	Ensure that the needs of refugees and related issues are reflected in the Equalities Action Plan and related strategic documentation to ensure a joined up approach to meeting need and raising awareness.	Regular attendance at refugee forum meetings - quarterly Actions to support refugee communities included in EAP - April 2006 onwards	Harmander Singh, Equalities and Inclusion	
	Deliver hollistic personal safety training course for refugee women. (Warrior Women)	Ongoing project	Phillipa Chipping Domestic Violence Team	

Comment [D11]: from Anjum Shabbir 26/4

Theme 2	Overarching Objective	Champion
Settlement	**To help refugees and asylum seekers with settlement by providing accessible appropriate information and access to services**	Vivienne Cencora THPCT

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
1. Where critical mass permits, to provide bi-lingual staff within mainstream services (voluntary and statutory sectors) to meet refugee needs.	Register bi-lingual staff who volunteer to act as interpreters and offer them appropriate training for this role. Explore how the Agenda for Change programme can help improve the use of staff's language skills in a structured way.	March 2007 March 2007	Sarah Mudd, Health: Barts and London Trust (BLT) Same as above	
2. To ensure the availability of interpretation and advocacy for smaller refugee groups.	Review the advocacy policy and set standards for the service. Invest in and develop the workforce for advocacy and interpreting services and develop more culturally diverse service models, integrating NHS and social care provision	March 2007 Outline bid for NRF to fund pilot project to test model for integrated interpreting and translation service submitted April 2006	Sarah Mudd BLT Margot Fonseca Social Services	

Comment [D12]: EMDAD – isn't there something in the business plans that we can pull into here about what we're doing? YES

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
3. To make mainstream services and their staff aware of the needs of refugees and their families, and adapt services accordingly.	Consult with clients & advocates/ partner agencies	July 2006	Colin Cormack Homeless and Housing Advice Service	
	Analyse and respond to consultation and develop action plan for Charter Mark Accreditation.	September 2006	As above	
	Develop and implement procurement strategy options to improve support to asylum seekers.	Strategy developed April 2006 Procurement process complete December 2006	Colin Cormack Homeless and Housing Advice Service	
	Develop staff awareness of refugee issues through training, website, and resources.	On going development Review Jan 07	Jane Connolly Children's Services	
	Run pilot project with Praxis to offer helpline and training to front-line staff in schools, building on the success of the New Residents' Service.	Evaluate pilot and extend to 20 further schools if this is successful (Sept. 2006)	Sarah Gale Children's Services	
	Distribute publications produced by Education teams on the culture and history of settlement of Somali families in Tower Hamlets to school staff.	Organise training sessions to be Delivered by Praxis in June & October 2006	Sarah Gale Children's Services	
	To respond to community	Open two new	Jamal Uddin	

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	requests for newly-arrived children to attend Community Language classes in order to continue learning their First Language	Somali language classes in addition to the three classes currently on offer out of school hours. Sept 2006	Children's Services	
	Ensure all newly-arrived pupils receive appropriate language support	Provide First Language Assessments for all newly-arrived pupils. Publicise service Sept 06	Jamal Uddin Children's Services	
	Include information on refugees for staff on intranet and include reference to needs of refugees in staff guidance on impact assessment	March 2007	Sarah Mudd Health: BLT	
	Ensure staff are able to access appropriate training opportunities in regard to different refugee groups and their cultures.	Ongoing development	Jan Hill Social Services	
	Training for managers around eligibility criteria and duties under the asylum bill.	Ongoing development	Jan Hill Social Services	
	Ensure staff are aware of the needs of diverse communities.	Ongoing	Tim Madelin, Health: THPCT	
	Increase staff understanding of refugees' physical and mental	Ongoing development	Ian Williamson, Health:	

Comment [D15]: John Beverton

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	health needs through training and information. Provide training to staff to increase their understanding of refugees' social care needs. Ensure that refugee groups are included in the User Involvement Strategy.	 Ongoing development March 2007	East London City Mental Health Trust Jan Hill Social Services Gilly Cottew Drugs Action Team	
4. To ensure that services collect management information with regard to service take up/referrals from refugees and regularly review and use it for service planning.	Improve recording of ethnicity at the point of referral to Social Care. Monitor and track key outcomes for newly-arrived children and young people.	Ongoing development Encourage schools to return data on refugee pupils and languages spoken and analyse the results. December 2006	Ann Goldsmith Social Services George Nyamundanda Children's Services	
5. To provide specific services that enhance the process of settlement.	Develop "People" Team in Accommodation Section to attend to issues regarding successful sustaining of temporary accommodation tenancy. Visit all new T/A tenants and employ key indicators to identify potentially vulnerable tenancies	September 2006 January 2007 and ongoing	Colin Cormack Homeless and Housing Advice Service As above	

Comment [D13]:

Comment [D16]: As above

Comment [D14]: from Ajum Shabbir 26/4

Comment [D17]: suggested by John Beverton following discussion at the ASMT

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	Ensure families without recourse to public funds provided with accommodation and/or financial support have ongoing support and review.	Ongoing development	Ann Goldsmith Social Services	
	Ensure effective arrangements for the transfer of support of asylum seekers with community care needs from Housing to Adult Services Directorates.	April 2006	Colin Cormack, Homeless and Housing Advice Service	
	Provide employment Advice and Guidance.	Ongoing	Vaughan Jones / Praxis	
6. To enable swift access to the labour market on the basis of equality of opportunity.	Set targets for under-represented groups in Action for Community Employment (ACE) Project.	March 2007	Mary Slater Health: BLT	
	Provide community groups with details of vacancies and opportunities available and offer advice on the Council's application procedure.	September 2006	Mark Keeble Human Resource, LBTH	
	Provide community groups and those working with Asylum Seekers and Refugees with contact details of the Council's schemes and those of other public sector employers.	September 2006	As above	

Comment [D18]: CBP 2.14

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	Ensure English language lessons are accessible and available to families through links to local providers.	Ongoing development	Ann Goldsmith Social Services	

Comment [D19]: This was queried as a social care action – should it be an education one, or is Ann happy with it, i.e. does it still reflect what is in the children's business plan?;

Theme 3	Overarching Objective	Champion
Citizenship	To encourage active involvement of refugees and asylum seekers in mainstream services and the wider community.	Margot Fonseca Social Services

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
1. To provide help/training support to understand British society and prepare for citizenship.	Provide support to families with English as a second language through the family centre and as part of the assessment process. Ensure interpreting services are available for all important information exchanges and meetings with families. Provide orientation courses.	April 2006 April 2006 Ongoing Service	Ann Goldsmith Social Services Ann Goldsmith Social Services Vaughan Jones Praxis	
2. To encourage engagement in civic and civil society.	Consult with clients & advocates/ partner agencies on the service levels offered to homeless households. • Give feedback to homeless households and their advocates and agencies. • Specifically consult on Choice Based Lettings. • Develop actions based on consultation. • Develop change agenda and timetable for implementation.	July 2006 September 2006 December 2006 March 2007 December 2006	Colin Cormack Homeless and Housing Advice Service	

Comment [D20]: EMDAD – as above – this should apply across the board. Has isabelle / Peter identified anything for the EAP taking corporate responsibility for language services? At least this should reflect into Adults social care as well – from EAP or business plan- *I have not seen anything -EH*

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	Include needs of refugees in patient and public engagement activities and in patient information strategy. Ensure that newly-arrived children and young people are given a voice. Ensure Health promotional materials are in a form accessible to refugee communities.	March 2007 DfES grant used to support children and young people's participation in the Children's Trust and analysis shared with each school - June 2006 Ongoing	Sarah Mudd Health: BLT Blossom Young Children's Services Tim Madelin THPCT	
3. To build the capacity of refugee community associations and voluntary groups as potential future service providers.	Ensure that needs of refugees are fully considered in development of joint health and social care commissioning strategies within framework of Improving Health and Wellbeing.	All strategies complete by March 2007	John Goldup Adult Services	
4. To encourage full participation in leisure activities, the practice of faith and cultural expression.	Promote the hospitals' multi-faith chaplaincy service and strengthen links between the service and community faith	March 2007	Sarah Mudd BLT	

Strategic objectives 2006-09	Key Activities 2006/07	Key milestone dates 2006/07	Responsible person and agency	Progress to date
	groups. Promote the usage of the Boroughs Sports and Art facilities and Libraries and Idea Stores to the refugee community.	 Develop and provide promotional literature of these facilities to key agencies by Sept 06	 Ray Gerlach Environment and Culture	
5. To foster good family and community relationships for the well-being of all.	Promote cultural understanding and good race relations in line with Race Equality Scheme.	2005-2008	Sarah Mudd BLT	

Tower Hamlets NHS
Primary Care Trust

Barts and The London NHS
NHS Trust

Review of Maternity Services Model of Care

Background

Barts and The London NHS Trust is the provider of choice for over 90% of women for maternity services who are registered with a GP in Tower Hamlets. For the 9% who go elsewhere, they are choosing other local hospitals in London.

Tower Hamlets PCT and Barts and the London have agreed that the current model of maternity care, needs to be reviewed in order to meet the standards set out in national standards set out in relation to maternity services and to meet the needs of local woman and their families. The review will cover services provided in hospital, community and other settings.

This review is also an opportunity to engage practice based commissioners and local community groups in the re-design of a critical local service. It is also timely given the current spotlight on national reconfiguration of maternity services.

Aims

The aim of this review is to consider the current model of care that Tower Hamlets PCT commissions from BLT in light of and to develop a service specification for implementation in the 2007/08 SLA. Midwifery services are key elements of the Operating Framework for 2007/086 and the review will need to highlight areas for future commissioning plans in line with the National Service Framework.

This review will identify the following key areas set out in national standards:

- Services that are woman-focussed and family centred
- Appropriate provision to meet local need
- Mapping and development of networks of care and provision for women who require specialist care.
- Identifying and agreeing clinical standards between providers and commissioners in relation to safety, quality and user satisfaction that will deliver improvement in health outcomes for women and babies.

The review will take into account:

- Identifying barriers to accessing maternity services
- Views of local women and families
- Benchmarking key outcomes (clinical, quality and patient satisfaction)
- Women's awareness of choice
- Service interface with Primary Care, Mental Health services and other specialist health and social care providers.

In addition the review will make recommendations as to the structure Tower Hamlets PCT and Barts and The London NHS Trust need to adopt in order to ensure full implementation of the recommendations and the discharge of local responsibility for Maternity Services Liaison with the local community.

The Review will be overseen by a Review Board. This will report to the Maternity Services Strategy Implementation Group to ensure a wider strategic fit and then into the respective organisations.

Membership of the Review Board is suggested as:

Nurjahan Khatun	(PCT NED) – Chair
Caroline Alexander	Dir of Nursing THPCT
Kay Riley	Dir of Nursing BLT
Jeremy Burden	Dir of Commissioning THPCT
Gail Beer	Dir of Ops BLT
Mel McColgan	General Manager BLT
Mai Buckley	Assistant Director Maternity Services BLT
Clare Wood	Associate Director – THPCT commissioning
Marion Thompson	THPCT Children's Centre Lead
Esther Trenchard Mabere	THPCT Public Health
Dr Shan	Practice based commissioning lead
Dr Judith Littlejohn	GP
Siân Howell	Professional Executive Lead
BLT consultant	Anita Sanghi
Denise McEneaney	Maternity Development Manager
BLT midwife	Nigel Bishop

Working alongside and feeding directly into the review will be the Maternity and Midwifery User Involvement Group chaired by the PCT with representation from a range of community groups including Jagonari Centre, Somali Womens Health and Social Action for Health .

Meetings
It is anticipated that the Review Board will meet on a monthly basis for 2-3 months. Administrative support for the Review Board will be provided by Barts and The London NHS Trust.

External Reviewer/Review Team
An external reviewer/review team will be identified by Tower Hamlets PCT and Barts and The London NHS Trust to undertake this project. It is anticipated that this review will be completed by March 2007. The costs relating to this will be shared across Tower Hamlets PCT and Barts and The London NHS Trust.

A project team made up of key managers and clinicians within Tower Hamlets PCT and Barts and The London NHS Trust will take forward the work commissioned by the Review Board.

Tower Hamlets Primary Care Trust
Commissioning Intentions 2007/08

1. Introduction

This document outlines THPCT's commissioning intentions for 2007-8. It sets out the background and context within which the PCT is operating, both local and national, and identifies the targets for health improvement and service delivery that need to be achieved by March 2008..

Following the introduction of Commissioning a Patient Led NHS, THPCT is required to operate within the 'commissioning regime' that is currently being established by NHS London.

In future years, the PCT will be expected to develop a range of plans as part of a planning cycle which will standardise the planning process across London. The planning cycle revolves around the development, review and implementation of

- The **Strategic Plan,** which **establishes** direction and sets priorities in light of the changing environment, will be submitted annually, have a major refresh every three years, and provide a five- to ten-year outlook

- The **Operating Plan,** which describes priorities, detailed targets for the year ahead, financial plans and action plans to deliver the Strategic Plan's goals. It will be produced annually

- The **Capability Development Plan, which** sets out the capabilities required to deliver the strategy, current capability gaps, and how these will be filled. It will be produced in parallel with the Strategic Plan: annually, with a major refresh every three years

For 2007/08, THPCT needs to develop an abbreviated Operating Plan. That document needs to incorporate the PCT's Local Delivery Plan (LDP) targets, actions as a result of Fitness for Purpose, and proposals for investment in health improvement initiatives within the context of the Choosing Health White Paper.

This summary document outlines the reasons for the commissioning decisions that will be detailed in the Operating Plan for 2007-8.

2. Commissioning Services for the residents of Tower Hamlets

We are responsible for commissioning health and health care services for the people of Tower Hamlets. To provide health services, reduce health inequalities and improve the care our users receive, we are allocated £360million pa of taxpayer's money to spend on behalf of our population. The PCT does this by commissioning services, either by itself, or in partnership with the London Borough of Tower Hamlets, the Tower Hamlets Partnership, local Practice Based Commissioners and other London PCTs. THPCT also acts as the lead commissioner for BLT for all London PCTs.

Because of the significant deprivation and relatively poor health in Tower Hamlets we are designated a spearhead PCT and required to meet more demanding targets for health improvement and reducing mortality. These include:

- Increased life expectancy, with a 10% reduction in the gap between Tower Hamlets and the England and Wales average by 2010
- Reduction in the number of deaths under the age of 75 from cardiovascular disease
- Reduction in the number of death sunder the age of 75 from cancer
- Increase in the number of people quitting smoking

Increasingly PCTs are required to commission services from a more diverse range of providers, including NHS Foundation Trusts and independent and third sector providers. This is part of a wider policy of increasing the capacity of the NHS so that we are able to deliver service improvements, such as the 18 week referral to treat target. They are required to work closely and effectively with primary care practices and other clinicians, patients and the public, and local government while supporting the development of practice-based commissioning (PBC).

2.1 The Population of Tower Hamlets

The make up and nature of the Tower Hamlets population is well documented, and detail can be found in the Annual Public Health report and local strategic documents.

Overall, the demographic profile of the population of TH paints a picture of a young, dynamic part of London, but one which is beset by inner city deprivation. Tower Hamlets is the second most deprived Borough in the country in terms of the average Index of Multiple Deprivation (IMD) rank (2004), and a number of its unique health indicators reflect the high levels of socio-economic deprivation. These include:

- Death rates that are higher than average for London and England.
- High mortality rates for cardio vascular disease and cancer, chronic obstructive airways disease and Diabetes
- High numbers of low birth weight babies
- High incidence of dental caries in children
- High prevalence of HIV and sexually transmitted diseases
- Suicide rates that are higher than average for London, and appear to be increasing
- High prevalence of depression, and very high emergency hospital admissions for schizophrenia

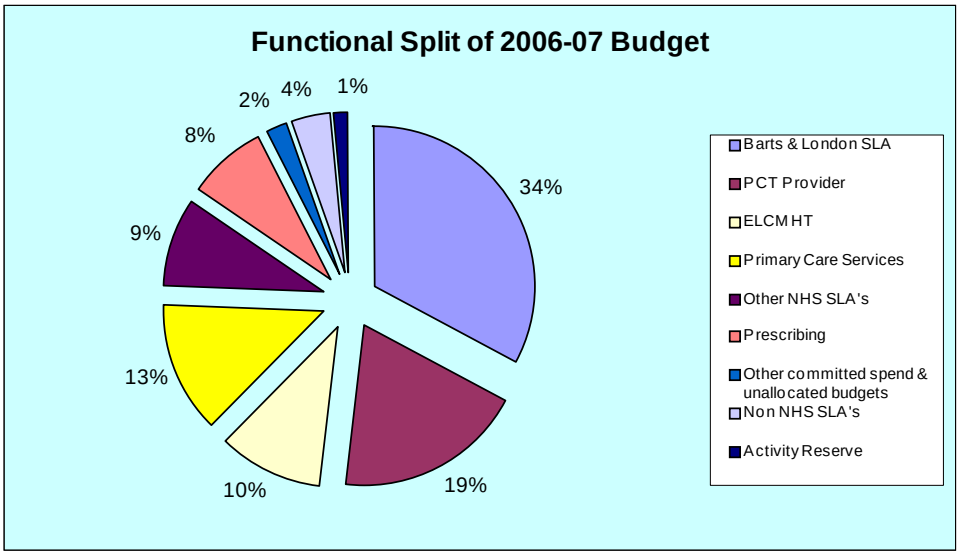
The population of Tower Hamlets is expected to grow significantly over the next 10 years. The table below sets out the projected growth over the next 3 years

	Tower Hamlets			London		
Year	GLA Dwelling Led Sc8.07	ONS 2004	GLA/ONS	GLA Dwelling Led Sc8.07	ONS 2004	GLA/ONS
2006	227.03	216.7	1.05	7560.51	7592	1.00
2007	236.03	219.7	1.07	7617.06	7653.3	1.00
2008	245.04	223	1.10	7672.33	7708.59	1.00

Note: The third and last columns of Table1 show the ratio of GLA to ONS projections. This makes it clear that while for London as a whole the total population projections are similar for Tower Hamlets GLA projects a 24% higher population than ONS.

3. Summary of Commissioning activities for 2006-7 – a look back.

In 2006-7, the PCT commissioned services designed to meet a range of both local and national targets. The table below gives an indicative split of the funds received by the PCT and where these have been invested. The single largest investment is with Barts and the London, however, it is worth noting that the PCT spends 40% of its budget on primary and community based services, when spend on primary care, PCT provider and prescribing are combined.



3.1 Promoting Health and Reducing Inequalities

In 2006/07 THPCT received the first of a recurrent allocation of 'Choosing Health' funding which has been awarded to 'Spearhead PCTs' in the most deprived parts of the country to promote health and reduce inequalities. As a result of the London wide financial position and the reduction in growth funding available to THPCT in 2006/07, a total of £845,000 has been invested in new Choosing Health programmes.

The top slice that was imposed on the PCT disproportionately affected this area of investment due to the decision to delay new investments rather than cut existing services.

This resulted in a two-thirds reduction in investment compared to our original plans. Funding was allocated where we had existing contractual commitments, mainly related to pick ups that had been agreed for NRF and HIF funded programmes.

Choosing Health funding has been used in 2006/07 to fund the School Health Advisers scheme, Schools Nutritionist post, the 'Options Team' (Women and Young People's Sexual Health service), the LBTH Healthy Lifestyles programme (which includes exercise on referral and 'MEND' a childhood obesity programme) and part of the LBTH Healthy Schools team.

Additional investment was also made into the smoking cessation service, in recognition of its importance as a local and national priority as the key intervention that will reduce health inequalities

We also invested in a project to improve the uptake and coverage of breast screening, because of the particularly low coverage of breast screening in Tower Hamlets.

3.2 Mental Health And Substance Misuse Services

Primary care mental health services received the full year effect of 2005/6 investment, as the enhanced depression service was rolled out, the support time and recovery service was established, and the community development workers and primary care consultant psychiatrist recruited.

In secondary services, 2005/6 has also been a year of consolidation, the NSF teams and community consultants bedding down, though ELCMHT has been adversely affected by funding top slices.

New investments in Substance Misuse included the Harbour Recovery Centre (an eight bed inpatient detox unit for non complex opiate users), the COMPASS needle exchange and a women's only drug service (due to launch early 2007).

3.3 Primary Care

In 2006/7 the PCT continued to commission a wider range of services from providers. We invested in rewarding general practices for achieving a high quality score (Quality and Outcomes Framework) commissioned 24 Enhanced Services from a range of practices, thus improving the range of services available locally, such as phlebotomy and enhanced care of people living with breathing problems.

In terms of capacity building, we commissioned a new practice site at Cable Street, and extensions at St Stephens in Bow, and the new Barkentine decant facility on the Isle of Dogs. The PCT invested additional funding in the successful Extended Opening Hours project in primary care, and expanded the salaried GP scheme to help practices grow and young doctors to get jobs in Tower Hamlets.

In dentistry, the PCT mainstreamed funding for the successful Community Dental Outreach Project, and expanded its capacity with an additional mobile unit. The PCT refurbished and expanded Wapping dental practice, and successfully secured 27 contractors onto the new national dental contract.

Community pharmacy continued to develop, with the Minor Ailments Scheme being rolled out across the Borough to over 20,000 registered users, and community pharmacists offering flu vaccine for the first time, in addition to GPs.

The PCT and local practices established the Practice Based Commissioning (PBC). Executive as the structure to drive forward the implementation of PBC. PBC is a key to the way that THCPT and local GPs and other clinicians commission services for the people of Tower Hamlets. The PBC executive, working with local practices have decided on their priority areas for work for 2007/08 and these are identified in the commissioning intentions table in section 6.2.

3.6 Acute services

We commissioned acute activity at 05/06 outturn including over-performance. Additionally, the PCT commissioned a new service designed to improve the patient experience of A&E at Barts and the London NHS Trust (BLT) with the establishment of the Clinical Decision Unit.

This saw in rise in total recurrent acute investment from £144 million to £154 million. The represents an increase of 7.2% including inflation.

The PCT also invested in new activity in line with recommendations from the NE London clinical networks. This included the Heart Attack centre, and additional resource made available for the impact of NICE guidance, especially on the availability of cancer drugs such as Herceptin.

We are currently on track to meet the waiting time targets for 2006/07; this is critical as part of planning next years activity profile in order to meet the 18 week referral to treat programme.

The PCT also consolidated its' position as the lead commissioner for Barts and the London NHS Trust across London.

4. National and Local Policy Context 2007/08

This section of the document details the policies, local issues and health improvement initiatives that form the context of the commissioning intentions outlined below.

4.1 National Policy

Commissioning a Patient Led NHS (CPLNHS) - published July 2005, this document set out the vision for next step in the reform programme for the NHS. It introduced a clear division between organizations that commission, or buy, services for the population, and services that deliver services for the population. It is intended to strengthen the focus on:

- Service responsiveness, providing what users want, rather than what services wish to provide
- Value for money (through competition to provide services)
- Choice for users by engaging them with the purchase, rather than provision of service, and therefore making their voices and wishes heard
- Clinical engagement with service redesign (Practice Based Commissioning)

4.2 Fitness for Purpose

The PCT was assessed as 'green' during the summer of 2006 as part of the DoH assessment of PCT's Fitness for Purpose to deliver the new commissioning framework. This was a useful

exercise as it identified areas in our current commissioning processes that require further development and resourcing. These include:

- Health intelligence and more systematic use of information
- Putting patients and the public experience of the NHS at the heart of service planning
- Better use of a suite of metrics designed to better manage and benchmark performance

4.3 Choosing Health - published in 2005, this document detailed the importance of supporting the population to make healthy living choices and the need for investment in prevention and health promotion. For Tower Hamlets there are some very clear actions that will impact significantly on the health of the population, while achieving national standards:

- Smoking cessation and tobacco control
- Reducing Obesity through healthy eating and increased physical activity
- Increasing the uptake of cancer-preventing screening, such as breast and cervical screening
- Improving sexual health, reducing sexual transmitted infections such as chlamydia and HIV and teenage pregnancy
- Reducing the incidence of alcohol and other substance misuse
- Improving the mental health and promoting the physical health of people with mental illness

The key priorities areas of 'Choosing Health' are to tackle obesity, to improve sexual health, to improve mental health, to encourage sensible drinking and reduce the number of people who smoke. Whilst 'Choosing Health' is relevant to all age groups, there is particular emphasis on helping children and younger people to lead healthy lives and promoting health and active life amongst older people.

4.4 Spearhead status

From April 2006, Tower Hamlets PCT has been designated a 'spearhead' PCT on the basis of the high levels of deprivation and associated health inequalities. Spearhead PCTs were awarded an additional recurrent allocation of funding to enhance the implementation of the Choosing Health agenda. The central aim of 'Choosing Health' is to reduce health inequalities by making it easier for people in deprived areas to make healthier choices.

The key principles underlying its approach are to enable people to make more informed choices about their health through better information and support (e.g. from health trainers).

4.5 Our Health, Our Care, Our Say –

published in the summer of 2006, this document strengthens the Governments drive to provide greater levels of service and care in the community, close to where people live, rather than in acute hospital settings. Combined with an increased interest in the care that people

with Long Term Conditions receive, and the push towards supporting patients in the informed self-management of their care, it encourages THPCT to commission more care in community settings and less from the local acute hospital.

This is driving change in the following areas:

- A need to redesign care pathways for the Long Term Conditions that most affect the local population (Diabetes, Respiratory Disease and Heart Disease)
- The variation in the quality of care that General Practice provides
- An intention to increase the range of services provided in a community setting.
- Pursuit of alternative models of service provision that offer greater value for money

4.6 Local Policy

Improving Health and Well-being in Tower Hamlets, published in 2006, sets the strategic direction for provision of primary and community services for the next 10 years.

In order to achieve it's aims, and improve the health and well-being of the local people, five strategic outcomes have been identified:

- Reduce inequalities in health and well being
- Improve the experience of people who use our services
- Develop excellent, integrated and more localised services
- Promoting independence, choice and control by service users
- Invest resources effectively.

4.7 Tower Hamlets Local Area Agreement

(LAA) – Agreed in April 2006, the LAA is a 3 year contract between Tower Hamlets Partnership and central government designed specifically to drive forward the implementation of the Health and Well Being Strategy. The LAA sets out locally agreed, high level outcomes that strike a balance between local and national priorities covering the following areas:

- Healthier Communities & Older People
- Children & Young People
- Safer, Stronger Communities
- Economic Development & Enterprise

The key high-level outcomes for health are:

- Increase life expectancy, and reduce the gap between Tower Hamlets and England
- Reduce deaths under age 75 from cardiovascular disease and cancer, and reduce the gap between Tower Hamlets and England

- Increase number of new or redeveloped primary care facilities
- Increase number of people quitting smoking
- Reduce adolescent obesity
- Reduce the percentage of 11-15 year olds who smoke regularly
- Reduce teenage conceptions

We are making good progress on life expectancy, cancer deaths and teenage pregnancy although sustained effort will be required to meet the inequalities targets.

4.8 User views of services that the PCT commissions

In common with other public sector organisations, the PCT regularly seeks the views of consumers on service and strategy plans and changes. The PCT supports a local Patient and Public Involvement Forum which enables members of the local community to comment directly on the services the PCT both commissions and provides.

The PCT also presents regularly to the Overview and Scrutiny Panel where PCT plans are scrutinised by local councillors.

Beyond this, however, our users report the following key concerns:

- There is variation in the quality and the range of services that different GP practices offer
- Easy access to primary care is equally variable.
- The quality of maternity services provided is a cause for concern
- Users want increasingly personalised services, which are provided locally.

There is more that the PCT can do to gather the views of users on the services commissioned. This will include working more closely with the structures that the LBTH has for consultation with the local community, such as inserting health related questions in the annual Residents Survey, and making better use of the Citizen's Panel for developing policy, and gaining feedback on patients' and carers experience of local health services. The PCT will also take an active role in the development of the new Local Involvement Networks (LINKs) signalled in the 'Our Health Our Care Our Say' document.

5. Financial Position of the PCT - Planning Assumptions

Table 1 below is a summary of the outline financial plan for 2007/08. It shows that the PCT will have approximately £12.4m net additional available resource. This is a 'best case' scenario and depends on NHS London not requiring additional 'top-slices' from PCT's with further capability. The values outlined below are a set of planning assumptions and are not intended to be definitive.

The planning assumptions outline the impact of the 3.6% top-slice on income assumptions and track through the impact of technical adjustments related to the Purchaser Parity Adjustment – PPA. The table shows that the PCT expected to receive £35.45 million as

growth funding in 2007/08 and the 2nd top slice from 06/07 would be returned both recurrently and non-recurrently – worth £2.4 million in cash and resource. Additionally the PCT would have the benefit of not having to make the 06/07 top-slice again, which effectively comes into play as a recurrent source of funding. Finally the PCT can expect to benefit from a 25% reduction in the Purchaser Parity Adjustment – PPA – in 07/08 reduced from 50% in 06/07. This has the impact of recurrently adding in a further £4.5m as a source of funding. Total sources of funding are therefore £54.7 million of which £2.4 million is non-recurrent.

Against these sums is firstly the 3.6% top slice notified by NHS London for 2007/08. This is worth £12.99 million. Net sources of funding are therefore £41.69 million and this is the figure issued to MP's in the letter from NHS London. It is therefore in the public domain. Technical adjustments related to the PPA will cost £6.2 million. These are made up of the following;

- Recurrent reduction in central budgets of £850k
- Cessation of the non-recurrent 06/07 PbR 'smoothing' adjustment. This is worth £3.5 million and will have to be funded recurrently from the PPA adjustment in 07/08
- The CDU cost of £1.1 million. Given that this is not new activity it is therefore within the PbR baseline but was not accurately valued in the original exercise. This will need to be funded recurrently in 07/08
- Loss of compensation payments for acting as the 'host' for central payments made to BLT in the PbR base year of 04/05. This is worth £756k and will need to be funded recurrently from the PPA adjustment.
- There are two immediate calls on available funding next year which are shown on the table as 'Pre-committed costs'. These are inflation and non-discretionary cost pressures.

Inflation has been calculated using the London NHS inflation guidance – 2.5% broadly on all closing recurrent baseline spend excluding Prescribing which has an 8% uplift in line with national guidance.

Non-discretionary cost pressures are costs which cannot be avoided and have to be picked up. Again these represent a planning assumption and are not definitive. They amount to £10.5m. The main components of this are;

- Recurrent impact of funding 06/07 services with 05/06 resource brokerage - £4.5 million
- Projected acute SLA over-performance - £1.6 million
- LPA and service costs for the Barkantine development part year - £1 million
- Specialist commissioning over-performance - £500k
- Projected risk share costs of the Forensic Mental Health SLA - £500k
- Prescribing overspend - £250k
- Payment of PBC DES achievement element - £238k
- Other smaller scale pick-ups constitute the balance of just over £2 million

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After taking account of inflation and pre-commitments, the PCT has a planning total of £12.5 million available for investment. There are some issues that will require funding as first calls on this sum because they are mandatory. Unlike the list of 'pre-commitments, the costs of these are still being worked up but the figures outlined are prudent. These are;

- The cost of moving all acute Providers to 18 weeks milestone net of demand management savings – £4m for THPCT in total but as a worst case with no demand management savings.

- Over-performance/risk reserves for 2007/08 – It would be prudent to assume £2 million given our experience of over-performance historically.

- The cost of IS Diagnostic activity - £1.7 million is the cost of IS Diagnostics outlined in the NEL Business Case. The exact amount required in 07/08 would depend on the start date for the contract but £1.7 million is a worst-case scenario. £1 million is more likely.

- It is likely that there will be a requirement to invest additional sums into Specialist Commissioning SLA's, particularly for the renal and HIV consortia. Based on an initial assessment a sum of £300k is prudent

- NICE drugs in excess of the Prescribing uplift. This would be for new high cost drugs – particularly cancer drugs – entering the market in the same way as Herceptin has last year and this year. Again this has to be at the early planning stage but a figure of £300-£400k is prudent.

Therefore it would be prudent to assume that around £8m of the £12.4 million would be required for these mandatory items. As a general planning guide approximately £5 million can be considered at this stage as discretionary and can be allocated for investment. Any further amounts are reliant on service redesign plans and the final cost of mandatory pressures being quantified.

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Summary Financial Outlook for 2007/08

Source of Funds	Recurrer £'000	Non Recurrent £'000	Total £'000
Growth allocation 07/08	35,447	0	35,447
06/07 growth given up for topslice	9,893	0	9,893
Return of 2nd 06/07 topslice	0	2,400	2,400
Return of 2nd 06/07 topslice	2,400		2,400
Impact of 25% PPA adjustment	4,543	0	4,543
Sub total	**52,283**	**2,400**	**54,683**
Application of Funds			
3.6% London topslice 07/08	0	12,993	12,993
Additional topslice	0	0	0
Recurrent central budget reduction	850	0	850
Loss of NEL sector PPA smoothing	4,600	0	4,600
Loss of Lead BLT payments IAT	756		756
Slippage of commitments to fund 2nd top-slice	2,400	0	2,400
Inflation/Generic cost pressures - Acute	5,092	0	5,092
Inflation/Generic cost pressures - Primary Care	1,105	0	1,105
Inflation/Generic cost pressures - Community	1,541	0	1,541
Inflation/Generic cost pressures - Prescribing	2,188	0	2,188
Sub total	**18,532**	**12,993**	**31,525**
Balance available for investment	**33,751**	**(10,593)**	**23,158**
Non - Discretionary Cost Pressures			
Full year effect of unavoidable cost pressures in 07/08	10,663	0	10,663
Sub total	**10,663**	**0**	**10,663**
Balance Available	**23,088**	**(10,593)**	**12,495**

6. Commissioning and investment plans for 2007-8

The PCT has to ensure that key national targets are delivered in 2007-8, as well as delivering on its local commitments in the LDP, the Spearhead Choosing Health agenda and the Health and Well-being strategy.

For ease, the totality of the commissioning function is divided into two:

- areas that the PCT will continue to invest in, as it did last year, to meet the core health care needs of our community;

- areas that require additional investment or management effort to change the current provision. These are identified below as the 'commissioning priorities'.

A range of General Commissioning Intentions, outlined below, will apply to all providers, whether on-going or in the 'priorities' section. These relate primarily to cross cutting health improvement priorities in support of the Improving Health and Wellbeing Strategy, and to achieving increased value for money.

General Commissioning Intentions

Area	Rationale	Required Outcome
Patient Experience	Health and Wellbeing Strategy	Patients reporting improved experience across all commissioned services Provision of regular data against agreed patient experience specifications in SLAs/contracts.
Smoking cessation	Health and Wellbeing Strategy	Accurate recording of smoking status when entering any NHS commissioned service Smoking cessation as part of pre-operative pathway (acute services) Opportunistic health promotion using routine interactions to promote healthier lifestyles. Provision of regular data against agreed specifications in SLAs/contracts.
Obesity and well being	Health and Well being Strategy	Opportunistic health promotion using routine interactions to promote healthier lifestyles. Provision of regular data against agreed specifications in SLAs/contracts.
Self Care	LPSA Target Health and Well being Strategy	Self care information and support built into all Long Term Conditions care pathways. Development of input to condition specific Expert Patient programmes.
Quality and safety	National Target	Provision of regular data against agreed quality and safety specifications in SLAs/contracts.
Diversity and Equalities agenda	Local Target	Provision of services that offer equitable access to all members of the community Evidence of action plans to develop a workforce which reflects the vision of the PCT in terms of its make up, and attitudes

		towards equality and diversity. Provision of regular data against agreed diversity and equalities specifications in contracts.
Needs assessment	Local target	Ethnic profiling in health equity audits Local Area Partnerships analysis
Value for money	National Target Health and Well-being strategy	Agreed activity and outcome data provided against specifications in SLA's contracts. Full Business Cases provided for increased investment in current services beyond agreed SLA/contract levels.
Protecting children	National Policy	Ensure all providers implement policies in relation to Every Child Matters
Performance Indicators	Improved performance management of providers	Range of performance indicators linked to health outcomes will be written into all service agreements

6.1 Services to be commissioned on an on-going basis

These are the services that the PCT will continue to invest in, just as we did last year to meet core health care needs:

- the majority of in- and out-patient services from Barts and the London,
- the continuing support and development of Primary Care, (including capital developments and quality agendas),a broad range of services for children and Older People
- a focus on quality improvement, and the redesign of Mental Health and Substance Misuse services,
- specialist tertiary services for TH residents
- programmes to support the delivery of LAA targets,
- improving Urgent Care services and increasing the range of Out of Hours support available for patients
- continuing implementation of elements of the Community Pharmacy and Oral Health Strategies
- support to the delivery of patient Choice and Choose and Book
- contracts with the independent sector already in place

Commissioning
'Priorities' for 2007-8

2007/08 is the second year of the 2006/09-action plan of our Health and Well Being Strategy. The PCT 's commissioning plans will reflect the objectives in the strategy, not just for next year but as part of building investment to meet our 10 year goals.

In addition, THPCT considers 2007/08 as an opportunity to build on those areas of investment where there has been real evidence of improving the health and well being of local communities. Our commissioning plans will therefore not just reflect the London priority areas but will include those areas of Choosing Health, with a real emphasis on prevention can add to improving the health of the people of Tower Hamlets.

1. NHS LONDON PRIORITIES				
Area	**Rationale**	**Required Outcome**	**Commissioning Intention and Actions**	**Lead**
18 Weeks maximum wait	National Target	18 week waiting time to be met within agreed activity levels with acute providers	Constraints policy agreed with BLT and other providers Investment	JB Commission from BLT and PCT provider arm
Urgent Care (including A&E 4 hour target)	National Target/Local Target/ Improved use of resources	Agree service model and specification for Clinical Decision Unit (CDU) Agree commissioned levels of activity. Increased choice of urgent care provision and appropriate use of those services. Minimise inappropriate use of A&E	Develop an Urgent Care Strategy Audit CDU admissions and propose action plan leading to clear, and agreed, specification Develop A&E to WiC streaming PBCe business case Develop full set of Metrics to monitor performance around urgent care by September 2007. Investment Business case for additional ECPs	AR Commission from LAS

Mental Health	National Target	Improved services in mental health with specific emphasis on community development workers and early intervention	Please refer to mental health section below	JB
Cancer Wait Target	National Target	Maintain 31 and 62 day maximum waiting time target for cancers.	Audit and performance manage 100% use of 2 week referral protocol in Primary Care Monitor provider performance	IB/JB
Healthcare Acquired Infections	National Target	50% reduction in rates of Healthcare Acquired Infections eg MRSA Reduced mortality	Regular collection and reporting of data on HCAIs from all providers Stronger monitoring of compliance with Infection Control standards.	CA
Choice in maternity	National Target	By 2009 women will have access, choice and continuity in maternity care	Maternity Review under way	JB
Reducing mixed sex wards	National Target	Reduction in mixed sex accommodation	Part of performance management regime with providers	JB
Choose and Book	National Target	Meet national targets	Continued investment into dedicated support	JB
CHOICE	National Target	Improve people's experience of NHS services and support their ability to make an informed choice of provider	Commission additional practice based advocacy support	JB/AR

Smoking cessation	National Targets	Achieve 2,025 '4 week quitters' (2007/08) Reduce smoking in pregnancy	Commission social marketing campaign for public and frontline staff including maximising impact of smoking ban Commission increased provision of 'level 1' and 'level 2' smoking cessation training for frontline workers across NHS, LBTH and voluntary sector and ensure that provision is spread equitably across the Borough Develop action plan to increase referrals to 'level 2' and 'level 3' smoking cessation support Commission specialist smoking cessation support for pregnant women and for mothers of young children Investment	IB Commissioning existing provider Commissioning from existing providers Commission enhanced service Commissioning from existing provider (specialist smokers clinic)
Tackling Obesity,	National Target	Halt the rise the obesity as per Local Area Agreement (LAA) targets. Reduce adolescent obesity	Commission a multi-agency action plan to maximise the impact of the Olympics and Paralympics on health and active lifestyles Promote healthy eating and physical activity in Children's Centres and in schools Implement NICE obesity guideline	IB Commissioning proposal (potentially to range of organisations) Commission existing providers (nutrition and dietetics department BLT) Tender (for training providers)

			Commission a wider range of healthylifestyle options for people at high risk of obesity related disease Commission a community dietician post with dedicated public health remit to take forward work on: • Breast feeding • Child nutrition • 5 A Day • Obesity care pathway • Community based food projects Investment	Commission from existing providers (Healthy Lifestyle Scheme – LBTH) Commission from existing provider (BLT)
Sexual Health Targets	National Target	Achieve sexual health targets (100% of patients seen within 48 hours of seeking an appointment.) Commission on an activity basis. Chlamydia Screening programme Reduce Teenage pregnancies in line with LAA targets	Develop an action plan to deliver the revised Sexual Health Strategy (including HIV prevention and targeted sexual health promotion) Develop project plan to introduce at least one level 3 clinics in primary care settings by end of 2007 (as part of implementation of Sexual Health Strategy) Develop project plan to ensure Chlamydia screening programme in place by September 2007. Mainstream pregnancy adviser and parent adviser to provide	JB/AR/IB Commissioning proposals (3rd sector, Women and Young Peoples Service, BLT – dual testing) Commissioning proposal to primary care Commission from existing providers (women and young people service (PCT), general practice, 3rd sector) Commission from existing providers (women and young

			support to pregnant teenagers and teenage parents Investment	people service/Options team (PCT), Bromley by Bow)
Financial Balance	National Target	PCT to deliver LDP targets and local targets.	Financial Plan in line with NHS Operating and Financial Framework	SS

2. PROMOTING HEALTH AND REDUCING HEALTH INEQUALITIES

Area	**Rationale**	**Required Outcome**	**Commissioning Intention and Actions**	**Lead**
Cardiovascular disease, diabetes and Chronic Obstructive Pulmonary Disease (COPD)	National targets Local public health priorities	Reduce cardiovascular disease mortality (in under 75s) in line with LAA targets Improved management of patients with Heart Failure Increase proportion of patients with diabetes offered and receiving retinal screening Reduce emergency bed days for respiratory and cardiac services (acute) in line with national target.	<u>Cardiovascular disease and Diabetes</u> Commission taskforce approach to improve performance and reduce inequalities in relation to identification and management of CVD and diabetes in primary care Commission post discharge support for patients following cardiac events (phase 2 coordination) Commission additional phase 3 and 4 cardiac rehabilitation Commission additional support to diabetic retinopathy screening Commission improved management of heart failure (by improved access to Echo services, roll out of enhanced service, education for patients	IB/AR/JB Detailed Business case required Commissioning proposal/Business case (PCT) Commission from existing provider (Healthy Lifestyle Scheme LBTH) Commission from existing provider (HIEL)

			and carers and initiation of specialist rehab programme) <u>COPD</u> Commission improved management of COPD through community based pulmonary rehabilitation and community based respiratory team	Business case required
Cancer screening (see also NHS London priorities)	National targets Health and Well being Strategy	Increase uptake of breast screening to above the local target (60%) in practices involved in the local enhanced service. Increase uptake of cervical screening to meet national target (80%)	Pilot enhanced service for breast cancer screening Performance manage general practices to achieve required screening levels and 100% use of 2 week referral protocol Upgrade digital mammography equipment at MEH Commission specialist advocacy/ DNA project to promote uptake of all screening programmes Investment	AR/IB Commissioning proposal for enhanced service Commissioning proposal for procurement Business case PCT
Tobacco control (see also NHS London priorities)	National targets Health and Well being Strategy	See NHS London Priorities	See NHS London Priorities	IB
Tackling Obesity, promoting healthy eating and physical exercise (see also NHS London priorities)	National targets Health and Well being Strategy	See NHS London Priorities	See NHS London Priorities	IB
Sexual health (see also NHS London priorities)	National targets Local public health priorities	See NHS London Priorities	See NHS London Priorities	JB/ IB

Action on TB	Meeting 7 London Standards	Ensure no increase in rates		IB
3. MENTAL HEALTH AND SUBSTANCE MISUSE PRIORITIES				
Area	**Rationale**	**Required Outcome**	**Commissioning Intention and action**	**Lead**
Quality	Poor quality of local services	Users and carers report improved experience of local mental health services Improved quality outcomes ie Care programme approach Patients report being offered a choice of treatment options Patients report that psychosocial issues are taken into account in their treatment Patients from BME communities report positive experience	Redesign as part of move to new premises at Mile End Investment Performance management of service agreements-	JB Commission from an external consultancy
Personality disorder	Local Target	No service currently available	Develop a Business case for service development Investment	JB Commission from ELCMHT
Talking therapies	Local Target National Target	Increased capacity in talking therapies in both secondary and voluntary sectors	Develop a Business case for service expansion Investment	JB Commission from ELCMHT/THPCT
Dual diagnosis	Local Target	Dual diagnosis strategy implemented	Action plan to complete and then deliver the dual diagnosis strategy Investment	JB Provider dependent on outcome of strategy

Primary/secondary care interface	Local Target User views	Improved communication pathways between primary and secondary care	Action plan to establish interface agreement and protocols Action plan to develop and implement simple referral pathways Redesign and investment	JB
Social inclusion	Local Target Stakeholder views	Decrease in number of local people on incapacity benefit who cite MH problems as the key reason	Develop a Business case for service development Develop Metrics for performance management Seeking joint funding for 2 year pilot.	JB
Out of Hours services	Local Target Demand Management	Increase the range of services available out of hours	Develop a Business case for pilot Develop Metrics for performance management Investment	JB
Workforce capability	Local Target	Increase the number of staff who have undergone 'cultural capability' training, and training around physical health in the inpatient setting. Increase awareness of MH issues in primary and community care staff	Develop a proposal for achieving these ends. Redesign of staff training programmes. Develop metrics for assessing change.	JB
Substance misuse	Local Target Demand management	Engage problem drug users in treatment programmes Reduce the number of those patients seen as 'frequent attenders' at A&E	Develop plans for achieving these ends. Develop metrics for assessing change Investment	JB
Alcohol misuse	National Public Health (Choosing Health) priority	Increase proportion of the population drinking within safe limits Reduce alcohol related harm Reduce the number of those patients seen as 'frequent at tenders' at A&E	Develop an action plan to Improve recording of alcohol consumption and provision of brief advice on sensible drinking for all commissioned services Develop partnerships to raise awareness of risks associated with excessive drinking and to	JB

			promote sensible Re-design	
Improving the physical health of people with mental illness	Local target	Review smoking policy at ELCMHT Staff training	Develop an action plan to address smoking and other healthy lifestyle issues at ELCMHT, including staff training.	JB/DS Commission existing providers (specialist smoking clinic, healthy lifestyles LBTH, community dietician)
4. PRIMARY AND COMMUNITY CARE PRIORITIES				
Area	**Rationale**	**Required Outcome**	**Commissioning Intention and action**	**Lead**
General Practice Access	Effective use of resources User feedback	Maintaining zero assignment levels Achievement of target with out WiC diversions 100% of practices enabling patients to book for non urgent appointments more than two weeks ahead. Expanded practice allowance	Support redesign of general practice systems with two change facilitators. Pilot expanded practice allowance. . Investment	AR
General Practice Quality	Local Target	Reduction in the variation of service quality and quantity between practices	Introduce systematic assessment, development and performance management of general practice, using a balanced scorecard approach. Performance manage key targets, e.g. cancer 2 week wait urgent referral protocol, cervical screening, use of registers etc.	AR
Pharmacy	Local Access Target Effective use of resources	Implementation of the community Pharmacy Strategy Improvement in Primary Care based prescribing Make Emergency Hormonal Contraception (EHC) available	Action plan to continue implementation of Pharmacy Strategy, including expansion of flu vaccine provision in pharmacies	AR

			Develop Business case for provision of Emergency Hormonal Contraception (EHC) Develop metrics to assess impact of these changes Investment	
Prescribing	Effective use of resources Local PH Target	Increase prescribing of statins across all practices in line with CHD work programme	Include Statin targets in prescribing incentive scheme Performance monitor implementation of agreed quality specification Save and reinvest	AR
Enhanced services programme	Effective use of resources Demand management	Increase range of service uptake of existing specifications to improve quality, choice, outcomes and reduce acute activity Review existing specifications	Review effectiveness of commissioned services by September 07. Develop plans for increasing range/uptake of services as a result of the review in preparation for 08/09 planning.	AR Review commissioned following tender
Service re-design to deliver improved services in: Mennorhagia Care; Wound Care; Intermediate Care; Dermatology; Minor Surgery;	Effective use of resources Health and Well-being strategy PBCE priorities	Improve standards of care given to patients. Reduce dependence upon acute hospital care services	Develop project plan for the redesign of each service: • Mennorhagia • Wound Care • Intermediate Care • ENT • Dermatology • Minor surgery • HB testing (including developing quality specification.)	AR
Optometry	Effective use of resources Links to national eye care pathways	Effective and timely referral for cataract surgery, reducing need for GP assessment and reducing ophthalmology outpatient attendance	Develop a project plan for the introduction of new admin referral systems with acute providers Develop action plan to design	AR

	Link to Low Vision Committee at LBTH		care pathways across primary (optometry) and secondary care, in preparation for 08/09 planning Investment	
Long Term Conditions	Improved support to people with LTC outside hospital	Reduction in emergency bed days Workforce development /community matrons	Develop action plan to review skill mix implementation in adult community nursing in line with the service model developed in collaboration with City University, LBTH and mental health. Develop action plan to review role of specialist nursing and pathway development. Develop interim solution for staffing skill mix in preparation for commissioning of 14 community matrons Commission additional Expert Patient Programme sessions Investment:	CA Tender
End of life services	Improved support to people dying outside hospital Local target	Baseline review	Gold Standards Framework Local Enhanced Service	AR
5. CHILDREN AND YOUNG PEOPLE'S SERVICE PRIORITIES				
Area	**Rationale**	**Required Outcome**	**Commissioning Proposal**	**Lead**
Vaccination and immunisation	National Target Local Target	100% GP coverage of childhood vaccination and immunisation targets	Performance management of general practice through quarterly contract monitoring visits Improve child health information systems to collect COVER data, through improvement in CHIA, or extraction of data via EMIS	AR

			Develop specification for hepatitis B vaccine pilots. Commission catch up campaigns to promote uptake	
Service re-design to deliver improved services in: **Asthma care;** **Epilepsy care;** **Continence care;**	Local Target	Improved services Reduce dependence upon acute hospital care services	Develop business cases for the redesign of service. Re-design and Investment £100k	JB
School health /Children's Centres services linked to Choosing Health targets and outcomes for Healthy Schools Programme and Children's Centres	Improve joint commissioning	Continued joint approach to school health, and links with extended schools, school clusters and children's centres	Develop clear re-design programme linked to specific priority areas Redesign	JB
Health visiting with development of a 'core health offer'	Effective use of resources	Clear and comprehensive service specifications for health visiting services	Develop action plan to review role of HVs, taking national work into account Develop service specification, including performance and outcome metrics. Redesign	JB
Child Protection: named doctor sessions	National Target	Enhancing child protection services	Investment	JB
Substance misuse	Increase access to services	Increase the number of young people accessing and completing treatment	Commission additional treatment placements in line with Drug & Alcohol Investment Plan Investment	JB
Child and Adolescent mental health services (CAMHS)	Improve joint commissioning Review of 3 year strategy	Services provided at extended schools and children's centres	Review joint commissioning arrangements Develop action plan to deliver planned outcomes Redesign and investment	JB
Children's oral health	Poor oral health	Reducing dental decay in line	Public health to review effective	AR

		with oral health strategy	interventions	Tender

6. ACUTE COMMISSIONING PRIORITIES				
Area	**Rationale**	**Required Outcome**	**Commissioning Proposal**	**Lead**
Maternity	User concern	Improved patient experience of all maternity services Introduction of birthing centre (BLT) Increased breast feeding rates.(BLT) Reduce sudden infant deaths	Work with providers to review service specifications around quality, and to reduce numbers of non-delivery ante-natal admissions (BLT) Commission specialist smoking cessation service for pregnant women and parents of young children Commission audit of breast feeding support in order to increase uptake Redesign Investment via Barkantine programme Commission 'Back to Sleep' campaign to promote correct sleeping position	JB/IB Commission existing provider (specialist smoking clinic) Commissioning proposal (Existing provider - HIEL?)
Admitted and non-admitted care	Agreed activity plan for acute services	High quality appropriate acute services Based on forecast outcome	Work with providers to agree new service levels – out-turn plus agreed uplift for 18 week target/growth. Performance manage	JB

			service agreement	
Consultant to Consultant referrals (C2C)	Demand Management	Establish improved control over internal referrals Reduction in unnecessary referrals	Agree referral management in line with London Wide Business Intentions and THPCT C2C guidance. Identify service outliers for further work. Redesign performance management of service agreements	JB
OPD: first to follow up ratio	National Good Practice	Set clear performance indicators to be commissioned with all providers	Work with providers to agree standard first to follow up ratios for elective work and Long Term Conditions patients. Performance manage Service agreements	JB/
Service re-design to deliver improved services in keys areas linked to ISIP and PBC priorities: **Musculo skeletal;** **Dermatology;** **ENT ;** **Plastics;** **Pain Care**	Demand Management	Revised activity profiles as part of SLA planning Improved patient experience	Agree work programme with provider to redesign services to achieve new activity profiles. Develop performance metrics Performance manage Service agreements	JB
Devices and high cost drugs	Demand Management	Cost controlled within agreed limits	Agree appropriate baselines with providers for 07-08.	JB
Diagnostics	National Target	Align commissioned services to 18 weeks and re-design programmes	Discuss unbundling of tariff for certain areas with providers. Redesign linked to 18 week target. Commission open access to echo	JB Tender

			Commission review of diagnostics across Tower Hamlets	
7.SPECIALIST COMMISSIONING PRIORITIES				
Area	**Rationale**	**Required Outcome**	**Commissioning Intention and action**	**Lead**
Specialist commissioning	Effective use of resource	Services commissioned to meet the needs of the TH population, taking account of the recommendations of clinical networks in - specialized cardiology - bone Marrow transplant - Haemophilia - NICU/PICU - Clinical genetics - Cleft lip and palatte - HIV - Renal		JB/BH
Review of commissioning and funding for complex and continuing care	Effective use of resources	Transparent decision making process for funding services based on agreed criteria Clear and comprehensive commissioning intentions and service specifications	Develop action plan using evidence from Deloittes Review	JB/SS

For each of these areas, there will be specific action plans and targets that the PCT will monitor to ensure progress is being made.

Finally, there are some areas where we believe that the services we are commissioning are either not as effective as we would wish, or are not offering good value for money. These are services that we will no longer commission next year. We will use the money previously spent on those services to buy different, and/or more effective, ways of providing care for that client group. These are:

- Those procedures that have are considered of low clinical value as set out by the Chief Medical Officer
- Commissioned services that, following review and evaluation, are not contributing to our strategic objectives
- Current acute activity that is outside of national benchmarks ie consultant to consultant referrals

THPCT December 2006

Appendix 2

PCT Operating Plan 2007/08 Commentary Template

NHS London

Note: This document lays out all commentary and finance and activity data that should be submitted in the 2007/08 Operating Plan. However, for efficiency, we would recommend that only commentary is included in this document, with additional finance and activity data included as an annex (drawn directly from the Excel templates in Appendix 3).

PCT details

PCT name
Tower Hamlets PCT
Key contact at PCT (name, contact details)
Jeremy Burden Director of Strategic Commissioning Tower Hamlets PCT Trust Offices Mile End Hospital E1 4BG 0208 223 8951 Jeremy.burden@thpct.nhs.uk
Operating Plan date
15 January 2007

1. Past year performance

1.1. Chief Executive's summary of the year

Chief Executive's summary of the year

2006/07 has been a time of consolidation and steady progress for Tower Hamlets PCT, albeit against a background of national change and financial uncertainty. The HCC report and FFP review demonstrated that THPCT is getting the basics right as is well positioned for further developing itself as a commissioning organisation, able to commission the right services in order to improve health and well being of the local population.

Operationally four themes dominated the year:

- The continued roll out of the "Improving Health and Wellbeing in Tower Hamlets" strategy, which was launched in August 2006.
- The operational separation of commissioning and service provision within the PCT
- The continued drive to reduce health inequalities for the population, culminating in the joint appointment of a new Director of Public Health with TH Local Authority.
- The delivery of key performance targets.

Financial position

The PCT will meet or exceed all of its financial targets for the current financial year. The initial planning assumption was a surplus target of £700k. In November this was revised upward to £1.7m and for month 9 FIMS a £2.7m forecast surplus for the year. The main elements in the revised position are; under-performance on the Barts & the London SLA (out-patients in particular) and the consequent availability of over-performance contingency funds. Alongside this, the PCT has offered back £5 million worth of cash non-recurrently to NHS London.

Performance Against Targets

18 week wait – currently achieving the milestone for outpatient waits and good progress against inpatient waits. The main challenge relates to waits for diagnostic testing; there is good performance on MRI & CT scanning, but significant numbers waiting for audiology and neurophysiology testing. Our discussions with our main provider Barts and the London, both as lead commissioner for London and as local commissioner have progressed satisfactorily and we have a shared understanding on how to achieve 18 weeks

Cancer 31 and 62 day waits – There were some breaches earlier in the year for the 62-day wait and the PCT has put into place an action plan for the current year. We were hopeful that this would enable us to meet the 95% target if there were no further breaches but due to another breach we are unlikely to fully meet the 62-day target.

Health Inequalities (smoking cessation) – only 25% of planned numbers for 4-week quitters delivered at quarter two. This reflects a range of problems, comprehensive recovery plan in place.

Patient choice and booking – Although performance is good compared to others, it is below plan for this stage of the year, both for percentage of bookings through the system, and patients confirming that a choice was offered. Work continues with the major acute provider to achieve planned booking systems to time. Work is underway to ensure that survey results are correctly attributed and alternative methods of confirming that a choice was offered are being piloted. THPCT has consistently been in the top ten performing PCTs in London throughout this year and we put this down to the hard work of both the practices and the dedicated support team we have in place.

Sexual Health & access to GUM – Good progress towards national target. We also work closely with other

lead commissioners of GUM services across London where Tower Hamlets residents use services.

MRSA – Barts and the London have made significant improvements in managing health care acquired infections from a poor position at the start of 2006/07.

Health Status

Progress against LAA and LDP targets has been broadly satisfactory. During the year the PCT successfully improved breast-screening rates, although they remain lower than we would wish, and the most recent data show teenage conceptions continuing to fall. The PCT also met the 3-year smoking cessation target.

Overall mortality continued to improve and the PCT is on track to meet the life expectancy target. However, although trends for cancer mortality are encouraging, cardiovascular disease will be a challenge. Although mortality is falling, the PCT is currently projected to miss the national inequalities target, hence the focus on cardiovascular disease in our plans for the coming year.

Tower Hamlets is designated as a 'Choosing Health Spearhead PCT' and had originally planned to invest all of the Choosing Health White Paper funding identified for the year in health promotion and public health schemes. The developing financial framework in London meant that these plans had to be scaled back, but the PCT was nonetheless able to invest just over half a million pounds in health improvement this year. Further significant CHWP investments are planned for 2007/8.

Service level improvements

Substantial improvements in service have been delivered through 2007-8, particularly in Primary Care and in the provision of services in the community from modern, appropriate buildings:

Primary Care: The quality of general practice continued to improve, with the PCT's average QOF score increasing from 891 points last year to 972 this year. The seven general practices under PCT management because of prior performance issues have continued to evidence improved practice in a number of indicators, such as quality of prescribing.

In terms of capacity building, the PCT commissioned a new practice site at Cable Street, extensions at St Stephens in Bow, and a new decant facility at Barkantine, on the Isle of Dogs. The PCT invested additional funding in the successful Extended Opening Hours project in primary care bringing an extra 32,000 primary care appointments per year into play, and expanded the salaried GP scheme to help practices grow and cope with population growth. The PCT achieved its first ever full year without the need to assign a patient.

In 2006/7 the PCT continued to commission a wider range of services from general practice, commissioning 24 Enhanced Services, thus improving the range of services available locally, such as phlebotomy and enhanced care of people living with breathing problems, and helping to reduce inappropriate use of acute hospital services.

Dentistry: In dentistry, the PCT mainstreamed funding for the successful Community Dental Outreach Project, and expanded its capacity with an additional mobile unit. The PCT refurbished and expanded Wapping (PDS) dental practice, and successfully secured 27 out of 28 contractors onto the new national dental contract. It also secured some service developments in primary care settings as a result of the new commissioning arrangements.

The PCTs OOH Service was commissioned to provide OOH Dental coverage for the whole NE London sector and has done so successfully and in a cost effective manner.

Pharmacy: Community pharmacy continued to develop, with the Minor Ailments Scheme being rolled out across the Borough to over 20,000 registered users, and community pharmacists offering flu vaccine for the first time.

Urgent Care: The Tower Hamlets Urgent Care Network Board worked well on a range of issues. Across the system, attendances are stable despite a rising population, and key targets such as the A+E 98 % target continue to be met, with patients showing high levels of satisfaction with the OOH service provider. A new Commuter Walk in Centre was opened at Canary Wharf in April, to complement the existing WIC at Whitechapel. The PCT commissioned Dr Foster to undertake innovative work using social marketing

techniques to target young men who regularly attend A+E as a primary care centre with interventions aimed at increasing their knowledge of and confidence in primary care services.

Update on provider reconfiguration
The major reconfiguration issue for THPCT was the need to separate its commissioning functions from its directly managed services to ensure equitable treatment of all providers.

Demand Management Initiatives

The PCT's demand management programme focussed on reducing inappropriate use of both elective and emergency secondary care services.

Elective services. Practices in the Borough elected to have a Borough wide approach to PBC and have created a Borough wide, multidisciplinary PBC Executive to take commissioning decisions. All practices have PBC business plans and with the PCT have jointly funded a cooperative organisation to help them deliver on their plans. Initial data suggests so far a reduction in out patient activity of around 8% this year due to demand management and referral review at practice level.

The PCT has also invested in developing referral management services, commencing with a Clinical Assessment Service for Musculoskeletal Conditions. This is staffed by extended scope practitioners and GPSIs, with support from secondary care. The CAS appears to being having a sustained effect on GP referrals to Orthopaedics and Rheumatology, deflecting away approximately 50% of GP referral activity. An intermediate level service for Adult Dermatology has also been approved and will commence in March 2007. Plans to extend the model to manage a greater range of conditions are being advanced for 07/08, including further elements of musculoskeletal services, chronic pain, ENT, Gynaecology and Paediatric Dermatology

Non-Elective Services. The health economy wide Long Term Conditions strategy has been set up to tackle the primary drivers behind unplanned use of secondary care. Data from the period September 2005 to September 2006 suggest that the programme of disease specific pathway redesign, workforce development and self-care is having an impact. The PCT met the March 2006 milestone for total emergency bed days and is on target to also meet the milestone for March 07. This is against a backdrop of growth of over 20,000 in the registered population in Tower Hamlets from the baseline year.

Detailed analysis undertaken in 2006 has identified a small core of activities which require a more substantial focus, particularly improving management of COPD and other respiratory conditions within the community, improving control of risk factors for heart attack and stroke and expanding self-management capacity. These are all reflected in the PCT Commissioning Intentions.

The Enhanced Primary Care Access programme has also contributed to the stabilisation of A&E attendances which had been growing unchecked up until last summer. This has now levelled out and, with improved analysis of A&E useage by ward, will continue under control.

Major investments/disinvestments

There have been some significant investments within the financial year. In financial terms the largest single investment was in the Clinical Decisions Unit at the PCT main provider, Barts and the London NHS Trust. The PCT had supported the CDU non-recurrently for the last quarter of 2005/06 financial year and was delighted to confirm its recurrent commissioning of this as a key part of the joint urgent care pathway.

There has been substantial investment by the PCT into Mental Health and Substance Misuse services, and into improving health. 2006/07 saw:

- the opening of the Specialist Addictions Unit (SAU) in partnership with East London & the City Mental Health Trust.
- opening of the bespoke in patient facilities at MEH and the move from the Victorian buildings at St Clements.
- commissioning of the Tower Hamlets Support Advice and Recovery Service (a community based service offering practical and emotional support to people experiencing mental distress including anxiety and depression).
- joint commissioning with LA adult services of the Mental Health User Development Project, (a

project to coordinate and support meaningful service user involvement)

- recruitment of a Primary Care Community Psychiatrist to work closely with GPs and the Primary Care Psychology and Counselling Service.

In addition, Tower Hamlets has a very strong history of working across health and social care boundaries, and the PCT has utilised significant income from the 'Neighbourhood Renewal Fund' to pump prime service investment and was delighted to confirm that over £1m worth of NRF funded investments would be 'mainstreamed' this year. Amongst these are investments in, Emergency Homecare, Community Dental Access, Improving the Patient Experience, VHIU case managers and Hospital Avoidance schemes.

Major material variances between Planned and Actual Performance. More detail on these is given in the Director of Finance summary below. None of the variances outlined below contributed to a worsening of the PCT financial position.

Income

- Significant additional non-recurrent resource allocations were made to the PCT in-year.
- Recurrent reductions to central budget resource allocations of £1.7 million were factored in to revised expenditure plans and managed accordingly.
- Dental Patient Charge Revenue – The PCT is expecting to fall short of its PCR target by approximately £200,000. This is affecting all PCTs in England and is thought to be an artefact of the new General Dental Services contract.

Expenditure

- The SLA with Bart's and the London NHS shows a material under-performance for the year to-date in excess of £1 million.
- Over-performance on other SLA's shows a forecast over-performance of approximately £1.1 million.
- Other expenditure variances are not significant.

1.2. Summary of financial performance

Summary of financial performance: commentary

Summary. The original financial plan was revised substantially during 2006/07 as the requirements for London-wide top-slices were developed. In total the first top-slice removed £9.89 million non-recurrently from the PCT's resource allocation. This was followed by a second non-recurrent top-slice of £2.4 million and a recurrent cut in central budgets worth a further £1.7 million. In total, therefore, the PCT had some £14 million less funding than it had originally anticipated. This was managed by a mixture of deferring investments as the main measure, slippage on existing schemes, and cash releasing savings plans. The revised PCT position was a planning surplus of £700k. Essentially this recognised the return of the 05/06 annual accounts surplus as non-recurrent resource in 06/07. This was tested and validated during the wave 2 Fitness for Purpose (FFP) exercise.

Key Variances from 2006/07 Plan to Actual.

Income.

- planned resource reductions were decreased by the receipt of in-year IAT's for HIV Consortia reserves held on behalf of London PCT's, non-recurrent NHS bank funding and impairment funding for Barts & the London NHS Trust - BLT. The overall value of these is around £10 million.
- recurrent cuts to central budgets were factored into amended financial plans and managed by introducing a package of cash releasing efficiency savings. Although MPET funding in particular was cut, the level of expenditure was maintained in recognition of the key importance of this area.
- Dental PCR income shortfall of around £200k has been managed within overall Primary Care resource flexibility in the current financial year. The shortfall relates to a lower ratio of high band treatments within UDA performance by PCT dentists. Resource 'headroom' in particular from revaluation of primary care premises costs was used to fund the shortfall. PCR income counts as part of the 'Appropriations-in-Aid' planned income total for the year.

Expenditure.

- variances against plan are mostly in respect of additional non-recurrent funding allocations rather than activity driven over-spends. The adverse variance under 'Other' secondary Care costs is largely down to the application of the non-recurrent funding allocations referred to above – mainly £5.5 million and £1.8m impairment funding for BLT. However there are some expenditure variances outlined below.
- there is genuine under-performance on the out-patient element of the main acute Provider SLA with BLT. The PCT has validated and agreed this with BLT – there is some evidence that GP referral management activity is the cause of this favourable variance. Month 7 validated activity shows the gross under-performance as being in excess of £1 million.
- there is a small over-spend within the GP and prescribing functions but these are not significant overall – the main single item being a £250k GMS overspend due to the PCT taking a practice under PCT management and investing additional non-recurrent funds in-year.
- there is some £1.2 million of FOT over-performance on miscellaneous out-of-sector SLA's, which has not been sub-classified into the PbR service classifications on the template. The main element of this is over-performance of £1.1 million on the SLA with University College Hospitals NHS Trust – UCLH. The recurrent impact of this has been factored into the 2007/08 plan.
- PCT Provider Activity variance is an adjustment to the income and expenditure plan rather than an over-spend and relates to allocated budgets, which had not been allocated at plan date, being allocated throughout the year to month 9.
- the variances on 'Other' costs are adjustments to plan totals rather than over-spends and largely cancel out on a net basis – adjustment include the over-performance on out-of-sector SLA's referred to above.

Actual I&E Position at Month 9 and FOT. The current position - month 9 – is that the PCT has increased its planned surplus to £2.7 million. The main variant here is that the main Commissioning SLA with Barts & the London NHS Trust remains at under SLA plan value to month 6 and, subject to final activity reconciliation to financial values, month 7. There is now some evidence of a downward 'shift' in some key areas of activity. The main area is Outpatients where the difference between month 6 05/06 and 06/07 activity is statistically very significant and financially is in the order of ca £1 million. The PCT has assessed that there is a low risk of activity related contingencies being required in the remainder of 2006/07 for the BLT SLA. Overall Commissioning risks are within tolerance and will allow the PCT some resource flexibility which is reflected in the increased surplus.

The PCT Provider services will achieve financial balance within the net generic inflation uplift given this year. The Gershon savings programme has had significant success and will contribute over £1.3 million cash releasing savings which have been recycled into Provider services. In addition the PCT has saved the first tranche of its two-year management cost savings target. This is worth almost £500k with a further £600k to follow in 2007/08.

The Prescribing budget remains a key risk for all PCT's due to its sheer size - £27 million for THPCT. However the budget will be managed to plan in the current financial year due to the development of a strong Prescribing team integrated with an incentive scheme for GP's and targeted programs to switch from high cost branded to generic drugs e.g. Simvastatin. Uplift of 8% was allocated to the 2007/08 Prescribing budget based on the outturn from 2006/07 less the PPA assumed generic price cuts plus net ingredient cost inflation and population growth. The overall Prescribing budget is forecast to overspend by around £100k to year-end which is within tolerance.

The Primary Care service budget including GMS, PMS and Dentistry services is broadly operating within the 06/07 budget level and is not assessed as a risk to the overall achievement of financial balance. There have been some unplanned cost pressures arising from the PCT decision to take a GMS practice into PCT control in the short term. This has required around £250k worth of non-recurrent support to address quality issues. It is intended that financial support will be non-recurrent and is funded in 2006/07 via contingencies released by revaluing premises support costs.

Cash Position at Month 9 and FOT. The PCT has a total authorized cash limit of just over £365 million. This is consumed in three ways – payment of prescription charges reimbursed to pharmacists through the Prescription Prescribing Authority [PPA], General Dental Services [GDS] and the payment of the PCT's direct costs [such as commissioning costs, payments to primary care providers, payroll and non pay costs]. At the end of December 2006, the PCT's charge to the cash limit was £260 million, which equates to 71% of the total. In part this represents a lower than anticipated spend on capital schemes in the first seven months of the financial year. It is expected that the overall capital scheme total will break even and that the expenditure will be higher towards the end of the financial year. The PCT has brokered back £5 million cash to NHS London in the month 9 FIMS return and this will reduce the cash limit.

Balance Sheet Position at Month 9 and FOT. As at the end of December 2006 the following significant items are noted on the balance sheet.

- the forecast movement in Fixed Asset balances between 1st April 2006 and 31st March 2007 of ca £11 million. The PCT capital programme for the current year will add approximately £7 million to the value of PCT fixed assets. Indexation and revaluation of the assets makes up an additional £6 million movement all of which is added to brought forward asset values at the start of the financial year. There is a corresponding diminution of asset values by £3 million in respect of depreciation charges. This is expensed roughly uniformly over the course of the year.
- the 'NHS creditors falling due <1 year' balance brought forward includes a £22.6 million payment to BLT to fund their impairment costs. This is a one-off transfer and was funded from the NHS bank.
- There are no significant balances relating to pre 2006/07 on the PCT balance sheet and no concomitant financial risks.

Summary of financial performance: comparison between planned and actual performance

£m	**2006/07 plan***	**2006/07 forecast****	**Variance**
Income			
Recurrent revenue allocation	360690	360690	0
Non-recurrent revenue allocation	-34333	-21816	12517
Other income	1600	1600	0
Total income	**327957**	**340474**	**12517**
Expenses			
Commissioning activities:			
Primary care - GPs, prison healthcare, dentistry, and optometry			
GP	-35346	-35596	-250

Prescribing	-27347	-27447	-100
Other	-10191	-10191	0
Community and intermediate services	-47419	-47419	0
Mental health commissioning, pooled arrangements or jointly funded commissioning	-68876	-68876	0
Secondary care			
Provided under PbR	-8654	-8654	0
Inpatient elective	-5823	-5823	0
Day care elective	-34270	-34270	0
Inpatient non-elective	-9256	-8256	1000
Outpatient	-3230	-3230	0
Provided at local prices	0	-850	-850
Provided by third sector/not-for-profits	0	0	0
Provided by independent sector	0	0	0
A&E	-8253	-8253	0
Other	-31499	-41727	-10228
Ambulance services	-4967	-4967	0
Tertiary and specialist commissioning	-27484	-27484	0
Total cost of commissioned services	-322615	-333043	-10428
Provider activities:			
Pay expenditure	-58358	-58858	-500
Non-pay expenditure	-23308	-23762	-454
Less - provider income	81666	82620	954
Net provider costs	**0**	**0**	**0**
Other costs			
Other pay expenditure	-1081	-1081	0
Other non-pay expenditure	-518	-929	-411
Depreciation and amortisation	-3043	-2616	427
Exceptional items			-105
Total cost	**-327257**	**-337774**	**-10517**
PCT surplus/deficit in year	**700**	**2700**	**2000**

* Should be in line with FfP submission
** Based on 9 months of actuals plus 3 months of forecast

1.3. Other major issues

Other major issues
Change of PEC arrangements and setting up of Practice Based Commissioning (PBC) exec. As part of the PCT organisational change the PCT reviewed the role of PEC following the establishment of a borough wide PBC executive covering all practices. The PEC is now responsible for the clinical elements of the strategic commissioning function of the PCT, with the PBC executive taking a lead on service re-design. The PEC now leads on the clinical quality of the strategic commissioning process, and is progressing the clinical leadership agenda. The PBC exec is actively exploring how to secure the alignment of the Local Areas Planning Groups (LAPS) with local PBC commissioners, **Agreed Improving Health and Well Being Strategy (H&WB)**. LBTH and PCT agreed a joint 10-year strategy aimed at improving health and well being through sustainable investment into primary and community services. The implementation of H&WB is a key element of the Local Area Agreement, with s specific focus on reducing inequalities. **Restructuring of Executive team and building closer relationships with London Borough of Tower Hamlets.** The PCT and LBTH, as part of the IH&WB strategy, are currently putting in place new management arrangements for joint commissioning and provision for a range of services. This is due for completion later this year. A clear example of both PCT and LBTH commitment to this project is the recent appointment of joint Director of Public Health and a pending joint head of Human Resources. **Service Level Agreement Issues**. The PCT agreed all of its SLA baselines in year and has no Service Level Agreement disputes outstanding. Additionally there are no material debtor or creditor balances pre 2006/07 in dispute. **Barts and the London New Hospitals Project.** The PCT contributed significantly to the activity and financial information in the final business case for the BLT PFI scheme submission. A joint 10-year activity model was agreed and from that a set of financial assumption which underpin both the NHP and the PCT's acute commissioning assumptions. The PFI project was granted DH/Treasury approval and the re-development is underway. **Mental Health Services.** March 2007 will see adult mental health services move from the Victorian setting of St Clements to a purpose built state of the art facility on the Mile End Hospital Site. This will complement the recently opened Specialist Addiction Unit which opened in Autumn last year. **Substance Misuse.** The Drug and Alcohol Action Team (DAAT) commissioned the first inpatient detox unit for young Bangladeshi men in 2006. This service has been commissioned to meet the specific needs of the Bangladeshi community who otherwise, were sending their young men to private clinics abroad.

2. Future commissioning plans

2.1. Strategic overview

Strategic overview

THPCT plans to use the development of Strategic Commissioning to drive forward plans to improve the health of the local population and increase the provision of health care services in the community setting. Significant work on these aims has already been undertaken in preparing the Commissioning Intentions for 2007-08, and some of the detail is presented here.

Snapshot of Tower Hamlets

The most comprehensive mapping of deprivation across England undertaken by the ODPM resulted in the following key findings:

- Tower Hamlets is the second most deprived Local authority in England with an average IMD score of 45.88. It also has the second highest proportion of the people living in the most deprived super output areas in the country.
- Deprivation in Tower Hamlets is evenly spread across the borough, with pockets of severe deprivation in all areas.
- 58.7% of children in TH were living in income-deprived families (with income 60% or more below the average.
- In 2004 13% of men and 12% of women of working age were unemployed - amongst the highest in the country.
- 48% of the population in the last census described themselves as from a non white ethnic group (34% Bangladeshi).
- Life expectancy was 72.9 years for men and 78.9 years for women (compared to 76.0 and 80.8 for London and 76.2 and 80.7 for England).

Population Health Status

The make up and nature of the Tower Hamlets population is well documented, and detail can be found in the PCTs Annual Public Health report and local strategic documents. Overall, the demographic profile of the population of TH paints a picture of a young, diverse and dynamic part of London, but one which is beset by inner city deprivation. Tower Hamlets is the second most deprived Borough in the country in terms of the average Index of Multiple Deprivation (IMD) rank (2004), and a number of its unique health indicators reflect the high levels of socio-economic deprivation. These include:

- Death rates that are higher than average for London and England.
- High mortality rates for cardio vascular disease and cancer, chronic obstructive airways disease and Diabetes
- High numbers of low birth weight babies
- High incidence of dental decay in children
- High prevalence of HIV and sexually transmitted diseases
- Suicide rates that are higher than average for London, and appear to be increasing
- High prevalence of depression, and very high emergency hospital admissions for schizophrenia

In addition, the population of Tower Hamlets is expected to grow significantly over the next 10 years, increasing the challenge to health services and the demand to reduce inequalities. Because of the significant deprivation and relatively poor health in Tower Hamlets we are designated a spearhead PCT and required to meet more demanding targets for health improvement and reducing mortality. In addition, the PCTs Commissioning Intentions for 2007/08 set out our plans to ccommission a multi-agency action plan to maximise the impact of the Olympics and Paralympics on health and active lifestyles. Our targets for next year include:

- Increasing life expectancy, with a 10% reduction in the gap between Tower Hamlets and the England and Wales average by 2010
- Reducing the number of deaths under the age of 75 from cardiovascular disease
- Reducing the number of deaths under the age of 75 from cancer
- Increasing the number of people quitting smoking

This is the background against which commissioning decisions have been developed for 2007-08.

Current services commissioned

THPCT commissions the majority of it's services from four key providers:

Barts and the London for acute services – to the value of £106,690 or 32% of the total commissioning budget.

The PCT provider arm – to the value of £62,972 or 19% of the total budget (to be checked)

East London and the City Mental Health Trust – to the value of £ 34,622 or 10% of the total budget

Primary Care Services – to the value of £73,020 (includes prescribing) or 21% of the total budget.

A 'look back' at services commissioned and delivered in 2006-07 resulted in these key themes:

- The top slice imposed on the PCT disproportionately affected health promotion and reducing inequalities work, as the decision was made to delay new investments rather than cut existing services. This resulted in a two-thirds reduction in investment compared to our original plans.
- Primary care mental health services received the full year effect of 2005/6 investment, although ELCMHT has been adversely affected by funding top slices. New investments in Substance Misuse also went ahead.
- The PCT continued to commission a wider range of services from community and primary care providers, including investment in improving access to services locally and out of core hours.
- The PCT commissioned acute activity at 05/06 outturn including over-performance, and commissioned a new service designed to improve the patient experience of A&E at Barts and the London NHS Trust. This resulted in a rise in total recurrent acute investment from £144 million to £154 million. The represents an increase of 7.2% including inflation.
- The PCT also invested in new activity in line with recommendations from the NE London clinical networks.

Key Challenges

The three key challenges for the PCT in the coming year can be summed up as

- Limiting, or reducing, the growth in acute service activity at BLT by clear service specifications and developing alternative service pathways involving community services.
- Improving the health and wellbeing of the Tower Hamlets Population through a range of partnership

working and active interventions

- Improving the availability and accessibility of a range of health services in the community setting, including Out of Hours.

Our plans to meet these challenges are set out in the Health and Well Being Strategy.

Medium Term Objectives and Priorities for THPCT.

Along with delivering key national targets and local commitments in the LDP, the Local Area Agreement, the Spearhead Choosing Health agenda and the Health and Well-being strategy set additional challenging targets for the PCT.

The commissioning intentions have therefore been divided into 'ongoing' and 'priority' areas, the latter being targeted in terms of management time and resources to drive forward key achievements. The 'priorities' offer an opportunity to build on areas of investment where there has been real evidence of improving the health and well being of local communities, and to improve the quality and availability of services for our population.

A range of General Commissioning Intentions will also be applied to all providers, whether on-going or in the 'priorities' section. These relate primarily to cross cutting health improvement priorities in support of the Improving Health and Wellbeing Strategy, and to achieving increased value for money.

Relationships with stakeholders.

Relationships across all stakeholders are very good. The PCT is a core member of the Tower Hamlets Partnership with Director level leadership across all planning groups. Evidence of this is the Local Area Agreement which is seen as the vehicle to progress the Health and Well Being Strategy.

PCT has excellent executive and clinical relationships with local primary care contractors as well as Trust management and clinical colleagues.

Supplier Configuration

The PCT sees 2007-08 as an important transitional year for service providers in Tower Hamlets. It is the year when the rigours of service specification will be fully developed and implemented for many services not used to the discipline, where performance metrics and performance management become main stream, and where the leading role that providers hitherto held in the instigation of new services is challenged for the first time. It will therefore be a year of preparation and upskilling, ready for the increasing robustness of the market, both for commissioning and provider staff.

It is anticipated that the availability of a full calendar year planning framework to be released by NHS London in March 2007 will allow new providers, particularly from the voluntary and third sectors, to prepare for entering the market in 2008-09. The PCT will be supportive to this development and extend the same opportunities for learning as it does to it's provider arm. The TH Partnership is currently developing a Third Sector Commissioning Strategy to cover both heath and social care.

From April 2007, the PCT will be working with Amicus, an independent sector provider of diagnostic services. This will create additional capacity in support of moving to the 18-week target.

Management of the PCT provider arm

The PCT restructured in 2006 to separate its commissioning functions from its directly managed services. This will continue into 2007-08, with an increasing emphasis on developing the necessary skills to function efficiently as an arms length organisation. Support will be provided in working with the commissioning-led agenda, including increasing capacity in core skills such as use of data to demonstrate value for money, negotiating service specifications and measuring performance and outcomes.

2.2. 2007/08 commissioning plans

Commentary on breakdown of income and cost
Income and costs profiled – as per spreadsheet

2007/08 in-year breakdown of income and cost													
£m	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	**Total**
Income													
Total cost of commissioned services													
Net provider costs													
Other costs													
Surplus/deficit													

2.2.1. 2007/08 PCT targets

2007/08 PCT targets

As a PCT anticipating financial surplus, THPCT is working to deliver the full suite of targets outlined below:

- LDP targets (already admitted onto STEIS)
- LAA targets
- All targets detailed in the revised 2007/8 Planning Framework for London (incorporating the key Operating Framework 2007/8 from DH)
- Spearhead PCT targets from Choosing Health White Paper.
- Targets from key local strategies to reduce health inequalities and improve access to services.

Further detail on the impact this has on commissioning is in the appended *THPCT Commissioning Intentions*, 2007-8 document.

2.2.2. Income

Significant changes in planned income

The main assumption in the income plan for 2007/08 are outlined below;

Recurrent Assumptions

- THPCT will receive £31 million of recurrent growth funding as per the exposition book.
- It will receive £4.1 million non-recurrent 'growth funding' (deemed recurrent) funding as per the exposition book.

Non-Recurrent Assumptions

- The NHS London 3.6% top-slice has been factored into the planning total non-recurrently for 2007/08. This accounts for a resource reduction of just under £13 million.
- THPCT has not recurrently committed any of its gain under the Purchaser Parity Adjustment mechanism for PbR transition. This equates to just over £18.6 million in total. However the original PPA calculation needs to be revised downward by £4.5 million due to data errors in the original BLT stage 2 PbR return and cost pressures to the PCT arising from lead BLT SLA historic lead payment included in the2004/05 income quantum. To be clear about this – the recurrent historic BLT SLA value is £4.6 million higher than the stage 2 PbR return discloses. The revised PPA total not recurrently committed is therefore just over £14 million.
- The resource planning total has been reduced by £4.6 million non-recurrently to account for resource reductions in respect of the 25% PPA transition in 07/08. This leaves a residue of £9.4 million PPA gain to the PCT which has not been recurrently committed. This has been offered up to NHS London as additional resource flexibility from THPCT and has been agreed with Jonathan Wise. The resource plan for 2007/08 therefore includes a non-recurrent deduction of £9.4 million and it is assumed this will be actioned by NHS London in the initial Vista output for 2007/08. It is assumed that this will be paid back as 50% in 2008-09 and 50% in 2009-10.
- There is no assumption on payback of 2006/07 initial top-slice next year in line with the Operating Framework assumptions. However it is assumed that both the 2006/07 second top-slice and the PCT current year surplus are both received back next year. These are worth £2.4 and £2.7 million respectively.
- As far as the movement from 2006/07 plan to 2007/08 plan resources goes, adjustments to the resource limit planning total have been assumed which reconcile back to the £369.5 million plan outlined below. The most significant items are outlined below – deductions to resource limits are shown in parenthesis;
- NHS London 3.6% top-slice – (£12.99 million)
- NHS London additional resource offer – (£9.4 million)
- Additional MFF required on planned 07/08 SLA activity - (£2 million)
- Reduction re PPA to 25% – (£4.7 million)
- Second 06/07 top-slice received back - £2.4 million
- Revised 06/07 planning surplus received back - £2.7 million
- Central Budgets, Dental allocation etc - £24 million

Income – comparison between historical achievement and current plan

£m	**Plan**	**Forecast***	**Current plan**		
	2006/07	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Recurrent revenue allocation	360690	360690	396136		
Non-recurrent revenue allocation	-34333	-21816	-28241		
Other income	1600	1600	1650		
Total	**327957**	**340474**	**369545**		

* Based on 9 months of actuals plus 3 months of forecast

2.2.3. Spending plans

Commentary on significant spending plans

(a) Investment into 18 weeks: THPCT plans to achieve this through mixture of additional planned, purchased activity as well as re-design which reduces inappropriate activity and increases capacity
(b) Planned increase in mental health spend due to new investments to meet unmet need, respond to action plans and improve quality of services
(c) Significant increase in planned investment into Choosing Health as part of drive to reduce inequalities as part of Spearhead PCT planning
(d) Continued investment into primary care in line with list growth trends

More detail on these plans can be found in *THPCT Commissioning Intentions 2007-8* (appended)

Commissioning expenses – comparison between historical achievement and current plan

£m	**Plan**	**Forecast***	**Current plan**		
	2006/07	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Primary care - GPs, prison healthcare, dentistry, and optometry					
GP	-35346	-35596	-40121		
Prescribing	-27347	-27447	-30049		
Other	-10191	-10191	-10467		
Community and intermediate services	-47419	-47419	-51439		
Mental health commissioning, pooled arrangements or jointly funded commissioning	-68876	-68876	-73334		
Secondary care					
Provided under PbR					
Inpatient elective	-8654	-8654	-10384		
Day care elective	-5823	-5823	-6987		
Inpatient non-elective	-34270	-34270	-41119		
Outpatient	-9256	-8256	-9906		
Provided at local prices	-3230	-3230	-3876		
Provided by third sector/not-for-profits	0	-850	-871		
Provided by independent sector	0	0	-1800		
A&E	-8253	-8253	-8910		
Other	-31499	-41727	-36807		
Ambulance services	-4967	-4967	-5141		
Tertiary and specialist commissioning	-27484	-27484	-28671		
Total cost of commissioned services	**-322615**	**-333043**	**-359882**		

* Based on 9 months of actuals plus 3 months of forecast

2.2.4. Activity plan

Commentary on significant changes in activity

Acute. Planning for acute commissioned services is proceeding on the following assumptions:

- 2007/08 will be based on forecast demand for services in 2006/07. For BLT this is based on M6, plus/minus any change in the size of the waiting list in this time period, and then projected to year-end using weighted SLA phasing.
- This will reflect actual changes in demand, specifically a forecast reduction of circa 3 %in first and follow up OPD activity.
- Impact of demand and referral management schemes.
- Additional activity to achieve the 18-week RTT target.
- Population planning growth is 3% in general but specialties will vary according to the impact of RTT and demand management programmes.

Inpatient elective and 18 week planning. In-patient planning has taken account of population growth, meeting waiting time targets and demand management.18-week planning is based on achieving milestones and targets through a combination of investment and re-design.

Our key focus is on the inpatient waiting list with specific specialties including ENT, plastics, trauma and orthopaedics, ophthalmology and general surgery (please see day case assumptions below). There are already re-design work streams underway through the Integrated Service Improvement Plan (ISIP) in plastics and ENT. The ISIP Board is a joint meeting between the PCT and BLT and is chaired by the PCT Director of Strategic Commissioning. BLT has an internal 18-week Board chaired by the Director of Operations with senior PCT input.

For out-patients we have identified demand management plans for plastics, dermatology and trauma and orthopaedics. We have already removed the impact on first and follow up reductions in 2006/07 activity into 2007/08 plans and expect to see a significant impact on dermatology and trauma and orthopaedics activity with the further development of the Clinical Assessment Service.

For diagnostics, we have bottlenecks in neurophysiology and audiology. Both have action plans to mitigate these blockages.

Day case. Growth in line with 18 week planning and greater percentage of activity moving from in-patient in line with integrated service improvement plan (15% increase in general surgery, 13% in trauma and orthopaedics, 38% in ENT 5% in plastics). These planned increase are reflected in the activity profile.

In-patient non-elective

(a) Forecast outturn, including an estimate of change in demand due to current year population growth and seasonality effects.

(b) population growth of 3% will require investment

(c) Impact of demand management schemes

Our focus (as reflected in our commissioning intentions) is on investment into the case management team and their ability to effectively manage high intensity users. By shifting the focus next year to admission avoidance rather than expediting discharge will result in reducing 852 spells.

Outpatient (new and follow up). As noted above there has been a marked reduction in actual 1st OPD activity in 06/07. This is reflected in 07/08, but partly offset by a non-recurrent increase in activity due to 18 weeks planning but will expect to see this fully reflected in 08/09. Analysis indicates that this is a step change in behaviour by GPs.

Combined with the impact of the referral management scheme, specifically the clinical assessment service means we are planning minimal growth in line with 18 week planning for total OPD activity.

We are planning on maintaining a ratio of 1:2 for first to follow up appointments. There will be variation across specialties, as we are planning for an increase in follow ups in specific specialties noted above in the section on out-patients. This reflects a more complicated case mix as a result of referral management planning.

A&E attendances. Stabilisation of A&E attendances has been a key feature of 06/07. This is due to a number of a factors including favourable seasonal weather, primary care extended hours programme, pharmacy first, better mapping and consistent publicity campaign aimed at deterring inappropriate attendances. The PCT will also bring forward its Urgent Care Strategy in 07/08. An assessment has been made for growth due to population changes, and demand management strategies.

All figures (other than non-elective which is not included) reconcile back to the Local Delivery Plan submissions for 2007/08 as a start point for 2007/08 planning and will form part of negotiations for service agreements.

Other areas:

Choosing Health. We are proposing a significant increase in activity as part of our commitment to reducing health inequalities. Key to this will be investment in new activities focussed on smoking cessation, obesity, better monitoring of cardio vascular disease and healthy lifestyles.

Mental Health. Significant new investment into personality disorder service and an expansion of Talking Therapies. These are currently gaps in service provision but we are planning for a reduction in continued acute in patient over-performance.

We are currently reviewing a draft activity profile for commissioned services as part of the developing commissioning plan. We anticipate this being ready early in March.

Primary care. Planning for 2% list growth. Continued investment into the primary care estate as part of health and well being strategy. This is linked to a programme of planned shifts in activity from BLT i.e. re-commissioning sexual health services in primary care

Specialist Commissioning. THPCT will invest in line with the specialist commissioning Health Delivery Plan. One significant change is the move to increase IVF cycles from one to two as part of progress to meeting NICE guidelines, which stipulates 3 cycles by 2008/09.

Provider arm. The provider arm will be increasing activity in the management of patients with Long Term Conditions – in particular by increasing nursing capacity in community matron roles and for the care of patients with chronic respiratory disease or heart failure.

They will also be implementing the Audiology action plan to achieve compliance with the 18 week target, and developing joint plans with BLT to support achievement of the 18 week target in some shared service areas.

Investment plans are set out in THPCT commissioning intentions 2007/08 which is appended.

Commissioning activity plan – total					
'000 spells, net of demand forecast					
	Plan	**Forecast***	**Current plan**		
(attendances – outpatients)	**2006/07**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Inpatient elective	5730	5513	5834		
Day case	14737	14240	15089		
Inpatient non-elective	21000	20057	19986		
Outpatient (new and follow up)	66480	65775	65925		
A&E attendances	119514	119280	120428		
* Based on 9 months of actuals plus 3 months of forecast					

Commissioning activity plan 2007/08 – by trust						
'000 spells	**Top 4 trusts**				**Remaining activity**	**Total**
(attendances – outpatients)	**Trust 1**	**Trust 2**	**Trust 3**	**Trust 4**	**Other**	
Inpatient elective	4976	329	41	86	402	5834
Day case	12871	850	105	223	1040	15089
Inpatient non-elective	17900	64	403	139	1480	19986
Outpatient (new and follow up)	57396	4089	791	782	2867	65925
A&E attendances	120428	0	0	0	0	120428

2007/08 in-year breakdown of activity plan					
'000 spells (attendances – outpatients)	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Inpatient elective	1576	1284	1343	1631	5834
Day case	4074	3320	3470	4225	15089
Inpatient non-elective	4997	4597	4997	5396	19986
Outpatient (new and follow up)	17800	15163	14504	18458	65925
A&E attendances	30107	27698	30107	32516	120428

2.2.5 Cost improvement, turnaround, and commissioning efficiency plans

Commentary on cost improvement/turnaround plans

Most of the CIPs outlined below fall within the PCT Gershon Savings Targets ['Gershon savings plans] – The target is for the Provider to achieve recurrent cash releasing savings on the SLA internally commissioned by the PCT - £1.4 million. The Gershon savings programme is summarised below. As at the end of December 2006 - £440,000 worth of Discretionary budgets have been removed from budgets. Procurement savings have also yielded recurrent saving forecast to achieve £500k (£375k as at the end of December 2006). This does not take account of work being done by the London Procurement project which will see further Procurement savings commencing in the last month of the current financial year.

The last CIP is for Management Cost savings as required under 'Commissioning a Patient Led NHS'. PCT's are required to generate total cash releasing management costs of £250million per annum by the end of 2007/08. The THPCT share of this is £1.1million of which £413k was saved in 2006/07 mainly by disestablishing 7 wte management posts. PCT's were required to submit a detailed plan on how management cost savings were to be achieved and the second tranche of management cost savings is shown below - £500k. A joint piece of work is currently being developed by the three inner sector PCT's and the East London & City Mental Health Trust to work up a transition to use of NHS Shared Services by mid 2007.

Cost improvement/turnaround plans

£m	**Net saving**				
	Plan	**Forecast***	**Current plan**		
	2006/07	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Procurement Savings	500	500	500		
Reduction in Bank & Agency Usage	500	410	400		
Review of discretionary budgets	440	440	0		
Skill Mix Review	0	-40	225		
Review of OAT Charging	0	0	50		
Review of Non-Charged Activity	0	0	75		
Review of Provider Casemix	0	0	50		
CPLNHS Management Cost Savings	413	413	500		
Initiative 9					
Initiative 10					
Other initiatives					
Total	1683	1543	1800		

* Based on 9 months of actuals plus 3 months of forecast

Commentary on commissioning efficiency plans (e.g., demand management, prescribing efficiencies)**

Our plans for acute activity are set out in 2 sections, referral management and demand management.

Referral management

1. Clinical Assessment services have been, or will be, set up to transfer referrals from Primary Care away from hospital and towards alternative community provision in the following services:

- Rheumatology and Trauma and Orthopaedics: 60% transfer

- Dermatology: Adults - 45% transfer, Children - 45% transfer
- ENT- reduction of 200 cases from 2006-7 figures for first three quarters

2. Consultant to consultant referrals:

Seeking a 10% reduction across all specialties in acute providers In line with our agreed policy.

3. Clinical exclusions policy

A range of procedures is excluded from commissioning agreements because they do not offer good value for money, or are clinically of limited/doubtful effectiveness in line with our agreed policy.

4. GP referral to OPD

This LES scheme is designed to support practices reviewing their referrals to acute providers. The aim is not to prevent appropriate referrals rather it is designed to support peer review with in practices as part of PBC.

Demand management
The PCT has three main strands to its Demand Management plans. These are:

1. Reduce demand on A&E

Planned reduction in the inappropriate use of A&E by improving and increasing the streaming of patients from A&E to the Whitechapel Walk in Centre.

2. Improve the management of high intensity users (VHIU's) as part of the PCT's Long Term Conditions Strategy

- Identify, divert and sustain VHIUs through the Hospital Avoidance Team and case managers. Planned 50% reduction on mean number of A&E attendances of 06/07 cohort
- Increase capacity of the community respiratory team (part year effect): planned reduction of 35 spells – 15 at short stay tariff for COPD without complications, and 20 at care of older people with complex needs and a respiratory diagnosis
- Increase pulmonary rehabilitation uptake and increase community provision (part year effect): planned reduction of 32 spells at standard tariff for non elective copd admission without complications
- Enhance local Heart Failure services: planned 10% reduction in first OPD appointment over 2006-7 outturn.
- Enhance local stroke services: planned 10% reduction in first OPD appointment over 2006-7 outturn.

3. Effective prescribing

Analysis done by the PCT Prescribing team has shown that there are significant potential savings available from specific targeting of the area of Statin prescribing. In particular there are savings in excess of £500k which would be possible from the clinically appropriate switching of patients currently prescribed Atorvastatin to the much cheaper generic Simvastatin. This has been identified as a common savings area for PCT's by the NHSII metrics reports on NHS performance. However, it should be borne in mind that only a maximum of 30% of cash releasing savings would be available to PCT's as 'real' savings. Under the covenants agreed via Practice Based Commissioning, 70% of all savings on baseline budgets must be made available to practices for reinvestment into Commissioned patient care. The PCT has therefore included prudent cash releasing savings from this source. To support the switch, an incentive scheme has been commissioned through the Practice Based Commissioning Executive and clinical guidance to GP's is being developed. Support for this initiative from clinicians at BLT has also been sought and agreed in principle.

Commissioning efficiency plans (e.g., demand management, prescribing efficiencies)					
CAS - Musculo-Skeletal	0	28	44		
CAS - Dermatology	0	-45	62		
C2C Referral Review	13	0	231		
Clinical Exclusions Policy	0	0	134		
A&E Streaming to WIC	0	100	100		
Service Redesign	0	0	4		
LTC	974	630	633		
OP - GP Referral Review	0	0	100		
Review of GMS ES	0	0	0		
Prescribing - Statins etc	0	0	177		
Other initiatives					
Total	**987**	**713**	1485		

2.2.6. Practice based commissioning (PBC) initiatives

Explanation of PBC approach

Current Year 2006/07. PBC has got off to a good start in Tower Hamlets with 100% coverage of PBC and each practice submitting a DES PBC plan. All 36 general practices in Tower Hamlets are active Practice Based Commissioners. All have a business plan, and have elected multidisciplinary representatives onto a Borough wide PBC executive which commissions on their behalf. The creation of the PBC Executive (PBCE) was very much linked to revision of the role and function of the Professional Executive Committee (PEC) and updating of the PCT's Integrated Governance Framework also done this year. The PEC was reconstituted to have a strategic commissioning role and the PBC Executive was set up to develop and deliver the operational commissioning plan – being directly accountable to the PEC. The key developmental milestones for PBC this year were;

- Budgets were issued to practices early in the financial year. They were based on historic budgets as outlined in PBC guidance but a local approach was taken in some initial weighting of 06/07 budgets based on a 'fair shares' approach capped at agreed 'pace of change' levels.
- Budget and activity information is routinely provided (monthly) to practices
- Practices and the PBCE are supported through a DES and a LES, and managerial and technical support from PCT staff in both the commissioning and finance teams
- Establishment of a Commissioning Executive – the PBCE. A PBC Commissioners Executive has been established to oversee the development of PBC across Tower Hamlets. The PBC Executive is designed to be a clinically led forum which brings together the views of the individual practices as commissioners. It is through the PBC Executive that the practices as commissioners are formally involved in the PCT's commissioning strategy and decisions and will lead/be involved in all partnership and contract meetings. The PEC has also delegated to the PBC Executive responsibility for service redesign of those areas covered by PBC budgets (i.e. for 2006/7 acute hospital services)
- Development of a PBC Framework that links into the PCT's Commissioning Intentions for 2007/08.
- Involvement in the Improvement Foundation's PBC learning.

- PBC budgets for 2006/07 include Acute SLA costs and prescribing budgets totalling approximately £130 million.

2006/7 was a year of learning for both the PCT and practices as PBC was introduced and began to operate. The achievements of PBC this year are significant and include the following;

- The PCT has encouraged practices to use PBC to focus on referrals management and demand management activities.
- Month 8 acute Outpatient data shows under-performance in Outpatient specialties of >£1 million. Analysis of monthly practice based data shows clear evidence of a 'step' change in the referral behaviour of many practices to OP specialities.
- The establishment of a Clinical Assessment Service (CAS) for musculo skeletal problems. Recurrent savings will begin to be seen in acute musculo-skeletal specialties later in the financial year and developing in 2007/08. There have been 881 referrals to CAS between May and 8th December with the numbers of referrals per month gradually increasing – approx 1880 for 2006/7 year is the forecast.
- A Business case has been developed and approved for a Dermatology CAS to commence at the end of 2006/07.
- Service redesign priorities have been developed and agreed by the PBCE and the PEC and are mainstreamed in the PCT commissioning intentions for 2007/08. This is outlined in more detail below in the 2007/08 deliverables.

Strategic Approach for 2007/08.

There are a small number of key strategic themes for PBC development in 2007/08. These are outlined below;

- The PCT will continue to develop the 'fair shares' budget methodology agreed for 06/07 and move practices closer to targets.
- Budgets for Mental Health services plus Community and Intermediate services will be added to PBC budgets in 2007/08. The commissioning scope of PBC will therefore be developed and extended with executive responsibility for service redesign in these areas added to the PBCE's delegated powers by the PEC.
- 70% of forecast savings on baseline PBC budgets will be available to practices for reinvestment into patient services. Adhering to this agreement is important in providing appropriate incentives for practices to take up PBC and to progress service redesign. Following the PCT reconfiguration, the PBC executive is now leading on service re-design. This will increase in scale over the next 12 months as business cases for projects are brought forward.
- Practices are entitled to make recommendations about how to reallocate resources freed up from their indicative budget made from service redesign and more cost effective treatments. Resources will be "freed up" by changing or reducing referral behaviour or a practice or group of practices providing an alternative which is cheaper, or by a practice referring to another practice or another service (e.g. CAS). Detailed plans for either service redesign or new services (which require new investment from freed up resources) need to be supported by a business case. All business cases will be treated on their merits and in a manner which is timely, transparent and achieves probity. Plans to address a national or PCT priority can expect to be approved, subject to a set of agreed criteria.
- PBCE Commissioning intentions are included explicitly in the Commissioning intentions for 2007/08.
- Further incentives are being developed locally to replace the 06/07 DES for PBC management.

Deliverables for 2007/08. PBCE priorities for 07/08 have been agreed as:

- Reduction in A+E attendances
- Implementation of new pathways for:
- ENT
- Menoraghia
- Wound Care
- Direct access ECHO/ECG
- Minor surgery
- Haematuria
- HB testing

These were developed in partnership with the PBCE, practices and the PCT and are mirrored in the PCT's commissioning intentions. In addition, practices will continue to implement 24 commissioned enhanced services covering areas such as COPD, Anticoagulation and Diabetes.

2.3. PCT provider plan

Provider plan
Tower Hamlets PCT Provider services comprises Community and Intermediate services – located within the Provider Development Function, Urgent Care and Out of Hours services, Primary Care GP practices under PCT control, hosted Pooled budget arrangements, Public Health and a number of corporate and overhead functions. The size of the PCT overhead function is enlarged by lead arrangements for the Inner North East London Health economy – specifically for financial services and procurement. The PCT also hosts specialised Commissioning on behalf of the NE London sector. Approximately 1400 staff are employed within PCT 'Provider' services and the total spend is over £80 million per year. Services are commissioned internally by the PCT, with an increasing focus on contestability, value for money, and quality assessment in line with Commissioning a Patient Led NHS and Fitness for Purpose. In 2006/07 the Provider Development Directorate established business plans for all services with development plans to improve quality, service and financial performance. In line with Choosing Health and Our Health, Our Care, Our Say the Directorate is committed to re-design care pathways for long term conditions, increase the range of services provided in the community, improve the experience of patients and users, and pursue alternative models of service provision that offer greater value for money. For 2007/08 the Directorate is commissioned to provide and improve a range of services to meet national targets including sexual health, adolescent obesity, CVD, diabetes and COPD, mental health and children's services.

2.3.6. Provider income

Commentary on sources of provider income (i.e., income from other PCTs or commissioners)
The planned budget overall for PCT Provider services will be approximately £85.2 million. The main source of income for PCT Provider services is from the internal SLA with the PCT itself. This will amount to approximately £64 million in 2007/08. In addition the PCT Provider Service has a significant number of Service level Agreements in place with both PCT's – particularly the inner North East London PCT's, Newham and City & Hackney – and Barts and the London NHS Acute trust. The latter SLA, for mainly Therapies and Pharmacy services, is the most substantial in income terms being worth approximately £4 million. In total SLA income is worth £20 million. Appropriations in Aid account for the other £1 million income within the overall Provider. This comes from a number of sources including premises rental income and miscellaneous service income.

Provider income – comparison between historical achievement and current plan

£m	**Plan**	**Forecast***	**Current plan**		
	2006/07	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Provider income	81.66	81.491	85.23		

* Based on 9 months of actuals plus 3 months of forecast

2.3.7. Operating resources required to deliver provider plan

Resources required to deliver provider plan
Within PCT Provider Services is the Provider Development Function containing most of the direct Community

and Intermediate Care Directorates. Some of these services are provided not just to Tower hamlets residents but also to inner north east London PCT's under SLA, OAT's with other PCT's and embedded within the patient care pathway at BLT – in the case of physiotherapy services. The turnover for the Provider Development Function is £45 million in 2006-7. THPCT Commissioning intentions and financial plan for 2007/08 supports the continuing development of the Provider Development Function, with the following general service objectives:

- To work with community and hospital based services to improve their quality and responsiveness to patients as well as increasing their accessibility in local settings.
- Reduce the need for hospital and residential care so that people will have greater choice of care and support.
- Increase the availability of culturally appropriate services and provide more interpretation and advocacy to support patients.
- Work in partnership across organisations and in multi disciplinary teams to provide integrated services, so that patients feel that they are receiving care from a single agency.
- Share costs across organisations and to bring information systems together so that for adults and children there will be a single assessment process.
- Continue to develop the quality and responsiveness of directly managed primary care practices

Within the Provider Development Function are the following key services;

Urgent Care including Walk-in Centres and the GP Out of Hours service.

Specialist and Community nursing services

Dentistry – provided to both City & Hackney and Tower Hamlets PCTs.

Older People and Rehabilitation services (including stroke and disability services) – delivered in close conjunction with a number of acute trusts, including Barts and the London NHS Trust.

Children's Services - operating as part of the local Children's Trust in partnership with the London Borough of Tower Hamlets.

Women's and Young People services - provides sexual health and family planning services, with counselling.

Foothealth service – podiatry, routine and specialist diabetic foot care, biomechanics clinics, electrosurgery, nail surgery and day case foot surgery.

Speech and Language, Occupational and Physio- therapy services – also provides acute physio and OT services for BLT under a service level agreement.

Audiology - an east London wide service, providing audiology services and newborn hearing screening services in Tower Hamlets, City and Hackney and Newham.

Learning Disabilities - jointly funded service with the London Borough of Tower Hamlets.

Psychology and Counselling Services

Financial Assumptions. Included within the overall Provider services forecast 07/08 budget is an assumption that approximately £1.5 million worth of cash releasing 'Gershon' savings will be made. The internal PCT Provider Service Level Agreement is being uplifted by net inflation of 2.5% in line with generic uplift outlined in the Operating Framework for 2007/08. The individual Gershon savings plans are contained within section 2.2.5 above – Cost Improvement Programmes.

A further assumption is that an additional £500k worth of Management Cost savings will be made - as outlined

in the second tranche savings plans for 'Commissioning a Patient Led NHS' – (CPLNHS). These savings are cash releasing but do not count toward the net inflation uplift for PCT Provider.

Provider operating expenses – comparison between historical achievement and current plan					
£m	**Plan**	**Forecast****	**Current plan**		
	2006/07	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Pay	-58358	-58358	-60218		
Non-pay	-23308	-24262	-25015		
Total provider operating cost	81666	82620	85233		
** Based on 9 months of actuals plus 3 months of forecast					

2.4. Capital plan

Plans for investment and disposal

The PCT will have operating capital of approximately £3 million in 2007/08. Approximately £1.7 million of this is the PCT's recurrent capital resource limit and £400k relates to the sale of Newby Place Health Centre to LIFTCo for development under the NHS LIFT programme. Financial close on this specific scheme is planned for the end of the current financial year with actual asset disposal in 2007/08. Higher levels of capital funding were available for 2006/07 due mainly to the re-phasing of non-recurrent NEL strategic capital for the redevelopment of Mile End Hospital, specifically the relocation of Mental Health services from the existing site at St Clements hospital. The PCT therefore has a relatively modest recurrent core capital programme with £200-£300 spent on routine maintenance each year and the rest on a rolling refurbishment programme - mainly to the facilities and wards at Mile End Hospital.

There are three major factors which affect the management and development of the PCT estate -

1. A key part of PCT provided Community and Intermediate services are delivered at Mile End Hospital which is one of the largest Community hospitals in the country. The recurrent notional capital resource limit is under £2 million and so there is limited scope for strategic capital investment.

2. The on-going redevelopment of the Mile End Hospital site and Bid for Community Hospitals Capital Regeneration Funds. 2006/07 is the final year of the 4-year capital build project to relocate Mental Health services from the existing site at St. Clements to a purpose built facility on the Mile End Hospital site. This project has cost £34 million and has been paid for out of strategic North East London Capital funds. The project has been managed by the East London & the City Mental Health Trust whilst the funding arrangements have been hosted by the PCT. The asset is currently shown as an AUC on the balance sheet of the PCT. It is a key part of the Estates planning strategy for next year, and the financial balance sheet management, that the asset will move into ELCMHT ownership. Discussions on this issue are currently at an advanced stage. It is not anticipated that any impairment risk will accrue to the PCT.

   The Mile End redevelopment is a key feature of the PCT's plans and encompasses the project to accommodate mental health services relocating from St Clement's Hospital and the proposal to redevelop the site under the community hospitals initiative announced in summer 2006 in the White Paper Our Health, Our Care, Our Community: Investing in the Future of Community Hospitals and Services. If the PCT's bid for funding through the community hospitals initiative is successful, it will see the development of new, state-of-the-art healthcare buildings at Mile End that will be central to the delivery of high quality services to the residents of Tower Hamlets, with building works likely to start in 2009/10. It would bring the total capital investment required to meet the PCT's objectives over the 2006-2012 planning period to £44.6 million

3. *Improving Health and Well-being in Tower Hamlets*, the over-arching strategy for primary and community care services developed jointly with the London Borough of Tower Hamlets, which identifies a series of health and social care networks and associated developments based around the Local Area Partnerships (LAPs) and embedded with the joint Local Area Agreement – LAA. This is primarily a revenue expenditure stream and the costs of this are reflected in the PCT's strategic financial plan. The PCT has a comprehensive Estates and Capital Strategy which underpins IHWB. In phase one of this there are ten major schemes for the four localities planned over the 3-5 years. These will deliver brand new integrated care facilities with Primary Care, Community Care, Integrated Care and some secondary care services all under one roof. A complete regeneration and redesign of service provision and facilities is intended.

   The first IHWB facility to be delivered will be the redevelopment of the Barkantine Primary Care practice which will open in December 2007. This is a new build of approximately 4000 square metres and will see the provision of;

   - the existing GP practice plus significant list growth
   - an integrated Primary Care model including dentists and an on-site pharmacy
   - a community Birthing Centre
   - mental health outreach teams
   - re-provision of community services teams including district nurses, school nurses, psychology team and so on

The financing of phase one of the IHWB estates strategy is a mixture of LIFTco development, third sector investment models and RSL partnership agreements. The PCT has taken a 'mixed' financing model approach and a Strategic Outline Business Case has been produced which summarises each scheme within a 'phase one' document. The revenue costs of phase one have been factored into the PCT's 10- year strategic financing model.

2007/08 financial year will see work commence on site for another of the PCT's schemes at St.Pauls Way in Poplar and financial close for the Newby Place LIFT development. A fourth scheme at Harford Street, Stepney, is currently being built and will open in early 2008. The remaining schemes will follow shortly after.

A key assumption in this model is that weighted capitation based funding will continue to flow into those PCT's who have significant population growth. This is outlined in more detail in section 2.6.1 on financial risk.

Investment and disposal strategy – comparison between historical achievement and current plan

£m	**Plan**	**Forecast***	**Current plan**		
	2006/07	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Investment in fixed assets (non-maintenance)	-7341	-6066	-3071		
Investment in fixed assets (maintenance)	-250	-250	-275		
Investment in other assets					
Asset disposals	0	0	400		

* Based on 9 months of actuals plus 3 months of forecast

2.5. Summary of key assumptions

Key assumptions
Financial All financial assumptions are in line with the London Operating Framework. These are outlined below together with other financial assumptions. In particular; ▪ 2006/07 PCT surpluses to be repaid in full in 2007/08 ▪ The second PCT 06/07 top-slice is to be returned in 07/08 ▪ Repayment of initial 2006/07 3% top-slice to be deferred beyond 2007/08 (to be repaid in full by 2010) ▪ top-slice of 3.6% in 2007/08. ▪ Tariff inflation at 2.5% (5% inflation net of 2.5% CIP) ▪ PCT Provider inflation net 2.5% with 2.5% CIP.(Gershon savings). ▪ PPA on the same basis as 2006/07 albeit reduced by 25% ▪ Prescribing uplift of 8% ▪ GMS & GDS uplift of 2.5%. ▪ Additional revenue flexibility of £9.4 million has been returned non-recurrently to NHS London to be paid back in tranches of 50% in 2008/09 and 2009/10. This is an explicit assumption in the PCT 3-year financial plan. ▪ The offering up of £9.4m non-recurrently committed PPA adjustment is deemed to be in lieu of additional top slice to high relative growth Pacts. In total, and including the 3.6% THPCT will be offering up £22m resource flexibility in 2007/08. THPCT's expenditure plan for next year assumes that no additional top slices will be made. Significant investments are included, particularly in reducing health inequalities and mental health services. Further top slices would compromise this investments ▪ Additional MFF pro-rate on net additional activity commissioned in 07/08. ▪ BLT 'refreshed' activity quanta as per the revised 10-year finance & activity model for the NHP. ▪ Population growth element in SLA's at 3% ▪ Demand management schemes will deflect £1.3 million worth of activity mainly IP non-elective ▪ The cost of RTT fully reflected in both 06/07 outturn and 07/08 plan and agreed with BLT. ▪ Over 90% of the value of THPCTs' demand management plan is within non-elective in-patient activity and is worth just over £900k. This element of the demand management plan centres around management of very high intensity users and is a key assumption in setting 2007/08 plan. **General** ▪ All commissioned providers will comply with the general commissioning intentions detailed in section 6 of the *THPCT Commissioning Intentions – 2007-8* (appended) ▪ All commissioned providers will meet Health Care Commission Core Standards and demonstrate plans to achieve HCC developmental standards ▪ Acute activity planning will include 18 week planning in line with national timetables and milestones ▪ Service planning in line with London Operating Framework (as revised), population growth.

2.6. Risk analysis

2.6.6. Financial risk

Commentary on financial risks
From the perspective of service provision THPCT is well placed to manage financial risk in three key areas 1. It has one very major provider of secondary care which is local – Barts & the London NHS Trust 2. It has one secondary Mental health provider which is locality based – East London & the City Mental Health Trust 3. It has one Community and Intermediate Care provider which is part of the PCT structure - the PCT Provider services based at Mile End Hospital and outwith at GP surgeries. All three providers have demonstrated financial stability over the past five years and there are no unresolved financial issues between the THPCT as a commissioner and its Providers. Risk management is made less problematic when the number of significant providers is few rather than many. The functional risks associated with the financial position and viability of THPCT come under the following headings; **Payment by Results**. The risk is clearly that under PbR most activity is paid at full price and there are limited tolerances and marginal rates for additional activity. This means that over-performance on activity quanta will have a serious financial impact. There are a number of ways in which PbR risk is being managed by the PCT. The key factor here is that the vast majority of the PCT's acute activity comes from a single Provider – Barts and the London NHS Trust (BLT). In operational terms therefore, activity risk can be focussed. Firstly the PCT commissions event, spell and HRG level activity information in PbR compliant format from a consortium information service – the East London Common Information Service ELCIS. Monthly data from NWCS (Clearnet) is analysed and compared to activity reports produced by BLT using sophisticated statistical comparison techniques. The PCT uses this information to performance manage activity and cost reports produced by BLT. The benefit of this 'bottom up' approach is that the PCT can Quality Assure current activity cost information, confidently model activity trajectories over the next months and assess the impact of Demand Management plans. The PCT has worked in partnership with BLT and shared this approach at monthly performance management meetings. Some success has been achieved over the last two years in controlling SLA over-performance and this has contributed greatly to the financial stability of the PCT. However there is a significant risk for the end of the current year and early next year due to the fact that the NWCS system was 'switched off' at the end of December 2006. Its replacement is the Secondary Users Services (SUS) system. Migration of raw data from NWCS to SUS is ongoing and will not be available for testing until the middle of January 2007 at the earliest. **Population Growth Impact**. Associated with the PbR risks outlined above, but also in all other commissioning areas, is the impact of population growth on demand for services. This outputs very clearly in additional acute activity costs and primary care list size inflation. THPCT has a 10-year activity and financial tool which includes the model of population growth used by the GLA to inform future service provision. This model differs to the ONS model in that it is based on the number of projected dwellings, which is itself a function of planned building development. The Thames Gateway area is projected to be one of the highest population growth areas in the country over the next ten years. THPCT has used the model to project future capitation based funding and activity costs and as such it is a key planning tool. The principle of capitation based funding and the PCT's strategic 10-year model have been used to demonstrate activity and financial flows in the PFI business model underpinning the New Hospitals project for Barts and the London NHS Trust. It has also been used to plan the 5-year capital service development plan which is at the heart of the PCT's Improving Health & Wellbeing Strategy. The PCT has assumed that the principle of capitation based funding will be upheld in respect of overall NHS financial resource allocations over the next ten years. Departure from this key planning assumption would constitute a significant strategic risk to the PCT. Further work around modelling and fine tuning the LBTH element of population growth has been taken on by the Public Health department's 'Blue Book' group which will link to the PEC in its revised role as a strategic commissioning executive.

Demand Management. The obvious risk of investing in Demand Management schemes is that they do not deliver assumed levels of savings and they are often relatively expensive. One of the benefits of commissioning a well-specified information service for validating activity has been mentioned in the section above – i.e. the PCT can assess with reasonable accuracy the impact on specific HRG's of its Demand Management plans. THPCT has invested significantly into demand management schemes over the last 18 months and has been very prudent in setting financial savings targets from those. The key risk in such investments is that they require clear evidence to assess that they represent good value for money. This needs to be measurable either in reductions of activity quanta or in measurable quality improvements such as length of stay or rates of day case surgery. THPCT produces a monthly Commissioning report that identifies the impacts of Demand Management initiatives and validates savings assumptions against this. The PCT will disinvest from those areas where no reasonable evidence is forthcoming to support continued investment. Areas of best practice nationally will be scrutinised via the PCT's Demand Management sub-committee of the board. Recommendations for funding Demand Management initiatives are subject to a formal business case review process b y this group.

Practice Based Commissioning. ELCIS use the same monthly activity reports outlined above to produce practice based budget statements by HRG**.** Monthly reports are delivered according to an agreed timetable along with referrals information. The PCT finance function has recruited a specific post to liaise with ELCIS to produce, review and issue monthly PBC budget statements to practices.

It is crucial to the success of PBC that budgetary information is fit for purpose, that practices are adequately resourced and that appropriate incentives are in place. The section on PBC above 2.2.6 describes this further.

Gershon Savings

The PCT has established a 'Gershon savings' group to oversee the delivery of the savings target. The target of £1.3m for the current year will be substantially achieved and planning for 2007/08 is well developed. The group includes the Director of Finance, the Head of Procurement and Heads of Service representatives from Provider Services. It is chaired by the Deputy Chief Executive and progress is reported monthly in the Finance and Performance Board report.

A key delivery area will be the achievement of recurrent establishment savings through reductions in agency and bank staff use. This particular area is both the largest and technically most difficult element within the Gershon target, accounting for some £500k. The PCT is ensuring that savings targets are delivered in this area by setting up a dedicated bank and agency staffing work stream as a specific focus within the Gershon group.

Additional resource top slice

As outlined in section 2.5. THPCT is offering up additional £9.4m over and above the 3.6% top slice for next year. THPCT expenditure plan contains significant investment , particularly in reducing health inequalities and increasing mental health services. Any further resource top slice would clearly adversely impact these plans.

2.6.7. Service provision risk

Commentary on services provided and associated risks
The risks associated with service provision for THPCT come under two main headings: **Meeting all national and local targets** **The services offering the greatest short-term risk to the delivery of targets are all associated with workforce and capacity issues**. These are: the 18 week wait, the reduction of HCAIs, improving the management of patients with Long Term Conditions, and the improvement in overall service quality in some

primary care practices and in the Mental Health/Substance misuse provider.

18 week wait. With investment and redesign, all major service providers are currently anticipating delivery of the 18-week target. The margins for error are, however, minimal, and if any provider finds that their capacity planning is inaccurate there will be little scope, in year, for changing their plans significantly. THPCT are well aware of this risk and are currently challenging assumptions and plans that appear less than robust. Close monitoring of performance against trajectories is also planned for 2007-8 to identify and address any difficulties as early as possible. THPCT has already agreed early principles with BLT as lead commissioner for London Pacts and this is reflected in both the activity profiling set out in activity planning section and commissioning efficiencies.

Audiology has been identified nationally as a risk area across the NHS in respect of the 18-week target. Within Tower Hamlets, an action plan has been drawn up and is currently under review.

HCAIs: The risk in this area is around the development and implementation of appropriate reporting and performance management processes. The extension of the target from hospitals to all health care settings brings challenge around auditing, reviewing and then changing practice in a wide range of settings. A programme of review and of staff training has been put in place for 2007-8, and it is possible that increased reporting will initially suggest that performance is deteriorating rather than improving, because the baseline was not previously known. Performance against these new indicators will be closely monitored by providers and commissioners, with a view to rapid response if necessary.

LTCs: There is a range of difficulties in achieving significant in-year improvement in the care of these patients. These include the need to establish new services, recruit additional staffing whose skills are relatively scarce, audit and performance manage key areas that are performing below average and shift dominant care pathways away from hospitals and towards community settings. An associated shift in the culture of services caring for these patients from control to empowerment is also an underlying issue. The provider services have a detailed action plan in place to drive the necessary changes, and the commissioners are developing performance indicators to monitor the changes. Quantifiable plans are set out in the commissioning efficiency section.

Primary Care: A small number of Primary Care practices perform consistently below benchmarked acceptable standards, and local patient surveys continue to identify primary care access as a significant concern. THPCT has taken direct management of a number of previously poorly performing practices, and has established a robust performance management regime and balanced scorecard to monitor practice performance. Practice performance will be closely monitored throughout the year, and corrective action taken swiftly, if necessary.

Mental Health and substance misuse: There continues to be a range of issues around the quality of service provision by the major MH provider to THPCT. The PCT has been working closely with the provider to change the situation, and substantial investments have been made to support improvement. However, some of the change required is cultural or behavioural, and even with extensive management intervention and monitoring, these can be the hardest and slowest things to change. The need to enhance staff skill levels to meet new challenges, and the anecdotally increasing dependency and need of the local population means that achieving improvement is hard for all concerned. While action plans and performance management frameworks are in place for key areas, there remains concern about how totally the changes can be achieved in year and therefore the impact on targets.

The second main category of risk relates to the population's demography and health. This is a relatively young population, although one with relatively poor health and a high prevalence of risk factors. As this population ages, and particularly the South Asian component with a high prevalence of diabetes and other risk factors, there is a danger that morbidity and mortality from cardiovascular disease and diabetes will worsen. Furthermore, making a change depends partly on supporting people to make lifestyle changes, for example taking more exercise, reducing obesity, smoking and teenage pregnancy rates. While there is clearly room for service improvement to reduce health inequalities in many areas, these interventions will impact initially on a ‘tail’ of easier to influence individuals, as has happened with smoking cessation. Here, great success was initially

achieved in encouraging smokers to quit, but the success has tailed off, as the individuals who were motivated to give up have become non-smokers, and the residual smokers are those who are not persuaded of the desirability of giving up. Achieving the necessary lifestyle changes to continue and really impact on the long term health of the community will be dependant on reaching less willing participants, and may be made more difficult by the deprivation and diversity of the area.

Finally there is a substantial time lag between making changes in lifestyle and risk factors and morbidity and mortality. This is particularly the case for cancer and respiratory disease and to a lesser extent cardiovascular disease.

THPCT has already agreed a range of targets as part of the Local Area Agreement with the LBTH. These set out clear targets which reflect the ambition of both THPCT and LBTH in tackling some of the key underlying inequalities across the borough. The risks outlined underlie our intention to invest substantially in improving health, early detection and better management of patients with risk and with disease. However, they will continue to pose a challenge.

Taking these factors into account, it is anticipated that the PCT will achieve its health improvement targets for 2007/8, but that, in the longer term, some of these lifestyle choice issues will become increasingly challenging in delivering improvements.

2.6.8. Governance risk (including emergency planning and quality)

Commentary on governance and associated risks

Risk: Quality not embedded in the commissioning process
Action:

- incorporate the quality specification for provider and commissioned services within agreed SLAs. The achievement of the quality specification is monitored through each SLAs performance management arrangement and reviewed twice yearly at the PCTs clinical governance sub-committee. The quality specification will include;
- a requirement for all providers to demonstrate evidence that they have effective mechanisms in place to monitor the quality of the patient experience and that they are acting on feedback
- a range of clinical and public health outcomes will be included within the quality specification
- an expectation that core standards will be met (all provider organisations will be expected to show their evidence logs as part of the performance management process)
- Restructuring the PCT's clinical governance sub-committee (CGSC) in order to ensure that quality of all commissioned services is effectively monitored/developed. These new arrangements, as well as the performance management of the range of providers by the commissioning teams, will ensure that quality and the patient experience is effectively embedded in the commissioning process.
- Embedding relevant quality metrics and mechanisms to monitor and manage this information effectively

Risk: Inability to demonstrate that we are meeting the duty of quality across provider services
Action:

- With the change to the PCTs CGSC new structures/processes within the provider directorate will be developed/embedded so that clinical governance is effectively coordinated and managed within the new organisational arrangements. This may include the need for allocation of resources to support development of processes.

Risk: Lack of effective and timely clinical leadership/engagement and service user engagement within all service redesign/decommissioning discussions/ ineffective service redesign

Action:

- Ensuring an effective evidence base for decision making
- Continue to develop the clinical engagement network and infrastructure to support
- Ensuring that there are appropriate arrangements in place to assess and advise project managers on the implications of service redesign on governance arrangements - particularly critical considering the range of new models of care being proposed and associated changes in expectations on the workforce and the cross

The major incident and business continuity plans was updated and tested in accordance with NHS emergency planning guidance. We applied the principles of integrated emergency management (assessment, prevention, preparation, response and recovery) and consulted major partners (Acute Trust, Local Authority, neighbouring PCTs). Training on the updated plans was undertaken by the Major Incident Team (Directors). The Designated operational emergency planning officer oversaw the maintenance of plans and the incident room. The updated plans are on the PCT intranet. Briefings and training for staff at all levels in the organisation is still to be undertaken.

Risk: Emergencies which have a major impact on business continuity
Action:

- The major incident and business continuity plans have been updated, in consultation with our major local partners and neighbouring PCTs. They have been tested in accordance with NHS emergency planning guidance and the plan has been widely publicised and is available to all staff. We will undertake a more substantive exercise during 07/08.
- Directors have received training and we are developing and will implement a programme for briefing and training other relevant staff across the PCT during 07/08.

Risk: Flu pandemic
Action:

- The PCT is leading the production of a multi-agency plan which is in its final draft, agreed by partners and will be signed off by the PCT and other organisations by April. This addresses the principal issues such as communication, contingency planning, health and other service continuity as well as preparation.
- We have a PCT plan which has been updated following the London exercise last year. That will be updated based on the feedback from the HPA and in coordination with the multi-agency plan.
- We are still awaiting national guidance on some important issues and others need resolution at a London level. We are working with the London group to mitigate the risks posed by the absence of guidance.

2.6.9. Other risks

Commentary on any other risks
Suitability of information systems. Fitness for purpose identified that THPCT needed to enhance its' systems for reporting information. We have moved quickly to bring forward plans already in our ICT business plan to mitigate this risk ▪ Practice Based Commissioning. A report is produced monthly for each practice. ▪ Balanced Scorecard. This has been redeveloped and is now managed by the Information department ▪ Midas and Performance Accelerator. Two new IT applications have been developed Midas – a web based tool allowing viewing of hospital HES data and reports, Performance Accelerator – a web based tool allowing the monitoring of the PCT's governance and performance management framework. ▪ Data Warehouse. With the implementation of Emis Web in 2007, we are looking to create the foundation for a data warehouse based on the GP data sets of the 38 practices within Tower Hamlets, which are currently being uploaded to Emis Web, with the hospital data sets returned by the acute

systems. The potential of such a system is enormous.

Barts and the London (BLT) PFI: as part of the final deal for the FBC for the new hospital at BLT it was agreed to reduce the originally planned bed numbers by 250. BLT is currently reviewing the impact on the building programme. THPCT is also in discussion with BLT on the opportunities this affords to accelerate the pace of shifting activity from BLT into primary care settings as part of the Health and Well Being Strategy.

3. Declarations and self-certifications

3.2. Board statements

Commentary

Appendix 1

PCT Operating Plan 2007/08 Self-Certification

NHS London

1. Declarations and self-certification

The Board is required to confirm that:	
Board processes	**Tick**
The Board maintains a register of its members' interests, and can specifically confirm that no members of the Board have material conflicts of interest	☒
The Board is satisfied that all Directors are qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	☒
A selection process and training programmes are in place to ensure that non-executive directors have appropriate experience and skills	☒
The decisions taken by the Board comply with its legal duties	☒
The Board is satisfied that the PCT operates its systems of financial and clinical governance in accordance with recognised good practice for NHS organisations	☒
Strategy and planning	**Tick**
The Board is satisfied that the PCT has produced a current strategic plan as required by the PCT Commissioning Regime for London (not applicable in 2007/08)	☐
The strategic plan defines specific strategic goals around the health status of the population, clinical outcomes, and patient experience (including diverse and hard-to-reach groups), which include health improvement and the reduction of health inequalities (not applicable in 2007/08)	☐
Clinicians, patients, the public, and other stakeholders were involved in developing the strategic plan (not applicable in 2007/08)	☐
Appropriately detailed contracts and SLAs have been agreed with providers	☐
The Board is satisfied that the assumptions used in operational planning are clear, transparent, reasonable, and consistent with the PCT's contracts and SLAs	☐
Delivery	**Tick**
The Board is satisfied that the necessary planning, performance management, and risk management processes are in place to deliver the operating plan	☐
The management team has the capability and experience necessary to deliver the operating plan	☒
The PCT has processes in place to ensure appropriate management and staff are recruited to discharge the PCT's functions	☒
The PCT has processes in place to ensure management and staff are adequately trained, developed, held to account, and incentivised to deliver against the PCT's objectives	☒
The PCT's information systems are suitable for fulfilling its financial and clinical needs and the information is used for performance management	☒
Financial governance	**Tick**
The Board is satisfied that the PCT has effective financial accounting and reporting arrangements, providing accurate, timely, 'true and fair' accounts and reports	☒
The PCT manages its significant financial risks effectively, with a Board-approved risk management strategy (using the format recommended by the Department of Health) and internal audit function	☒
The PCT has arrangements to ensure probity and propriety in the conduct of its business, including a register of interests, a counter-fraud and corruption policy, and a complaints procedure	☒
The PCT's information systems are suitable for fulfilling its financial and clinical needs and the information is	☐

used for performance management	
Clinical governance	**Tick**
The Board is satisfied that, to the best of its knowledge and using its own processes (supported by Healthcare Commission metrics and including any further metrics it chooses to adopt), the PCT has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	☒
The Board is satisfied that plans are in place to ensure that all relevant national core standards and targets can be met going forwards *[see table in Section 2]*	☒
The PCT has effective processes for monitoring (in qualitative and quantitative terms) the experience of the full range of patients and other users of services provided by the PCT	☐
The PCT has effective processes for monitoring (in qualitative and quantitative terms) the experience of the full spectrum of patients and other users of services commissioned by the PCT (including primary care)	☐
The PCT effectively monitors and manages (a) the clinical and public health outcomes of its own provider arm, with clearly tracked, owned and understood metrics and a system of intervention; and (b) that its provider clinicians are appropriately qualified and trained	☐
A broad cross-section of practices are involved in the work of the PCT, including being represented on PECs, participating in designing care pathways, and reviewing provider data	☒
The PCT is achieving its targets as set out in the Local Area Agreement	☒
Relationship management	**Tick**
The PCT engages effectively with local authorities and a wide range of other partners to provide coordinated health and social care	☒
The PCT has complied with major NHS London and Department of Health initiatives and requirements in the past year, including Serious Untoward Incident notification	☒
The PCT has responded appropriately, in a timely manner, to all major regulators and audit reports	☒
The PCT has robust and constructive relationships with all its providers	☒
The PCT obtains and understands input from a representative, broad group of patients through a public patient involvement strategy	☒
Emergency planning	**Tick**
The Board is satisfied that the emergency preparedness function is appropriately governed and managed in accordance with NHS guidance	☒
The Board is satisfied that sufficient resources have been identified for the emergency preparedness function planning, and that these are in place	☒
An up-to-date Major Incident Plan is in place containing all elements required by the NHS Emergency Planning Guidance (e.g., consultation with major partners)	☒
Emergency preparedness is supported by appropriate exercises, training and testing	☒
Overall compliance	**Tick**
The Board will ensure that the PCT remains at all times compliant with its statutory duties and operates within the parameters set by NHS London and the Department of Health	☒
The Board has considered all likely future risks to the PCT's compliance with its statutory duties and these parameters, their probability of occurring and potential severity, and the plans for mitigating them	☒
The Board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance	☒

Signed on behalf of the Board	
Chief Executive and Accountable Officer	**Chair**

PCT name
Tower Hamlets Assumptions : Where a declaration not applicable in 2007/08 the box has been left unchecked. Where it is requires that the Baord has seen the Operating Plan and given positive affirmation, this has ben left unchecked. The next PCT Board is on the 18th January when it will consider Operating Plan.

2. National core standards and targets

2.1. Existing national targets in 2006/07

The Board must confirm that the levels of service set through the 2003-06 planning round are being maintained by the PCT. These are considered the basics of what organisations should be doing.

The table below shows the existing national targets for PCTs.

Target
Access to a primary care professional within 24 hours and to a primary care doctor within 48 hours
Maximum waiting time of one month from diagnosis to treatment for all cancers
Maximum waiting time of two months from urgent referral to treatment for all cancers
Maximum waiting time of two weeks to first outpatient appointment for all urgent suspected cancer referrals
All ambulance trusts to respond to 95% of category A calls within 19 minutes
All ambulance trusts to respond to 75% of category A calls within 8 minutes
All ambulance trusts to respond to 95% of category B calls within 19 minutes
Access to crisis services and comprehensive child and adolescent mental health service for all who need them
All hospital appointments booked for patient convenience, with patients able to choose from at least four different health care providers for planned hospital care paid for by the NHS
Minimal level of delayed transfers of care
Minimum of 80% of people with diabetes offered screening for early detection (and treatment if needed) of diabetic retinopathy (with 100% by 2007)
Maximum wait of 26 weeks for inpatients
Maximum wait of 13 weeks for an outpatient appointment
Maximum wait of three months for revascularisation
Practice-based registers updated so patients with coronary heart disease and diabetes receive appropriate advice and treatment in line with national service frameworks; practice-based registers and systematic treatment regimes – including appropriate advice on diet, physical activity, and smoking – cover the majority of patients at high risk of coronary heart disease, particularly those with hypertension, diabetes, and a BMI greater than 30
Ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help
Maximum four hours wait in A&E from arrival to admission, transfer, or discharge

2.2. New national targets in 2006/07

The Board must confirm that the PCT has plans in place to ensure that the new national targets can be met going forwards. These targets cover what PCTs are required to do to demonstrate they are developing and sustaining improvement.

The table below shows the new national targets for PCTs.

Target
Reduce the under-18 conception rate by 50% by 2010, including by guaranteeing access to a genito-urinary medicine (GUM) clinic within 48 hours of referral
Reduce mortality rates from heart disease and stroke by at least 40% in people under 75, with a 40% reduction in inequality between the bottom fifth of areas and the population as a whole, by 2010
Reduce mortality rates from cancer by at least 20% in people under 75 by 2010, and reduce inequalities by 6%
Halt year-on-year rise in obesity among children under 11 by 2010
Reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%
Increase the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care by 2008
Offer a personal care plan for vulnerable people most at risk and reduce emergency bed days by 5% by 2008
Ensure nobody waits more than 18 weeks from GP referral to hospital treatment
Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth
Increase the participation of problem drug users in treatment programmes by 100% by 2008 and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes
Ensure individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys
Reduce adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less
Achieve year-on-year reductions in MRSA levels, expanding to cover other healthcare associated infections

Appendix 3
Financial and Activity Template

Introduction

This document provides the financial and activity templates which PCTs should complete as part of their Operating Plan for 2007/08.

Instructions

Further detailed instructions for the completion of these templates will be provided following consultation with a number of PCT Finance Directors. Comments are provided on the various worksheets to aid in completion.

Sheet descriptions

Summary financial forecast - this sheet is used to provide an overview of the current and future financial position of the PCT and is critical to the evaluation of financial risk rating of the PCT.
Cash position overview - this sheet is used to provide a brief overview of the cash position of the PCT; this information is not used in the risk rating of the PCT.
Secondary care - this sheet is used to provide an overview of the levels of activity that are being commissioned by the PCT from acute care; it also allows evaluation of the impact of demand management initiatives on activity levels.
Commissioning efficiency plans - this sheet is used to provide details of demand management iniatives (across all settings of care), together with their estimated financial impact.
CIPs and turnaround - this sheet is used to provide an overview of the impact of cost improvement programmes and turnaround plans.
07 08 Operating Plan exhibit - this sheet is used to provide input to the exhibits within the 2007/08 operating plan and is mostly a direct summary of the blue tabbed sheets, but requires some information to be directly input

Cell colour coding

PCTs **must** complete all pale yellow shaded cells in the template - they are the only unprotected cells.
White cells contain information calculated by the template
Results of check cells are shown in **red** where there is misalignment between inputs and should be corrected prior to submission

Generic instructions

All financial figures should be entered in £'000
Please ensure all costs are entered as negative numbers

Summary financial forecast

The figures you enter in this sheet will automatically populate the 2007/08 Operating Plan exhibit worksheet
Please ensure all costs are input as negative numbers

£'000	Plan 2006/07	Forecast* 2006/07	Forecast 2007/08	Forecast 2008/09	Forecast 2009/10
Income					
Recurrent revenue allocation	360690	360690	396136		
Non-recurrent revenue allocation	-34333	-21816	-28241		
Other income (excluding income from provider activities)	1600	1600	1650		
Total income	**327957**	**340474**	**369545**		
Expenses					
Commissioning activities:					
Primary care - GPs, prison healthcare, dentistry, and optometry:					
GP	-35346	-35596	-40121		
Prescribing	-27347	-27447	-30049		
Other	-10191	-10191	-10467		
Community and intermediate services	-47419	-47419	-51439		
	-68876	-68876	-73334		
Mental health commissioning, pooled arrangements or jointly funded commissioning					
Secondary care					
Provided under PbR					
Inpatient elective	-8654	-8654	-10384		
Day care elective	-5823	-5823	-6987		
Inpatient non-elective	-34270	-34270	-41119		
Outpatient	-9256	-8256	-9906		
Provided at local prices	-3230	-3230	-3876		
Provided by third sector/not-for-profits	0	-850	-871		
Provided by independent sector	0	0	-1800		
A&E	-8253	-8253	-8910		
Other	-31499	-41727	-36807		
Ambulance services	-4967	-4967	-5141		
Tertiary and specialist commissioning	-27484	-27484	-28671		
Total cost of commissioned services	**-322615**	**-333043**	**-359882**		
Provider Activities:					
Pay expenditure	-58358	-58358	-60734		
Non-pay expenditure	-23308	-24262	-24519		
Less - provider income	81666	82620	85253		
Net provider costs	**0**	**0**	**0**		
Other costs					
Other pay expenditure	-1081	-1081	-1108		
Other non-pay expenditure	-518	-929	-5874		
Depreciation and amortisation	-3043	-2616	-2681		
Exceptional items		-105			
Total cost	**-327257**	**-337774**	**-369545**		
PCT surplus/deficit in year	**700**	**2700**	**0**		
PCT normalised position (excluding exceptional items)	**700**	**2805**	**0**		

* 9 month actuals plus 3 month forecasts

Cash position overview

This worksheet requests a brief overview of the PCT's cash position

£'000

Forecast cash limit 2007/08	366612
Return of 2006/07 loan (-ve) / deposit (+ve)	5000
Forecast 2007/08 loan (+ve) / deposit (-ve) requirements	0
Total (Forecast cash utilisation)	**371612**

Secondary care commissioning activity

This worksheet requests the PCT's secondary activity and cost forecasts. Note that this should reflect the PCT's best information about levels of activity
Please ensure all activity reductions are input as negative numbers
Please ensure all costs are input as negative numbers (cost savings will then appear as positive numbers)

£'000
Spells, or attendances as appropriate

These baseline figures represent what would occur should you not have any demand management initiatives from 07/08

This is the 'in-year' reduction in activity due to demand management that needs to be entered by PCT

	Baseline Demand Forecast (excluding all demand management in 06/07, 07/08 and 08/09)					Impact of demand management (savi					Net Demand Forecast (including all demand management)				
	Plan 2006/07	Forecast 2006/07	2007/08	2008/09	2009/10	Plan 2006/07	Forecast 2006/07	2007/08	20 09	2009/10	Plan 2006/07	Forecast 2006/07	2007/08	2008/09	2009/10
Total Yearly Activity															
Inpatient elective	5730	5513	5834								5730	5513	5834		
Day case	14737	14240	15189					-100			14737	14240	15089		
Inpatient non-elective	21436	20345	20838			-436	-288	-852			21000	20057	19986		
Outpatient (new and follow-up)	67480	66070	67381			-1000	-295	-1456			66480	65775	65925		
A&E attendances	119514	119280	120428								119514	119280	120428		
Cost															
Inpatient elective	-8654	-10479	-11088			0	0	0			-8654	-10479	-11088		
Day case	-5823	-9035	-9574			0	0	0			-5823	-9035	-9574		
Inpatient non-elective	-35224	-33915	-35089			954	630	998			-34270	-33285	-34091		
Outpatient (new and follow-up)	-9349	-6970	-7335			93	-17	210			-9256	-6987	-7125		
A&E attendances	-8253	-7789	-7772			0	100	100			-8253	-7689	-7672		
Other secondary costs	-31499	-31499	-58057			0	0	0			-31499	-31499	-58057		
Total costs	**(98,802)**	**(99,687)**	**(128,915)**												
Total cost savings (before implementation cost)						**1,047**	**713**	**1,308**							
Net cost											**(97,755)**	**(98,974)**	**(127,607)**		

This is the gross cost impact of demand management (i.e excluding implementation costs)

Commissioning efficiency plans

(e.g., demand management and prescribing efficiencies)

The figures you enter in this sheet will automatically populate the 2007/08 Operating Plan exhibit worksheet
Please ensure all costs are input as negative numbers
Please ensure savings are input as positive numbers

£'000

Item	Description of initiative	Gross forecast savings					Implementation Costs					Net forecast savings				
		Plan 2006/07	Forecast 2006/07	2007/08	2008/09	2009/10	Plan 2006/07	Forecast 2006/07	2007/08	2008/09	2009/10	Plan 2006/07	Forecast 2006/07	2007/08	2008/09	2009/10
CAS - Musculo-Skeletal	CAS - Musculo-Skeletal	60	158	194			-60	-130	-150			0	28	44		
CAS - Dermatology	CAS - Dermatology	0	0	162			0	-45	-100			0	-45	62		
C2C Referral Review	C2C Referral Review	13	0	231			0	0	0			13	0	231		
Clinical Exclusions Policy	Clinical Exclusions Policy	0	0	134			0	0	0			0	0	134		
A&E Streaming to WIC	A&E Streaming to WIC	0	100	100			0	0	0			0	100	100		
Service Redesign	Service Redesign	0	0	4			0	0	0			0	0	4		
LTC	LTC	974	740	833			0	-110	-200			974	630	633		
OP - GP Referral Review	OP - GP Referral Review	0	0	100			0	0	0			0	0	100		
Review of GMS ES	Review of GMS ES	0	0	0			0	0	0			0	0	0		
Prescribing - Statins etc	Prescribing - Statins etc	0	0	777			0	0	-600			0	0	177		
Other initiatives												0	0	0		
Total		**1047**	**998**	**2535**			**-60**	**-285**	**-1050**			**987**	**713**	**1485**		

CIPs and turnaround plans

The figures you enter in this sheet will automatically populate the 2007/08 Operating Plan exhibit worksheet
Please ensure all costs are input as negative numbers
Please ensure savings are input as positive numbers

£'000

Item	Description of initiative	Gross forecast savings					Implementation Costs					Net forecast savings				
		Plan 2006/07	Forecast 2006/07	2007/08	2008/09	2009/10	Plan 2006/07	Forecast 2006/07	2007/08	2008/09	2009/10	Plan 2006/07	Forecast 2006/07	2007/08	2008/09	2009/10
Procurement Savings	Savings from Internal PCT Sou	330	320	500			0	0	0			330	320	500		
Reduction in Agency and bank	Reduction in bank	500	410	400			0	0	0			500	410	400		
Budget review	Removal of Discretionary budge	440	440	0			0	0	0			440	440	0		
Skill Mix Review	Skill Mix Review	0	0	250			0	-40	-25			0	-40	225		
Review of OAT Charging	Review of OAT Charging	0	0	50			0	0	0			0	0	50		
Review of Non-Charged Activit	Review of Non-Charged Activity	0	0	75			0	0	0			0	0	75		
Review of Provider Casemix	Review of Provider Casemix	0	0	50			0	0	0			0	0	50		
Management Cost Savings	CPLNHS Management Cost Sa	413	413	500			0	0	0			413	413	500		
Initiative 9 [please specify]												0	0	0		
Initiative 10 [please specify]												0	0	0		
Other initiatives												0	0	0		
Total		**1683**	**1583**	**1825**			**0**	**-40**	**-25**			**1683**	**1543**	**1800**		

2007/08 in-year breakdown of activity plan						
'000 spells (attendances – outpatients, A&E)	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**Check to secondary care**
Inpatient elective	1576	1284	1343	1631	5834	5834
Day case	4074	3320	3470	4225	15089	15089
Inpatient non-elective	4974	4576	4974	5372	19896	19986
Outpatient (new and follow up)	17800	15163	14504	18458	65925	65925
A&E attendances	30107	27698	30107	32516	120428	120428

Tackling the 18 Week Patient Pathway: January 2007 Board Update

1. Background

1.1 The NHS Improvement Plan included a DH Target for no-one to wait longer than 18 weeks from GP referral to hospital treatment by December 2008.

1.2 The DH set milestones which the NHS is expected to meet as part of moving towards meeting the target. The rationale for the milestones is that achieving the milestones will require local health economies to work closely together, implementing the 10 High Impact Changes and delivering on key agendas, including the Integrated Service Improvement Plan (ISIP).

The milestones set in the DH Implementation Framework are detailed below.

	Mar 06	*Mar 07*	*Mar 08*	*Dec 08*
Outpatients	13	11	5	18 weeks in total
Diagnostics	26	13	6	18 weeks in total
Inpatients	26	20	11	18 weeks in total

Table 1

1.3 These milestones were adjusted in November 2006 as the DH sought to accelerate the pace at which the NHS addressed 18 weeks. The revised milestones set out by the DH for March 2008 will be **85%** within 18 weeks for admitted patients and **90%** for non-admitted patients.

1.4 These are extremely challenging targets for the NHS as a whole to achieve. The estimated cost for 2007/08 for the NHS as a whole is estimated at £1,400m, with £1,000m on reducing waiting times and £400m on improving access to diagnostics.

1.5 In addition, the expectation is that by December 2008, all primary care referrals covered by the 18 week pathway to be made through Choose and Book. Current performance for November 2006 showed that overall TPCT GPs are currently using Choose and Book to make 54% of all referrals to secondary care. The challenge is to continue progress towards the March 2007 target which is set at 90% of referrals made through Choose and Book.

2 Principles and definitions

2.1 The underlying principle of the 18 week programme is that patients should receive excellent care without unnecessary delay. The target focuses closely on pathways that either do or involve medical or surgical consultant led care. The programme sets a maximum time of 18 weeks from the point of initial referral up to the start of any treatment necessary for all patients who want it and for whom it is clinically appropriate.

2.2 Key to understanding the 18 week programme is the definitions used when the measurement begins at the start of the patient journey to when it stops ie clock starts, clock continues and clock stops. It is important to note that the 18 week programme is restricted to fundamentally elective inpatient and outpatient activity.

2.3 Referrals from GPs to therapies and mental health services in primary and community settings are not covered by the 18 week programme. However, there is an expectation that local health communities will work towards reducing waiting times. This will include a focus on areas where there are known capacity issues, including psychology services.

2.4 Clock starts

For most patients the start of the elective pathway begins with a GP referral to a consultant in secondary care. 18 weeks also covers referrals to hospital consultants from:

- General dental practitioners
- GPs with a special interest
- Optometrists and Orthoptists
- A&E }
- Minor Injury Units } where patients are transferred to an elective pathway
- Walk in Centres }
- Sexual Health clinics
- National screening programmes (for non-malignant conditions)

- Specialist nurses are allied health professionals where PCTs have agreed this locally
- Consultant to consultant referral for a different condition (other than the one in the original referral) agreed by primary care
- Cancer services (including the 62 day wait)

2.5 Clock Continues

The clock continues along the pathway when the patient is receiving care as part of the 18 week programme. This includes:

- Diagnostics (as part of the pathway)
- Therapies (as part of the pathway)
- Consultant to consultant referrals for the same condition
- Tertiary referrals
- Multi-organisational pathways ie where patients are referred from one organisation to another
- Intermediate services

2.6 Clock Stops

The end of the 18 week pathway and clock stop will be at the start of definitive treatment. Definitive treatment is defined as:

- Admission as a day case or inpatient
- Start of outpatient treatment
- Fitting of a medical device decided on by a consultant
- Start of active monitoring
- No need for treatment in secondary care
- Patient declines treatment

It is important to note that the clock does not stop when a patient is admitted for a diagnostic procedure.

3. Data Collection and Monitoring

3.1 Mandatory Formal data collection began in January 2007. Previously, eight pioneer sites worked with the DH to develop IT solutions to the following:

- Developing a management information system to track referral to treatment
- Agreeing tolerances and exemptions
- Developing integrated approaches to pathway management
- Developing and testing service improvement approaches

The DH has developed a specific methodology for useage. The PCT is now collecting data but it must be highlighted that, at this stage, it remains problematic and makes 18 week planning an inexact science.

4 National Priorities

Nationally 3 areas have been highlighted as presenting particular changes. The section below sets out the work taken forward locally.

4.1 Orthopaedics.

Locally, initiatives such as Physiotherapy screening for back pain prior to referral to a surgeon have been instituted. This has been supplemented by the Musculo-skeletal Clinical Assessment Service (CAS) set up in May 2006.

4.2 Audiology.

The majority of concern nationally stems from the estimated 20% of adult referrals which come from consultants rather than primary care. This is of particular interest as this is a service provided by the PCT and was recently identified as a national outlier in terms of waiting times. However, the Head of Audiology has confirmed the position with the DH that patients waiting

for planned reviews, including hearing and re assessments, are excluded from the diagnostic waits returns. This has resulted in a significant fall in the numbers of adults defined as waiting for a diagnostic service (and hence part of the 18 week programme). Locally, the picture has improved for adult hearing aid referrals from ENT.

	October	November	December
<13 weeks	176	125	65
> 13 weeks	170	136	23
52 weeks +	45	1	0

Table 2

This issue forms part of the review of ENT services included in the ISIP

4.3 Endoscopy.

This has been a major focus of the BLT service improvement programme and significant improvements in waiting times have already been achieved. There are currently only 4 patients waiting over 13 weeks.

5 Planning to meet the 18 week target

5.1 As part of planning for 2007/08 the PCT has agreed LDP trajectories for the move to 18 week waits with BLT. These will become a key performance measure for both the PCT with NHS London and between THPCT and BLT. The PCTs' Commissioning Intentions for 2007/08 have set out that we plan to meet the planned activity levels through a combination of service re-design and affordable investment. It is worth noting that at Month 8 (November) there were no patient breaches of either inpatient or outpatient waits for Tower Hamlets patients.

5.2 THPCT plans for 2007/08 are set out in the Operating Plan which is include in Board members pack and was submitted to NHS London on 15th January.

5.3 Both THPCT and BLT are modelling activity for next year on the basis of 4 week wait for outpatients, 4 weeks for diagnostics and 10 weeks for an inpatient work. This will be reflected in our contract with BLT. We feel this gives us the best opportunity to meet the March 2008 milestones. Our current plans (yet to be finalised and agreed) are that we will need to commission the following activity levels over the next two years:

	Stock reduction 2007/08	Stock reduction 2008/09
Outpatients (attendances)	**2376**	**264**
Day case (finished consultant episodes)	**842**	**149**
Inpatients (as above)	**330**	**58**

Table 3

(stock reduction is the amount of additional activity we need to commission in order to get the waiting times to meet national milestones. 18 weeks then becomes the normal planning framework).

The proposed stock reduction in 2007/08 represents approximately £4m of investment. Board members will note that this is the single largest proposed investment set out in the Pacts commissioning intentions for next year.

Table 4 below sets out our LDP trajectories in relation to the revised March 2008 milestones

% of admitted patients treated in 18 weeks (April 2007)	**33% (March 2008: 85%)**
% of non-admitted patients treated in 18 weeks (April 2007)	**85% (March 2008: 90%)**

Table 4

5.4 Outpatients

Current BLT average wait for outpatients is 7 weeks. The vast majority of specialties are below this as at the November 2006 snapshot. The main areas of concern are anaesthetics, colorectal surgery, ENT, neurophysiology and a range of paediatric specialties. However, the snapshot shows that there is considerable work to be done to meet the 2008 milestone and get to our local planning milestone of 4 weeks. As part of our contracting with BLT for next there will additional performance management indicators in place including agreed first to follow up ratios.

5.5 Diagnostics

Access has improved considerably over the past two years. Previously patients were waiting routinely over 26 weeks for a diagnostic procedure ie MRI, CT or ultrasound scans. For Tower Hamlets patients, there are only two areas where there are waits in excess of 26 weeks, audiology as noted above and neurophysiology at BLT. This area has improved since August when reporting began. At that point there were over 160 waiting over 13 weeks and of those 50 had waited over 26 weeks. This is now down to 120 (13 weeks) and 30 (26 weeks).

From 2005, patients facing long wait for scans have been offered the choice of going to another provider to have their scan more quickly. This has been rolled out in 3 phases with the 3rd phase due to begin in April 2007 when patients who do not have an appointment in 13 weeks will be offered choice. The procedure will still have to be completed in 13 weeks.

Finally, from April 2007, the DH contracted independent sector provider, Amicus, will begin offering diagnostic services in Tower Hamlets. This will represent an extension of both choice and capacity and will see additional MRI scans, echocardiogram, and ultrasound tests commissioned.

5.6 Inpatients

Average inpatient wait at BLT is 8 weeks. The main areas above this average are haematology, plastic surgery, trauma and orthopaedics and vascular surgery. Paediatric activity again remains a concern.

The PCT already has a robust service re-design programme in place managed through the ISIP Board. This has identified key areas for re-design which are linked to creating more capacity at BLT (increased day case rates instead of in patient work), improved efficiencies in line with the 10 high impact changes. In addition, Practice Based Commissioners have identified a number of areas for re-design, which will impact on outpatient work in 2007/08. These are set out in the Commissioning Intentions document.

In addition, the PCT needs to reduce inappropriate demand for acute services through its demand management programme. This will include

a) Pre-referral: improving the appropriateness of referrals to secondary care and maximising patients' ability to self care
b) Post first appointment: improvement throughput by maximising efficiency in the hospital part of the pathway (pre-admission, day case, diagnostics etc) and reducing inappropriate follow ups.
c) Discharge: Ensuring patients are discharged promptly, that follow up takes place in the most appropriate setting and the ability to self care is embedded in the discharge part of the pathway.

Recommendations

The Board is asked to note this report and to raise any points or concerns.

Strategic Commissioning
January 2007

Comments on the NHS London Primary Care Trust Commissioning Regime

Set out below are draft comments on the proposed Commissioning Regime, which have been discussed by London PCT CEOs. The Board is asked to support these comments on the Tower Hamlets PCT response to the consultation process

The Board may wish to specifically consider section 4 – Proposed Incentives – in the context of the framework of earned autonomy that the Board would wish to see implemented.

Summary - the regime is generally welcomed as clear and sensible. PCTs also welcome the opportunity to shape the development of the regime. It is suggested that the regime is reviewed after 12 months and revised in the light of experience.

i) **Risk assessment** - PCTs generally welcome the indicator based assessment of risk. Its transparency is attractive. However, there is concern that the system is too mechanistic, with an over-reliance on metrics. There should be greater scope for NHS London to use informed judgement in making risk assessments. In addition, it is considered that some of the metrics need further refinement. It is also proposed that there should be an appeal mechanism for PCTs to challenge risk ratings.

ii) **Financial assessment criteria** - further consideration of the metrics is required. It is considered that there are too many risk gradations – it is suggested that only three are needed. This would be simpler to operate but still sufficient to inform NHS London's approach to intervention. It is proposed that ALE scores are incorporated into the assessment. It is also suggested that activity-above-plan per se should not lead to a high risk rating, as long as costs can be contained within the PCT's financial plan.

iii) **Service provision criteria** - it is suggested that these might be better described as 'quality of services commissioned' criteria. It would be very attractive to have only one system of quality measurement and the aim should be to align NHS London's arrangements with those of the Healthcare Commission. However, it is recognised that the Healthcare Commission's ratings in future years will need to reflect Department of Health national targets and will need to be published earlier in the year. [The 2005/06 ratings were published in October 06]. LAA target performance should also be incorporated.

iv) **Governance criteria** - clarity is required regarding when the self assessment should be undertaken and submitted. It is proposed that the final assessment is submitted with the reviewed operating plan in March.

v) **Incentives** – 'earned autonomy' is considered to be the most significant and practicable incentive. In other words, PCTs that are performing well should be subject to lighter monitoring and given more headroom to 'manage their own affairs'. Ability to retain surpluses, reduced reporting requirements, greater flexibility to deploy capital (with a more limited requirement to submit business cases) and prioritised access to pilot development funding might be features of earned autonomy. Creation of an incentive pot by topslicing all PCTs is not supported. There is concern that a system of financial incentives could have perverse effects.

vi) **PCT provided services** - the regime makes little mention of PCT provided services. Further discussion regarding the NHS London role in assessing PCTs'

competence as service providers is required. If proposals to establish community foundation trusts emerge, it may be appropriate to transfer responsibility for performance management of PCTs as providers to NHS London's provider agency, in order that PCT providers seeking to become community foundation trusts are subject to the same regime as acute/mental health trusts seeking Foundation Trust status.

January 12 2007

TOWER HAMLETS PRIMARY CARE TRUST
FINANCE AND PERFORMANCE REPORT FOR THE PERIOD APRIL TO NOVEMBER 2006 – MONTH 8

FINANCIAL INDICATORS

The PCT's month 8 financial results show that the PCT is on target to achieve financial balance. The main points to note are:

1. The PCT has increased its planned resource surplus to £1.7 million in line with the favourable financial position of the PCT this financial year. This is now available for use by NHS London and will be returned in 2007/08.

2. Central budgets have now been issued by NHS London and show a recurrent shortfall of £1.75 million on initial budget assumptions. This is less than anticipated.

3. The PCT has validated the quarter 2 [month 6] Barts and the London NHS Trust [BLT] activity. Based on current performance the BLT service level agreement [SLA] will not exceed plan value. There is significant under-performance (>£1 million) in the month 6 position but this needs to be placed in the context of the overall BLT SLA value of over £100 million and cannot at this point be assumed as realised.

4. Savings Targets [Gershon savings plans] – Some good progress has been made in achieving Gershon savings so far this year, however achievement of all of the agency savings is unlikely and poses a cost pressure for the PCT Provider. This is outlined further later in the paper.

5. The PCT Provider function is on target to meet the statutory duty of financial balance.

6. The PCT Capital Development Committee agreed a revised capital plan on 10th November that addresses the risks around the two largest capital schemes. This is outlined in more detail in the section on capital expenditure below.

7. The PCT performance on its statutory duty to pay 90% of its creditors within 30 days has improved significantly over the past couple of months and is now at over 90% by value of invoices.

Key Performance Indicator Summary

Summary of PCT Financial Performance/Key Data	2006/07 Annual Plan A £000s	2006/07 Forecast Outturn B £000s	2006/07 Variance (A - B) C £000s	2006/07 Year To Date Plan E £000s	2006/07 Year To Date Actual F £000s	2006/07 Variance (E - F) G £000s
Financial Performance						
PCT Financial Balance	1,700	1,700	-	813	813	- 0
Under/(Over)spend against Cash Limit	-	-	-	-	-	-
Significant Financial Risks - Based on Materiality of Expenditure						
Commissioning SLA's	246,431	247,564	- 1,133	157,669	158,738	- 1,069
Prescribing Expenditure	27,347	27,447	- 100	18,201	18,218	- 17
Total G/PMS Expenditure	35,346	35,296	50	19,821	19,843	- 22
Capital Resource Limits and Expenditure						
Capital Resource Limit (CRL)	6,566	6,539	27	1,740	1,740	-
(Over) / Under spend against CRL	-	-	-	-	-	-

The table below gives a short summary of key performance indicators – KPI's. Further detail is provided in the main body of the report.

Financial Performance - The PCT is currently meeting its statutory duty of financial balance and is on target for a £1.7m surplus at the end of the financial year.

Significant Financial risks – Financial risks are within acceptable tolerance thresholds and management plans are satisfactorily well developed.

Capital Spend – The PCT Capital Development Committee agreed a revised capital plan on 10th November that addresses the risks around the two largest capital schemes. This is outlined in more detail in the section on capital expenditure below.

Financial Performance Detail

This section of the report summarises the overall financial position of the PCT and performance against budget for the year. As at 30th November 2006 the PCT is forecasting a surplus of £1.7m – **Figure 1.** Overall the PCT has achieved a year to date surplus of £813k.

Figure 1 – Overall PCT Finance Position at 30th November 2006

1. Operational Financial Balance	Annual Allocation £000	Budget to date £000	Actual to date £000	Variance to date £000	Year End Forecast £000	Forecast Variance £000
NHS Service Agreements	246,431	157,669	158,738	(1,069)	247,564	(1,133)
Non NHS Service Agreements	11,973	7,986	7,965	20	11,857	116
Prescribing costs	27,347	18,201	18,218	(17)	27,447	(100)
GMS Infrastructure Costs	25,944	13,739	13,676	64	25,894	50
GDS	7,727	5,098	5,320	(223)	7,977	(250)
PCT run Practices	9,402	6,081	6,167	(86)	9,402	0
Himp Priorities	0	0	1	(1)	0	0
Primary Care Premises Programme and LIFT Development Costs	798	537	537	(0)	798	0
Specific Reserves	17,201	905	(406)	1,311	15,884	1,316
IAT's	0	0	0	0	0	
Non-discretionary expenditure	0	0	0	0	0	0
Sub-Total	346,823	210,216	210,215	1	**346,823**	**(0)**
Operating Costs less non-discretionary expenditure	346,823	210,216	210,216	0	346,823	(0)
Revenue Resource Limit	348,523	211,029	211,029	0	348,523	(0)
Under/(over) spend against revenue resource limit	**1,700**	**813**	**813**	**0**	**1,700**	**0**
2. Provider Activities						
Gross Operating costs	81,666	54,550	54,529	21	81,491	174
Less: PCT provider misc income	(18,094)	(12,085)	(12,063)	(22)	(17,920)	(174)
Net Operating costs	63,572	42,465	42,465	(1)	63,572	0
Costs met from PCT's own allocation	(63,572)	(42,465)	(42,465)	(0)	(63,572)	0
(Under)/Over recovery of costs	**0**	**(0)**	**0**	**(0)**	**(0)**	**0**
2. Capital Programme	**6,566**	**1,740**	**1,740**	**0**	**6,539**	**27**
3. Public Sector Payment Policy						
- By Value	**95%**	**95%**	**97%**	**2%**	**90%**	**-5%**
- By Number	**95%**	**95%**	**88%**	**-7%**	**90%**	**-5%**
4. Summary Operating Cost Statement						
Commissioning						
Gross Operating Costs	403,203	247,719	247,476	243	403,203	(0)
Less: Miscellaneous Income	(119,952)	(79,968)	(79,725)	(243)	(119,952)	0
Commissioning Net Operating Costs	283,251	167,751	167,751	(0)	283,251	(0)
Provider						
Gross Operating Costs	81,666	54,550	54,529	21	81,491	174
Miscellaneous Income	(18,094)	(12,085)	(12,063)	(22)	(17,920)	(174)
Provider Net Operating Costs	63,572	42,465	42,464	(1)	63,571	0
Total Net Operating Costs	**346,823**	**210,216**	**210,216**	**(0)**	**346,823**	**0**

Figure 2 gives a summary of the position for the PCT 'Commissioning' function at the end of November. The key points to note are:

- Barts & the London [BLT] – the reported quarter 2 [month 6] position was validated by the PCT and indicates that the SLA has under-performed by around £1 million mainly on out-patient specialty costs This month 6 position includes BLT's valuation of the Clinical Decision Unit [CDU] activity. The overall value of the acute BLT SLA is £103 million and the level of under-performance needs to be put in context. The month 6 position does not guarantee that under-performance will carry through to the year end although it does mean that over-performance on this SLA can be assessed as 'low risk'.

- East London & the City Mental Health NHS Trust [ELCMHT] – this is a block contract, and as such is still forecasting breakeven at year-end.

  The Trust is currently overperforming on the Forensic Mental Health SLA, which is managed via the Specialist Commissioning consortium. To the end of month 8 there was over-performance of £55k. The best case scenario is that this remains at current patient levels resulting in an expected increase to £83k by year-end.

- There is a forecast over-performance on other acute SLA's of £1.1m. The main concern on out of sector SLAs is with University College London Hospital [ULCH], which continues to report over-performance [£370k] at month 8. The likely year-end over-performance is estimated to be in the region of £541k.

- The position on specialist commissioning led SLA's suggests a combined over-performance of £326k on the Guys and St Thomas and St George's SLAs. The over-performance at St George's is as a result of two emergency pelvic reconstructions and is unlikely to be recurrent. The over-spend at Guys and St Thomas is due to over-performance on day case spells and pet scans and an over-spend on critical care.

  The Royal Free NHS Trust is also reporting over-performance [£117k] at the end of month 8. If current activity levels continue this will stretch to £170k at year-end.

  The PCT is currently anticipating that the over-performance on SLA's will be able to be managed within the overall level of resources available in the current year.

- Non-NHS service agreements for 2006/07 total £11.9m. This includes both the Learning Disabilities Pooled Budget [£2.5m] and the Complex Children's' Pooled Budget [£0.4m]. Outside the pooled budget areas there is a significant cost pressure on the older persons continuing care budget. At month 8 there was an £193k overspend with the forecast year-end position increasing to £292k, with the trust committed to funding six new patients until the end of the year. This overspend is currently being contained by under-spends in NHS funded nursing care [forecast £166k] and young persons with disabilities [forecast £255k]

budgets. The PCT is strictly adhering to the Continuing Care criteria to manage further cost pressures. However further costs cannot be ruled out and the future risk exposure is difficult to predict as clients are low in volume but high value.

- The Prescribing budget is currently overspending by £17k on a budget of £27 million. This represents a significant improvement from the previous month, and is based on figures provided by the PPA. The forecast is an over spend of £100k by year-end with the main driver behind the position the increasing growth trend in the National Reallocation Factor, which currently stands at £616k. The National Reallocation Factor relates to items the PPA is unable to code to a particular organisation. All un-coded items are then allocated proportionately across the country each month.

- General Dental Services [GDS] are currently £222k overspent with a forecast overspend of £250k. This is entirely attributable to under-recovery of Patient Charge Revenue [PCR]. The DH has indicated that this is a national problem for all PCT's.

- As at 30th November, the PCT had £17.1 million of committed unallocated budgets. This includes such items as; the reserve to fund the anticipated acute SLA over-performance of £1.1 million, £5.5 million PFI revenue support to BLT, £1.7 million NHS London surplus contingency, the balance of Specialist Addictions Unit funding for the year, Connecting for health funding, NHS Direct funding, the balance of Exception Panel drugs funding and so on. Budgets are being moved out as the commitments become firm.

Figure 2 - Detailed PCT Commissioning Position at 30th November 2006

Annual Allocation £000		Budget to date £000	Actual to date £000	Variance to date £000	Year end Forecast £000	Forecast Variance £000
	NHS Service Agreements					
107,640	Barts and The London NHS Trust	72,045	72,045	0	107,640	0
63,572	Tower Hamlets Primary Care Trust	42,589	42,589	0	63,572	0
31,511	East London & The City Mental Health NHS Trust	21,008	21,008	0	31,511	0
3,122	East London & The City Mental Health NHS Trust - Forensic Service	2,081	2,137	(55)	3,205	(83)
1,486	Guy's & St Thomas' NHS Trust	991	1,108	(117)	1,656	(170)
1,704	Moorfields Eye Hospital NHS Trust	1,136	1,113	24	1,681	23
4,967	London Ambulance Service	3,312	3,312	0	4,967	0
2,613	NICU Consortium	1,276	1,312	(37)	2,650	(37)
730	PICU Consortium	487	483	4	736	(6)
403	BMT	269	266	3	398	5
358	Haem Consortium	239	247	(8)	370	(12)
319	BHR	213	213	0	319	0
537	Royal Free	358	371	(13)	556	(19)
1,604	High Secure Psychiatric Placements	1,070	1,070	0	1,604	0
1,251	University College London NHS Trust	834	1,204	(370)	1,792	(541)
24,612	Other NHS Service Agreements	9,764	10,263	(499)	24,906	(293)
246,431	Sub-Total NHS Service Agreements	**157,669**	**158,738**	**(1,069)**	**247,564**	**(1,133)**
	Non NHS Service Agreements					
2,256	Spot Purchase YPD	1,504	1,354	150	2,058	198
3,961	Drugs	2,641	2,641	0	3,961	0
370	HIV/AIDS Voluntary Sector	244	228	16	341	29
511	St Joseph's Hospice	341	341	0	511	0
2,019	Other Non-NHS Service Agreements	1,351	1,493	(142)	2,126	(107)
2,486	Pooled budget agreement with LBTH - Learning Difficulties	1,657	1,657	(0)	2,486	0
370	Pooled budget agreement with LBTH - Children's Trust	247	251	(4)	374	(4)
11,973	Sub-Total Non-NHS Service Agreements	**7,986**	**7,965**	**20**	**11,857**	**116**
27,347	Prescribing costs	18,201	18,218	(17)	27,447	(100)
25,944	GMS	13,739	13,676	64	25,894	50
7,727	GDS	5,098	5,320	(223)	7,977	(250)
9,402	PCT run Practices	6,081	6,167	(86)	9,402	0
0	Himp Priorities	0	1	(1)	-	0
798	Primary Care Premises Programme and LIFT Development Costs	537	537	(0)	798	0
17,201	Specific Reserves and Provisions	905	(406)	1,311	15,884	1,316
0	IAT's	-	-	0		
346,823	**Total Commissioning Revenue Expenditure**	**210,216**	**210,216**	**0**	**346,823**	**(0)**

Figure 3 gives the financial position for each of the clinical and corporate areas provided by the PCT at the end of November. The Provider financial position at the end of month 8 is break even.

Figure 3 - Detailed PCT Provider Position at 30th November 2006

Annual Allocation £000	Directorate	Budget to date £000	Actual to date £000	Variance to date £000	Year end Forecast £000	Forecast Variance £000
3,540	Urgent Care	2,254	2,267	(13)	3,540	0
9,017	Community Nursing	5,979	6,019	(40)	9,067	(50)
5,131	Dentistry	3,308	3,155	153	4,881	250
113	Continence	75	87	(12)	131	(18)
57	Tissure Viability	38	43	(5)	65	(8)
9,266	Older People and Rehabilitation	6,172	6,234	(63)	9,359	(93)
2,368	Children's Services	1,594	1,597	(4)	2,378	(10)
1,517	Women and Young People	1,011	991	20	1,487	30
1,262	Foothealth	842	805	37	1,207	55
1,314	Speech and Language Therapy	876	803	73	1,263	51
1,620	Audiology	1,080	899	181	1,226	394
1,719	Occupational Therapy	1,146	1,106	40	1,676	43
4,801	Physiotherapy	3,200	3,162	39	4,751	50
1,279	Psychology	853	819	34	1,209	70
874	Diabetic Service	583	497	86	784	90
191	Child Protection	127	143	(16)	215	(24)
729	Workforce Transformation	478	505	(27)	789	(60)
1,191	Corporate Functions	633	619	13	1,192	(1)
45,988	**Sub-Total Provider Development**	**30,247**	**29,753**	**495**	**45,219**	**769**
981	Governance	497	490	7	981	0
938	Education & Training	518	513	5	933	5
272	Research & Development	165	152	13	261	11
274	Infection Control	182	138	45	240	34
2,464	**Sub-Total Clinical Leadership**	**1,362**	**1,292**	**70**	**2,414**	**50**
2,333	Chief Executives Office	1,599	1,609	(10)	2,335	(2)
969	Primary & Community Care Commissioning	630	646	(17)	997	(28)
1,929	Public Health	1,158	1,211	(53)	1,948	(19)
2,633	Strategic Commissioning	1,704	1,697	7	2,633	0
533	Specialised Services Commissioning	356	327	29	489	44
3,931	Finance & Performance Management	2,604	2,614	(10)	3,940	(9)
9,237	Capital Development, Estates & Facilities	6,361	6,399	(39)	9,237	0
21,566	**Sub-Total Corporate & Support Directorates**	**14,411**	**14,504**	**(92)**	**21,580**	**(14)**
1,072	Pooled Budgets THPCT Host	715	684	30	1,023	49
3,041	Pooled Budgets Non THPCT Host	2,027	2,120	(93)	3,029	12
4,113	**Sub-Total Pooled Budgets**	**2,742**	**2,804**	**(63)**	**4,052**	**61**
1,619	Barts & The London NHS Trust SLA	1,079	1,079	0	1,619	0
3,043	Depreciation, Amortisation and Asset Impairments	2,029	1,737	292	2,616	427
1,565	Cost of Capital Charge	1,043	1,300	(257)	1,950	(385)
1,308	Ring Fenced Reserves	1,636	2,060	(424)	2,041	(734)
7,535	**Total Costs**	**5,787**	**6,176**	**(388)**	**8,226**	**(692)**
81,666	**TOTAL PROVIDER EXPENDITURE**	**54,550**	**54,529**	**21**	**81,491**	**174**
(81,666)	**Income**	**(54,550)**	**(54,529)**	**(22)**	**(81,492)**	**(174)**
	Overall Provider Function Financial Performance	**0**	**0**	**(0)**	**(0)**	**0**
(18,094)	**Other Income**	**(12,085)**	**(12,063)**	**(21)**	**(17,920)**	**(174)**
(63,572)	**PCT's Own Allocation**	**(42,465)**	**(42,465)**	**(0)**	**(63,572)**	**0**

As at 30th November the Provider Development Directorate is under-spent by £495k which is an improvement on the month 7 position. The main variances are:

- Community Nursing is currently reporting a £40k over-spend, which is forecast to grow to £50k by year-end owing to increased sickness and staff turnover giving rise to agency costs. The service has now employed a Business Manager to implement

ways of addressing these overspends and pulling together a plan to control agency spend.

- Dental is currently £153k under-spent year to date due to ongoing vacancies. The service is undergoing a recruitment drive to resolve this. The service is forecast to under spend by £250k at year-end.

- Older People and Rehabilitation service is overspent by £63k. This is driven by overspends on agency costs. These costs are partly offset by vacancies across the directorate.

- In Children's services the PCT funded cost pressures relating to medical staff salaries in September worth approximately £144k, and £40k to date for patient appliances. This has returned the service to financial balance.

- Audiology is under spent by £181k due to the transfer of £263k worth of digital hearing aid spend which has been capitalised in M8. This was agreed as part of the PCT saving plan to fund the 2nd top slice and will be moved to reserves in M9. It is therefore a technical surplus only. This has been offset by an over spend of audiology students which is over spending by £20k per month due an over subscription of students on the September rotation. Work is being done by Finance and Audiology to work through the situation.

- The Psychology service is yet to agree its 2006/07 budget. Finance is meeting with the service in December. The current reported budget is the rolled forward 2005/06 budget, revalued for inflation and the costs of Agenda for Change, with Gershon savings taken off. It is currently showing an under-spend of £34k

- The Diabetic service is currently showing an under-spend of £86k growing to £90k by year-end. This is driven by vacancies within the service.

- Workforce Transformation is overspent due to the need to meet a long-standing efficiency target of £47k on a recurring basis. If measures are not put in place to achieve recurring financial balance the department could face a significant overspending next year.

The Corporate and Support Directorates are overspent by £77k. The main variances are:

- Public Health is overspent by £53k. This is mainly due to an overspend against existing establishment. It is anticipated that the directorate will reduce their overspend to £19k at year-end by freezing vacancies.

The PCT has pooled budget arrangements with LBTH for Occupational Therapy, Learning Disabilities, Children's Services and the Home Equipment Store. THPCT is the host for Occupational Therapy only. As at 30th November pooled budgets were over-spent by £63k in total. This is driven by an over-spend on the Children's Services pooled budget offset by Occupational Therapy pooled budget under-spend.

The calculated depreciation charge for the full year is £2,616k, with most purchases or building upgrades not expected to be operational until later in the financial year and this is not expected to affect the depreciation figure from that quoted. The Cost of Capital calculation is less certain as it is based upon the average net assets between the closing balance sheet at 31st March 2006 and a forecast situation at 31st March 2007. The annualised Cost of Capital is anticipated to be around £1,950k and has been reflected in the November report.

The overall Provider income position is forecast to be £174k under recovered. The risk areas related to the potential loss of income from vacation of Aneurin Bevan House by the former North East London SHA [NELSHA], loss of NELSHA contribution for its share of Finance Consortium charges and a reduction in the NMET budget.

Savings Targets ['Gershon savings plans] – The target is for the Provider to achieve 2.5% cash releasing savings on the £55 million commissioned by the PCT - £1.4 million. The Gershon savings programme is summarised below. As at the end of November 2006 - £500,000 worth of Discretionary budgets have been removed from budgets. Procurement savings have also yielded an additional saving of £263,000 and the Procurement Consortium is negotiating on a further £150k worth of savings to come through over the next few months.

Progress on achieving agency and bank savings has been a lot slower than planned and it is now anticipated that this will result in a cost pressure for the provider services. The forecast under-spend in the Provider Development Directorate will be used to non-recurrently offset any shortfall in the current year agency and bank savings plan.

Description of Savings	Annual Plan	Amount to November 2006	Forecast to Year-end
Discretionary Budgets Saved	500,000	500,000	500,000
Agency and Bank Target Savings	500,000	0	241,000
Procurement Target Savings	400,000	263,000	400,000
Other sources	0	267,000	259,000
Total	**1,400,000**	**999,000**	**1,400,000**

Figure 4 outlines the balance sheet for the PCT and the cash flow position.

Balance Sheet

As at the end of November 2006 the following significant items are noted on the balance sheet.

- the forecast movement in Fixed Asset balances between 1st April 2006 and 31st March 2007 of ca £11 million. This is down to three main items
  - The PCT capital programme for the current year will add approximately £7 million to the value of PCT fixed assets.
  - Indexation and revaluation of the assets makes up an additional £6 million movement all of which is added to brought forward asset values at the start of the financial year.
  - There is a corresponding diminution of asset values by £3 million in respect of depreciation charges. This is expensed roughly uniformly over the course of the year.

- the 'non-NHS' debtor balance brought forward from 2005/06 includes approximately £1 million held on account by the PCT solicitors, Capsticks and Co. This relates to the balance of cash remaining on the two LIFTCo schemes for the Specialist Addictions Unit [SAU] and the Barkantine redevelopment. The revenue effect of both schemes was recognised in the relevant financial years – 2004/05 for the SAU and 2005/06 for the Barkantine. The debtor is therefore in lieu of cash and will be reversed out to the PCT bank account in the current financial year. The PCT has earned approx £60k interest on both accounts in 2006/07.

- the 'NHS creditors falling due <1 year' balance brought forward includes a £22.6 million payment to BLT to fund their impairment. This is a one-off transfer and was funded from the NHS bank.

Figure 4a - Tower Hamlets PCT Balance Sheet

Opening bal 01-Apr £000s		Bal at 30-Nov £000s	Movement to date £000s	Closing bal 31-Mar £000s	Forecast movement £000s
	FIXED ASSETS:				
0	Intangible assets	0	0	0	0
86,912	Tangible assets	93,353	(6,441)	97,594	(10,682)
372	Investments	373	(1)	372	0
	CURRENT ASSETS:				0
531	Stocks and work in progress	531	0	531	0
10,006	NHS Debtors	15,701	(5,695)	10,136	(130)
6,328	Other debtors	1,148	5,180	6,630	(302)
16,334	**Total Debtors**	**16,849**	**(515)**	**16,766**	**(432)**
0	Cash at bank in OPG accounts	1,047	(1,047)	0	0
0	Other cash at bank and in hand	0	0	0	0
0	**Total Cash at bank and in hand**	**1,047**	**(1,047)**	**0**	**0**
16,865	**TOTAL CURRENT ASSETS**	**18,427**	**(1,562)**	**17,297**	**(432)**
	CREDITORS:				0
(33,957)	NHS creditors falling due <1 year	(6,205)	(27,752)	(3,558)	(30,399)
(20,567)	Non-NHS creditors falling due <1 year	(27,301)	6,734	(38,671)	18,104
(54,524)	**Total amounts falling due <1 year**	**(33,506)**	**(21,018)**	**(42,229)**	**(12,295)**
(37,659)	**NET CURRENT ASSETS/(LIABILITIES)**	**(15,079)**	**(22,580)**	**(24,932)**	**(12,727)**
49,625	**TOTAL ASSETS LESS CURRENT LIABILITIES**	**78,647**	**(29,022)**	**73,034**	**(23,409)**
	CREDITORS:				0
0	NHS creditors falling due >1 year	0	0	0	0
0	Non-NHS creditors falling due >1 year	0	0	0	0
0	**Total amounts falling due >1 year**	**0**	**0**	**0**	**0**
(5,925)	Provisions for Liabilities and Charges	(4,968)	(957)	(4,200)	(1,725)
43,700	**Total Assets Employed**	**73,679**	**(29,979)**	**68,834**	**(25,134)**
					0
	TAXPAYERS EQUITY				0
25,419	General Fund	49,107	(23,688)	44,271	(18,852)
17,764	Revaluation reserve	24,046	(6,282)	24,046	(6,282)
7	Donated Asset Reserve	16	(9)	7	0
510	Government Grant Reserve	510	0	510	0
0	Other reserves	0	0	0	0
43,700	**Total**	**73,679**	**(29,979)**	**68,834**	**(25,134)**

Cash Flow

Figure 4b - Tower Hamlets PCT Cash Flow Statement

Plan £000s		Budget to date £000s	Actual to date £000s	Variance to date £000s	Year end forecast £000s	Forecast Variance £000s
325,682	Net forecast discretionary cash drawn down from DH	205,500	205,500	0	325,682	0
27,203	PPA recharges	17,511	17,511	0	27,203	0
10,531	Dentistry recharges	4,098	4,098	0	10,531	0
363,416	**Total charge to cash limit**	**227,109**	**227,109**	**0**	**363,416**	**0**
363,416	Cash Limit	199,959	199,959	0	363,416	0
0	**Under/(over)spend against cash limit**	**0**	**0**	**0**	**0**	**0**

The PCT has a total authorized cash limit of just under £360 million. This is consumed in three ways – payment of prescription charges reimbursed to pharmacists through the Prescription Prescribing Authority [PPA], General Dental Services [GDS] and the payment of the PCT's direct costs [such as commissioning costs, payments to primary care providers, payroll and non pay costs].

At 30th November 2006, the PCT's charge to the cash limit was £200 million, which equates to 56% of the total. In part this represents a lower than anticipated spend on capital schemes in the first seven months of the financial year. It is expected that the capital scheme will break even and that the expenditure will be higher towards the end of the financial year. It is, therefore, anticipated that the PCT will utilise its full authorised cash limit.

Figure 5 outlines the PCT capital expenditure against budget. The PCT is currently planning to invest £6.4m of its £6.6m capital resources across Tower Hamlets. The £80k headroom will be subject to additional capital resources bids that should be submitted to the Capital Re-Development sub group for approval. At the end of month 8, £1.74m of capital works had been undertaken – roughly 26% of the planned spend.

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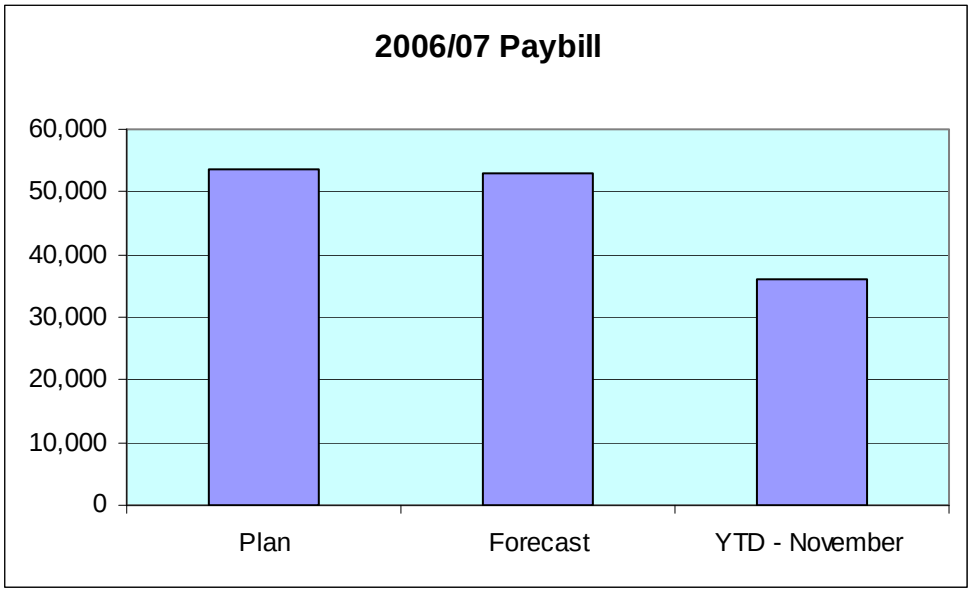
Annual Allocation £000		Budget to date £000	Actual to date £000	Variance to date £000	Year end Forecast £000	Forecast Variance £000
	Block Capital Allocation					
576	MEH Redevelopment - by PCT	403	403	-	556	20
300	Patient Environment Improvements	124	124	-	300	-
500	Rolling refurbishment of the Bancroft Unit to include 3 ward upgrades	220	220	-	500	-
174	Rheumatology Phlebotomy Departments Upgrade	-	-	-	174	-
150	Fire & Safety Schemes	37	37	-	150	-
100	Health & Safety Schemes	8	8	-	100	-
250	Backlog Maintenance/Fire Safety	87	87	-	250	-
515	Decentralise Main Boiler House	153	153	-	515	-
150	MEH Security Camera System	4	4	-	150	-
270	Phase 2 of Education Centre	226	226	-	263	7
150	Equipment Replacement Programme	-	-	-	150	-
140	Mobile Dental Van	-	-	-	140	-
90	Foot Health Mobile Clinic	-	-	-	90	-
246	NPfIT & ICRS	3	3	-	246	-
213	ICRS and PC'S and IT equipment	103	103	-	213	-
140	GP - PC's and IT equipment	26	26	-	140	-
13	IT (Others)	1	1	-	13	-
34	Connecting for Health Roll Out	34	34	-	34	-
41	Walk in Centre - IT systems	41	41	-	41	-
114	Refurbishment of Wapping PDS	114	114	-	114	-
29	Barkantine Decant Accommodation	29	29	-	29	-
34	Steels Lane -Telephone System	28	28	-	34	-
23	Disability Discrimination Act	23	23	-	23	-
1	CSSD Equipment for Capital Grant Funded Initiatives	1	1	-	1	-
1	Study Centre	1	1	-	1	-
475	Purchase of hearing aids	-	-	-	475	-
1,300	Purchase of St Paul's Way	-	-	-	1,300	-
5	Other Miscellaneous	-	-	-	5	-
170	CES605 - CES608	-	-	-	170	-
30	To be allocated to scheme CES611	30	30	-	30	-
15	SAU / Trust offices evaluation	-	-	-	15	-
15	SOC Community Hospitals Bus. Case	-	-	-	15	-
82	Contingency Reserve	-	-	-	82	0
6,566	**Capital Expenditure**	**1,740**	**1,740**	**0**	**6,539**	**27**

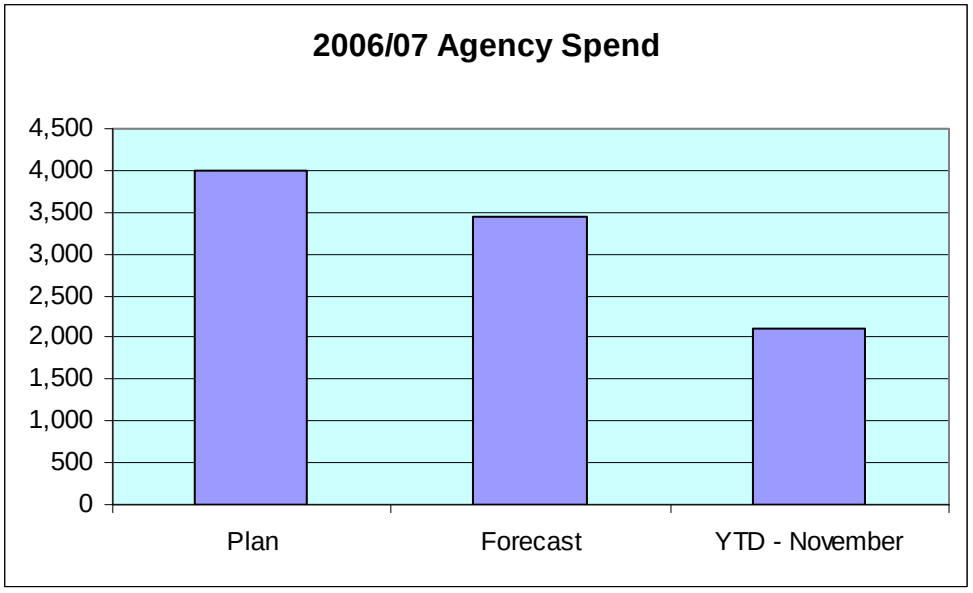
Figure 5 - Detailed PCT Capital Position at 30th November 2006

NON FINANCIAL INDICATORS

Payroll and Agency Expenditure



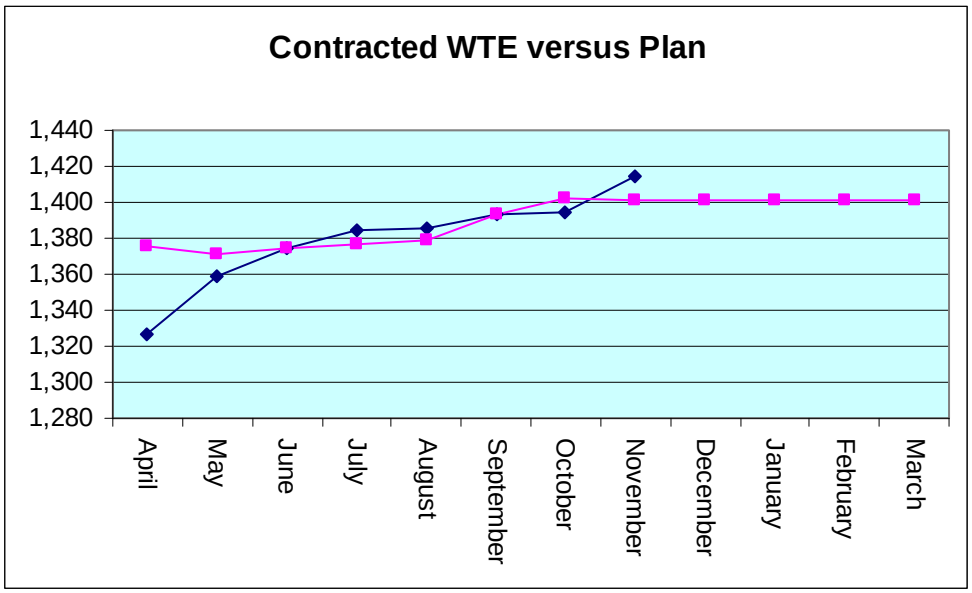
The payroll chart shows that overall the PCT pay bill is on course to be close to plan. The planned spend on staff is about £53.5million and the forecast is marginally within that total. November data is the latest available and shows year to date pay spend of £36.1million.

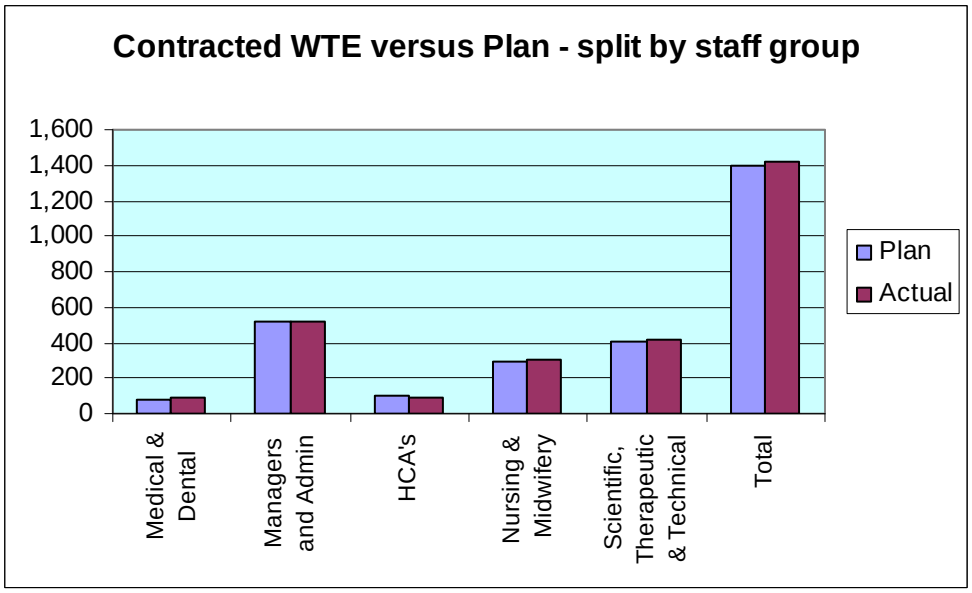


The PCT spend on agency in 2005/06 was over £6m. The work of the establishment review group is expected to yield a small under-spend against agency planned expenditure by the end of the financial year [£3.44m versus a plan of £4m].

Staff Numbers

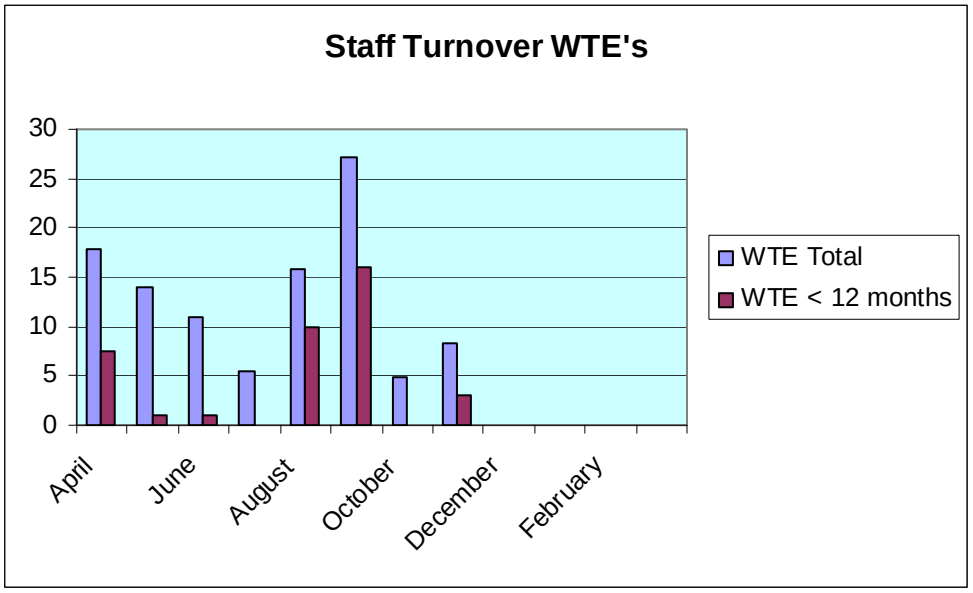
The contracted WTE information shows that the PCT has increased above its LDP workforce plan. There has been an increase in M8 of Medical and Dental staff and Management and Admin with a decrease of HCA's.





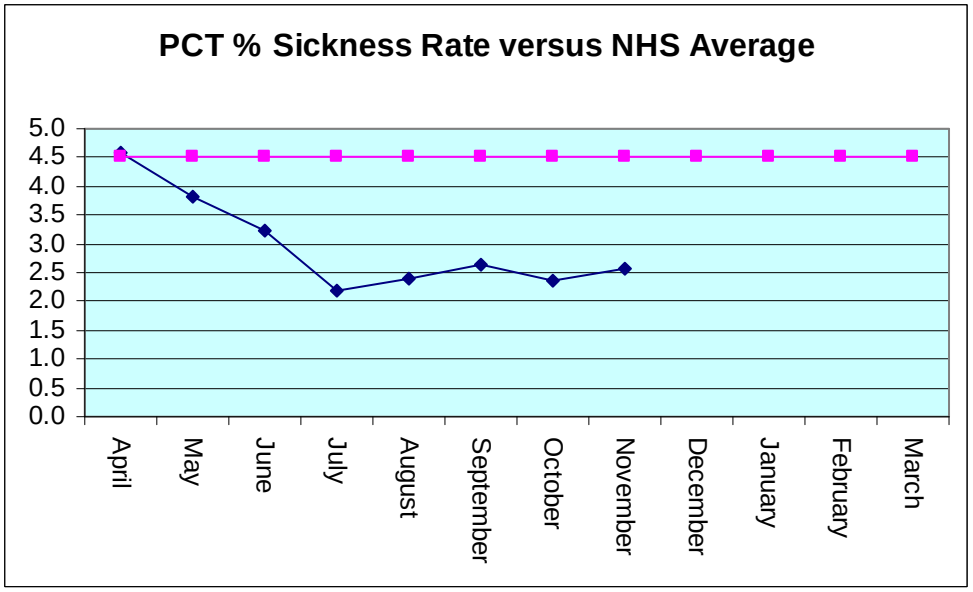
Staff Turnover

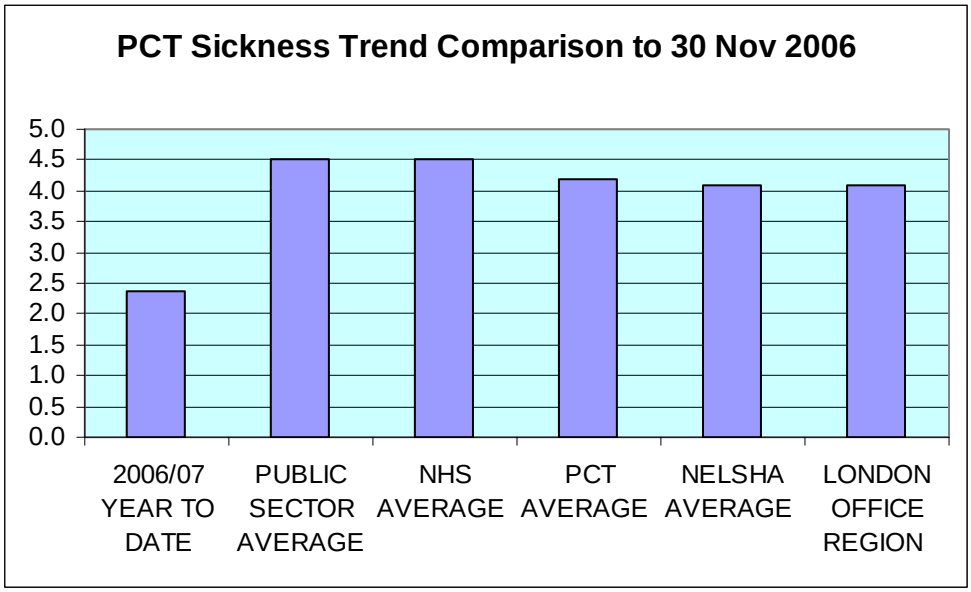
Staff turnover shows the total number of staff leavers in the month and the number of staff that have left within 12 months. Out of the total of over 1,300 whole time equivalents, it can be seen that the level of staff turnover is relatively low and points to a high level of stability in the PCT workforce.



Staff Sickness

The latest sickness absence survey [2005] gave a range of sickness averages across the NHS. The average rate of sickness for PCT's nationally is 4.2% and for the NHS as a whole is 4.5%. The latest data [November 2006] shows an average rate of sickness for Tower Hamlets PCT of 2.6% a slight increase on the previous month.





Conclusions

- The November Finance report shows that overall the PCT is performing satisfactorily against all of its financial targets for financial balance. Month 8 financial results in general show that the PCT is on course to achieve the planned £1.7m surplus at year-end;

- Monthly activity monitoring for the BLT SLA indicates the SLA will not over-perform over the full year value. Activity data for all SLA's will require careful monitoring;

- Overspending commissioned SLA's are being reviewed and actions put in place to manage them in year; and

- The PCT provider services are likely to achieve financial balance at year-end.

Recommendations

The Board is recommended to:

- Comment on the detail within the report;
- Note that recovery plans are being developed for overspending directorates within PCT Provider services; and
- Note the inclusion of non-financial indicators in the month 8 report.

Stuart Saw
Director of Finance & Business Development
January 12th 2007

Tower Hamlets NHS
Primary Care Trust

PERFORMANCE REPORT FOR THE PERIOD APRIL TO NOVEMBER 2006 – MONTH 8

Summary Report

The monthly report has now been split to provide separate finance and performance reports in line with the Healthcare Commission's Annual Health Check, where separate ratings are given for 'Use of Resources' and 'Quality'. This report focuses on the four elements of the 'Quality' rating used in the 2005/2006 ratings, and will be updated as required to reflect changes in the assessment to be used in the 2006/2007 ratings.

The first part of the monthly report is an outline summary of key performance issues. More detail on specific targets and risks is contained in the main body of the report. The reporting formats for existing and new targets have been changed from that used last year and are outlined below.

Annual Health Check Performance Indicators
Getting the basics right

Core Standards

On Core Standards the PCT is meeting the requirements for compliance with core standards and action plans have been developed for those where further improvement can be made. Overall the level of assurance that the PCT is meeting the Core Standards is high. The performance rating for this element of the annual health check for 2005/2006 was 'fully met'.

The reporting of Core Standards has been amended from the one used last year, which was based on compliance, to one that reflects the status of action plans and recording significant lapses should they be occurring. There is no traffic-lighting associated with this part of the report, although any lapses would be reported in red. For November there are no significant lapses or issues to report.

Existing Targets

The reporting of existing targets has been developed to differentiate between 'targets' and 'Indicators' and the data sources and new constructions for each indicator have been added. The traffic lighting and assessment have been changed to reflect the way in which the Healthcare Commission grade individual indicators. There is now a three-point scale and each indicator is either

A – achieved (shown as green)
U – underachieved (shown as amber)
F – failed (shown as red)

The report template has been amended to include actions, progress and accountabilities for those targets that are not being met. The achievement status for 2005-06 performance has now been updated to show the final outcome from the annual health check assessment, which resulted in a grading of 'fully met' for these targets. Progress for the current year has also been updated to reflect the new data constructions. The report also outlines where no updates were received or where relevant data is not yet available. The current PCT position against the 19 indicators (20 in 2005-2006) is;

- currently achieving -15 (17 in 2005/06) – Green
- under-achieving - 4 (2 in 2005/06) – Amber
- failing - 0 (1 in 2005/06) - Red
- no data available – 0 (not graded)

Overall there is reasonable performance across the existing targets for month 8, and although there is concern over the additional areas of underachievement, maintaining this level of performance would indicate an overall score of 'fully met' for 2006-07.

Annual Health Check Performance Indicators
Making and sustaining progress

New Targets

The report now includes the new targets, indicators and data sources and is formatted in the same way as the report for existing targets. It should be noted that although indicator constructions have now been updated for the current year, there are a number of changes therefore data is not available for all of them yet. The targets have also been grouped into the relevant priorities as originally described in 'National Targets, Local Action. The RAG performance colour regime is as per the existing targets. For 2005-06 performance, grading has been updated to reflect the actual outcome of the annual health check, for which an overall score of 'fair' was awarded for this section. For 2006-07 performance, the grading is based on the achievement thresholds for 2005-06, but it is likely that these will be increased to reflect the expectation of progress towards the 2008 targets. The current position against the 32 indicators (28 in 2006-07) for the new targets is

- Currently achieving – 15 (21 in 2005/06) - Green
- Underachieving – 9 (3 in 2005/06) – Amber
- Failing – 1 (4 in 2005/06) – Red. The PCT is failing to meet the target for Four week smoking quitters.
- No update/data available – 7 These have not been graded

It should be noted that a number of targets currently graded as underachieving are based on incomplete data obtained from the general practice information system. The position may therefore be better than shown at this stage.

Improvement Reviews

For 2006/2007, results from four reviews will be published, Substance Misuse, Heart Failure, Diabetes and Race Equality. These results will not be used directly in the 2006/2007 ratings, but will provide assurance against standards and identify where targeted assessments may be needed.

Section1: Compliance with core standards

In the October 2005 draft declaration, the PCT reported compliance with 23 of the 24 standards, as there had been no significant breaches of these standards during the six-month period covered by the declaration. However, the PCT recognised that further actions could be taken to improve performance against the standards in some areas. Progress against the resulting action plans will be monitored by the Risk Management committee and exception reported to the Board.

The November scorecard contains the updated status of the action plans and outlines that the PCT is still meeting the requirements for compliance with core standards. There are some outstanding and ongoing actions listed, which will be updated on a regular basis. Any significant lapses against core standards will be reported should they occur.

The final declaration for 2005/2006 was approved by the informal Board meeting on the 19th April 2006 stating full compliance with the core standards – with the exception of C9 due to “insufficient assurance” available for the full year, and sent to the Healthcare Commission on the 24th April 2006.

The PCT will be required to complete a declaration each year relating to its compliance with core standards.

Scorecard for Compliance with Core Standards

Domain	Standard	Description	Outstanding Actions/Significant Lapses/Key Concerns	Accountability	Target Date	Progress
Governance	C7	Clinical and corporate governance systems	Clarify current clinical governance arrangements in commissioning and establish clear processes to monitor quality standards for commissioned services	Mushtaq Jarral Jeremy Burden	February 2007	DOH has released their commissioning framework (13 July 2006), PBC Framework will be published in December 2006, the quality strategy or framework is expected during Autumn 2006. Clinical Governance Manager and Dr Russell, Medical Director currently reviewing the existing clinical governance strategy, which will have clear processes and standards (KPIs) for service providers. Dr Russell and Mr Burden have discussed this in the past but nothing agreed yet.
	C9	Records Management	Review storage of records	Anne Thompson	March 2007	Option appraisal produced & solutions being explored
Care environment and amenities	C21	Design/cleanliness of premises	Produce revised Estates Strategy for 2006 - 2011	John Eastham	January 2007	Draft Development Control Plan for Mile End Hospital completed September 2006. Workshop to determine way forward to be held 20 October 2006. Revised Strategic Service Development Plan for community premises and the joint document Improving Health and Well-being in Tower Hamlets already available. No progress on revising and incorporating these documents into the Estate Strategy document itself because of absence on sick leave. However as, these documents form the basis of the Estate Strategy and provide the key information necessary to determine the PCT's strategic direction for the period this is not a significant cause for concern. Revised date for completion provisionally January 2007.

Domain	Standard	Description	Outstanding Actions/Significant Lapses/Key Concerns	Accountability	Target Date	Progress
Public Health	C23	Disease prevention and health promotion programmes	Improve monitoring of ethnicity	Mark Caulfield Somen Banerjee	April 2007	The CEG have implemented the Patient Profiling data entry screen to all practices and ethnic monitoring data is now being collected, for new registrations, systematically at all practices. There is progress on the deployment of EMIS Web to all directly managed services. This will both enable clinicians to use the ethnic code if it already exists on the system, or entering onto the system and by so doing add completeness to the GP record. Ethnicity monitoring – the action plan was to develop an enhanced services in primary care to improve monitoring (LES 5). All 37 practices in Tower Hamlets are signed up for this for 2006/7. Data from the CEG for 2005/6 indicates that 55.4% of the practice population have ethnicity recorded and it is anticipated that this will improve over 2006/7

Section 2. Compliance with existing targets

The Healthcare Commission will assess the performance of NHS trusts in meeting the existing targets as described in National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006 to 2007/2008.

The scorecard outlines that the PCT is currently achieving 15 out of the total 19 indicators (17 in 2005/06), and under-achieving 4 (2 in 2005/06).

Commissioning of crisis resolution/home treatment service:
The substantive consultant started in August and in conjunction with the Team Manager is currently reviewing the operational policy. Referrals have increased, including from the wards, and staff issues have improved. An additional 4 social workers will be recruited to the team to provide an enhanced out of hours service. ELCMHT are confident of meeting the year-end target of 689.

Convenience and Choice:
Work is ongoing to ensure that all survey questionnaires are marked as THPCT so that patients' responses are correctly attributed.

Scorecard for Existing Targets

Target	Indicator & *Data source*	Lead and AD	Data provided by	2005/06 Outcome	2006/07 Progress	Notes and actions
Maintain a two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals.	All cancers: two week wait *Cancer waits database (Financial year 2006/2007)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere K Eilbert	A	A	Current performance 100% *Achievement threshold 2005/2006 >=97%*
Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005.	All cancers: one month diagnosis (decision to treat) to treatment *Cancer waits database (Financial year 2006/2007)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere K Eilbert	A	A	Current performance 100% *Achievement threshold 2005/2006 >=95%*
Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005.	All cancers: two month GP urgent referral to treatment *Cancer waits database (Financial year 2006/2007)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere K Eilbert	U	A	Q1 81%, Q2 100%, October 100% YTD 93.7% *Achievement threshold 2005/2006 >=92%*
Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours.	Access to a GP *PCAS survey* *Special data collection as at March 31st 2007*	A Ridley J Wardell	Mary Morgan	A	A	Currently achieving 100% *Achievement threshold 2005/2006 = 100%*
	Access to a PCP *PCAS survey*	A Ridley J Wardell	Mary Morgan	A	A	Currently achieving 100% *Achievement threshold 2005/2006 =100%*
All ambulance trusts to respond to 75% of category A calls within 8 minutes.	Category A calls meeting eight minute target *KA34 ambulance services (Financial year 2006/2007)*	J. Burden J Milligan	Carl Edmonds	A	A	74.9% October (THPCT 69.9%) *Achievement threshold 2005/2006 >=75%* *Underachieve >=70%*
All ambulance trusts to respond to 95% of category A calls within 19 minutes after the request has been made for transport.	Category A calls meeting 19 minute target *KA34 ambulance services (Financial year 2006/2007)*	J. Burden J Milligan	Carl Edmonds	A	A	98% October (THPCT 97.1%) *Achievement threshold 2005/2006>=95%*
All ambulance trusts to respond to 95% of category B calls within 19 minutes.	Category B calls meeting national 19 minute target *KA34 ambulance services (Financial year 2006/2007)*	J. Burden J Milligan	Carl Edmonds	F	U	84.7% October (THPCT 79.7%) *Achievement threshold 2005/2006 >=95%* *Underachieve >= 80%*

Target	Indicator & *Data source*	Lead and AD	Data provided by	2005/06 Outcome	2006/07 Progress	Notes and actions
Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005, and a comprehensive Child and Adolescent Mental Health service by 2006.	Commissioning a comprehensive CAMHS service *LDPR standard collection as at 31st December 2006*	J. Burden S Varley		A	A	CAMHS indicator is based on a yes/no to three questions around provision of services. All are yes, and should remain so until end of year as no service changes planned.
	Commissioning of crisis resolution/home treatment services *LDPR standard collection (Financial year 2006/2007)*	J. Burden D. Summers	D. Summers	A	U	Indicator measures number of episodes of home treatment against PCT allocation of national target (currently 689). Current Performance = 364 The substantive consultant started in August and in conjunction with the Team Manager is currently reviewing the operational policy. Referrals have increased and staff issues have improved. An additional 4 social workers will be recruited to the team to provide an enhanced out of hours service. Also an increase in number of referrals from the wards. ELCMHT are confident of meeting the year-end target of 689 caseload.
Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose a hospital and consultant that best meets their needs. By December 2005, patients will be able to choose from at least four or five different health care providers for planned hospital care, paid for by the NHS.	Convenience and choice - PCT booking *Choose and Book Extracts PCT Choose and Book utilisation plans (Financial year 2006/2007)*	J. Burden N. Canavan	Amy Winter	A	U	Current figure 45% Indicator has changed; performance will be assessed against the planned percentage in the 2006/2007 PCT Choose and Book Utilisation Plan (90% by March 2007)
	Convenience and choice - PCT facilities in place to support choice *National patient choice survey (financial year 2006/2007)*	J. Burden Sally Herne/Rhoda Iranloye	Rhoda Iranloye	U	U	Current figure offered choice 49% Current figure given information 26% New data collection. Performance will be assessed on percentage of patients responding positively to questions on choice and information provided
Delayed transfers of care to reduce to a minimal level by 2006	Delayed transfers of care (percentage of patients occupying an acute hospital bed whose transfer was delayed) *LDPR standard collection (summed across all 52 weeks)*	J. Burden C. Wood		A	A	Last update: 2.01%. LBTH, Acute =1, Non-acute =9 *Achievement threshold 2005/2006 <=3.5%*

Target	Indicator & *Data source*	Lead and AD	Data provided by	2005/06 Outcome	2006/07 Progress	Notes and actions
A minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy by March 2006, and 100% by 2007.	Diabetic retinopathy screening *LDPR standard collection (number offered at Q4, number identified at Q3)*	I Basnett S. White	A Powling	**A**	**A**	Nov 06 - 865 offered, 496 screened (57%) (9869 patients diagnosed by GP practices) April – Sep 06, 9869 offered, 5719 screened (58%) *Achievement threshold 2005/2006 >= 50% receiving screening*
Maintain a maximum wait of 26 weeks for inpatients	Number of inpatients waiting longer than the standard *Monthly monitoring return (financial year 2006/2007)*	J. Burden C. Wood	C. Wood	**A**	**A**	No breaches reported *Achievement threshold 2005/2006 <=0.1%*
Maintain a maximum wait of 13 weeks for an outpatient appointment	Number of outpatients waiting longer than the standard *Monthly monitoring return (financial year 2006/2007)*	J. Burden C. Wood	C. Wood	**A**	**A**	No breaches reported *Achievement threshold 2005/2006 <=0.1%*
Maintain the four hour maximum wait in A&E from arrival to admission, transfer or discharge.	Total time in A&E: minimum 98% of patients spend four hours or less in any type of A&E *QMAE Quarterly Return*	A Ridley J. Milligan	J. Milligan	**A**	**A**	November 98.5%, YTD 98.2% (Type 1&2) WIC 100% *Achievement threshold 2005/2006 >=98%*
Three month maximum wait for revascularisation by March 2005.	Patients waiting longer than three months for revascularisation *Monthly monitoring return*	I Basnett S.Overett	S.Overett	**A**	**A**	No Breaches *Achievement threshold 2005/2006 <=0.5%*
Deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help.	Thrombolysis - 60 minute call to needle time *Myocardial Infarction National Audit Project*	J. Burden C. Wood	C. Wood	**N/A**		Very low numbers as AMIs enter via Heart Attack Centre during working hours, avoiding need for Thrombolysis, therefore not included in rating for 2005/2006. Indicator has been redefined for 2006/07 and will be reviewed mid-year to assess the impact of primary angioplasty.
In primary care, update practice-based registers so that patients with coronary heart disease and diabetes continue to receive appropriate advice and treatment.	Practice based registers – patients called for review *LDPR standard collection*	A Ridley V. Cencora	L Gittins	**A**	**A**	End October Diabetes = 87.7% Data from 30 practices only Indicator has changed and now only measures numbers of patients on registers of people with Diabetes called for review in the last 12 months. Performance is measured against 2005/2006 plan, i.e. Diabetes = 66.34% *Achievement threshold 2005/2006 = 100% of plan*

Section 3: Compliance with new national targets

The Healthcare Commission will assess the performance of PCT's in working towards new national targets that have been set by the Government. As with the existing targets, operational and Director level leads have been agreed for all targets. The reporting approach will be broadly similar to that used for existing targets – outlined above. The Healthcare Commission updated the detailed target definitions and data constructions for the 2006/2007 assessments on 1st November, resulting in a number of changes to the scorecard. There are now 32 indicators associated with 14 new targets in total.

The scorecard indicates that the PCT is currently achieving 15 of the 32 indicators (21 in 2005/2006), underachieving 9 (3 in 2005/2006) and failing 1 (4 in 2005/2006). However, there are 7 indicators for which no grading is possible at this stage.

The PCT is failing to meet the target for four-week smoking quitters, only achieving 25% of the annual total by the end of month 6. An action plan to address this performance has been developed.

It should be noted that a number of targets currently graded as underachieving are based on incomplete data obtained from the general practice information system. The position may therefore be better than shown at this stage.

Although performance against the indicator for CPA 7-day follow up is within the tolerance allowed for achievement, this is slightly below target. The following comments should be noted for this indicator:

- Numbers involved are relatively small which can lead to greater swings month to month.
- CPA follow up is being discussed ELCMHT wide to ensure best practice is adopted across the boroughs.

Performance against the target for implementing NICE improving outcomes guidance has also been graded as achieved, although one of the multi-disciplinary teams has not been established by the deadline. Achievement thresholds for 2005/2006 were set at meeting milestones for 2 of 3 groups, a similar tolerance for 2006/2007 would allow achievement at meeting milestones for 5 of 6 groups.

Performance against the target for Breast Cancer screening has been regarded as underachieving rather than failing, on the basis of the most recent results available. However the construction of this indicator has changed and performance cannot be accurately assessed until achievement thresholds for the second part of the indicator are published, this may therefore revert to a failed target.

Commissioning of early intervention in psychosis services is currently graded as underachieving, but continued progress should result in meeting the planned target for this indicator.

Despite achieving the target for 2005/2006, at present the number of Very High Intensity Users being cared for in the community is below expectations and further

progress will need to be made to meet the target. An action plan to address this gap has been developed. There is also currently underperformance against the indicators for access to GUM clinics and GP recording of body mass index.

Underperformance has also been recorded against two new indicators relating to the 18 week target, although the targets are not expected to be reached until March 2007.

The indicators which have not been graded were for the reasons outlined below:

- Childhood obesity: data quality – this is a new indicator which should reflect the percentage of children in year R and year 6 with height and weight recorded. However, data is only available for year R and it is unclear how this will affect the grading of achievement against the target.
- Community matrons – this indicator has changed to include numbers of additional case managers but it is not clear how the two elements will be combined to demonstrate performance.
- For services for people with long-term conditions, data for 2005/06 suggests that there is a gradual decline in the number of emergency bed days in line with the national target, but the data source for this indicator has now changed and performance will need to be re-assessed. Figures reported up to month 6 of 2006/2007 (latest available) are already at 95% of the planned total for the year.
- Data collection for referral to treatment waiting times will not begin until January 2007, therefore this indicator has not been graded, although the expectation is that this would be achieved.
- Further details regarding assessment of the Experience of patients is still awaited, but is expected to be based on the Healthcare Commission patient survey.
- Older people's mental health: assessment of needs and services – this is a new indicator and data is currently being sourced to support assessment, although responses to part 1 are all positive.
- Infection control – the construction of this indicator is under review following the publication of the code of practice for the prevention of healthcare acquired infections on October 1st.

Scorecard for New Targets

Target	Indicator & *Data source*	Lead and AD	Data supplied by	2005/06 Outcome	2006/07 Progress	Notes and actions
Priority 1: Improve the Health of the Population						
Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	Blood pressure - percentage of patients with CHD whose last blood pressure reading (measured in last 15 months) is 150/90 or less *LDPR standard collection* *PCT local delivery plans* *(Financial year 2006/2007)*	A Ridley J Milligan	L Gittins	A	U	End October 79.5% patients with CHD in whom last blood pressure reading (measured in last 15 months) is 150/90 or less. Note – data from 30 practices only *Target is 81%* *Achievement threshold 20052006 >= 100% of plan* *Underachieve >= 90% of plan*
	Cardiovascular disease mortality *ONS (2004 – 2006)* *PCT local delivery plans (2005)*	I Basnett S.Banerjee	E.Trenchard-Mabere	A	A	The pooled directly age standardised mortality rate for 2003-5 is 141.13 per 100,000 for circulatory disease in under 75s This is less than the target for 2006 (PSA 01a1 and PSA 01a3) and reflects a sharp fall in mortality in 2005
	Cholesterol levels – percentage of patients with CHD whose last measured cholesterol (measured in last 15 months) is 5 mmol/l or less *LDPR standard collection* *PCT local delivery plans* *(Financial year 2006/2007)*	A Ridley J Milligan	L Gittins	A	A	End October 65.5% patients with CHD whose last measured cholesterol (measured in last 15 months) is 5 mmol/l or less Note – data from 30 practices only *Target is 63%* *Achievement threshold 2005/2006 >= 100% of plan* *Underachieve >= 90% of plan*
	Practice-based registers – percentage of practices with PCT validated registers of patients with > 30% risk in next 10 years *PCT local delivery plans* *LDPR standard collection* *(Financial year 2006/2007)*	A. Ridley V. Cencora	L. Gittins	U	U	86.5% of practices have PCT validated registers; planned target = 100% *Achievement threshold 2005/2006 >= 100% of plan* *Underachieve >= 85% of plan*

Target	Indicator & *Data source*	Lead and AD	Data supplied by	2005/06 Outcome	2006/07 Progress	Notes and actions
Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	Breast cancer screening for women aged 50 to 70 years *KC63 breast cancer screening return (Financial year 2005/2006)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere K Eilbert	F	U	Indicator has changed to include percentage of women aged 50-52 and 65-70 receiving screening. Thresholds will be set separately but combined to give overall performance Breast screening coverage is provided quarterly with a six-month lag. The latest data available is for 31/3/06. Part 1, women aged 53 - 64 = 51.4% Part 2, women aged 50-52 = 34.7%, women aged 65-70 = 40.4% (These two groups taken together = 37.9%) *Achievement threshold 2005/2006 >= 65%* *Underachieve >=50%*
	Cancer - implementation of NICE improving outcomes guidance (IOGs) *Cancer network IOG action plans (as at December 31st 2006)* *DH Improving Outcomes Guidance monitoring via STEIS (as at December 31st 2006)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere K Eilbert	A	A	Indicator updated to include establishment of MDTs for second set of milestones Specialist MDTs in place: Palliative care – 5 MDTs in place, Gynae – 1 MDT in place, Urology – 2 MDTs in place, Upper GI – 2 MDTs in place, Haematology – 2 MDTs in place, Head & Neck – MDT not yet in place – target June 06 These will be assessed at the cancer network level, with all PCTs in the network being scored the same
	Cancer mortality rate *PCT local delivery plans (2005)* *ONS (2004 – 2006)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere K Eilbert	A	A	Figures for 2005 = 127.85 (3 year pooled figure not yet available - pooled figure for 2004 = 146.45) *Performance assesses actual 3 year pooled rate against plan for middle year - target for 2005 = 132*
Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%.	CPA 7-Day follow up *Special data collection* *PCT local delivery plans (Financial year 2006/2007)*	J. Burden D. Summers	D. Summers	A	A	Currently 92.2% Numbers are relatively small which can lead to month on month swings, i.e two clients only were not followed up in October. *Performance is measured against plan*

Target	Indicator & *Data source*	Lead and AD	Data supplied by	2005/06 Outcome	2006/07 Progress	Notes and actions
	Commissioning of early intervention in psychosis services *PCT local delivery plans* *LDPR standard collection* *(Financial year 2006/2007)*	J. Burden D. Summers	G. Elias	N/A	U	144 to October The dip in September was owed to patients wrongly being discounted from the caseload. This cohort are now back on the caseload which explains the sharp increase in caseload. The service is now back on target. New indicator – measures number of people with newly diagnosed psychosis receiving early intervention. Target = 155
Reduce health inequalities by 10% by 2010 (from a 1997 - 1999 baseline) as measured by infant mortality and life expectancy at birth.	Infant health & inequalities: Breastfeeding initiation rates *PCT local delivery plans* *LDPR standard collection* *(Financial year 2006/2007)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere	A	A	% of women who initiated breastfeeding within the first 48 hours after birth: Q1 06 77.7% (777/999) Q2 06 74.5% (766/1029) April-September 06 76.1% (1,543/2028) Reported Quarterly, next due January 07 *Plan = 80%* *Achievement threshold 2005/2006 >= 75% of plan* *Underachieve >= 55% of plan*
	Infant health & inequalities: Smoking during pregnancy *PCT local delivery plans* *LDPR standard collection* *(Financial year 2006/2007)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere	U	A	% of pregnant women in Tower Hamlets known to be smokers at delivery: Q106 4.8% Q2 06 3.3% April-September 06 4.0% Reported Quarterly, next due January 07 *Target 2006/2007 = 4%* *Achievement threshold 2005/2006 <= 25% above plan* *Underachieve <= 45% above plan*
	Data quality on ethnic group *HES* *MHMDS* *(Financial year 2006/2007, Quarter 1 to quarter 3 only)*	J.Burden C.Wood	B. Garner	A	A	Q1 – 11% with no ethnic code No update *Indicator measures the percentage of consultant episodes with valid coding for ethnic category* *Achievement threshold 2005/2006 >=80%* *Underachieve >=60%*

Target	Indicator & *Data source*	Lead and AD	Data supplied by	2005/06 Outcome	2006/07 Progress	Notes and actions
Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26% or less.	Progress of four week smoking quitters *PCT local delivery plans* *Stop smoking services return*	I Basnett S.Banerjee	E.Trenchard-Mabere		F	New indicator – looks at four week quitters for 2006/2007 - Performance is measured against plan Annual target for 2006/7 = 1800 Q1&2 (Apr-Sep 06) 445 4 week quits (25% of annual target) Recovery Plan produced *Achievement threshold 2005/2006 >=100% of plan* *Underachieve >= 85% of plan*
	Smoking status among the population aged 15 to 75 years *PCT local delivery plans* *LDPR standard collection* *(Financial year 2006/2007)*	A Ridley B Brese	L Gittins	F	A	Note – data from 30 practices only – end Oct 2006 73.4% patients aged over 15 years whose notes record smoking status in the past 27 months Target = 80% *Achievement threshold 2005/2006 >= 75% of plan* *Underachieve >= 55% of plan*
Reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.	Access to genito-urinary medicine (GUM) clinics within 48 hours *PCT local delivery plans* *Health Protection Agency* *(Financial year 2006/2007)*	J. Burden P. Ibekwe	P. Ibekwe	A	U	November audit 88% of patients offered, 85% seen within 48 hours YTD 78.8% seen within 48 hours *Target 2006/07 = 90.6%* HPA Audit carried out quarterly
	Access to reproductive health services (contraception and termination of pregnancy) *Special data collection* *(as at March 31st 2007)* *DH abortions database* *(Calendar year 2006)*	R. Schaedel P. Young	P. Young	A	A	Change to indicator – now in two parts, part 1 asks a series of questions regarding strategy and processes, part 2 relates to access to termination of pregnancy services Part 1 – yes to all 5 questions, Part 2 = 72% *Achievement threshold 2005/2006 >= 60%* *Underachieve >= 40%*
	Teenage conception rates – difference in rate between 1998 and 2005 *ONS (Calendar years 1998 and 2005)*	I Basnett P. Ibekwe	P. Ibekwe	A	A	In 2004, there were 174 conceptions in girls aged under 18 in Tower Hamlets, a rate of 43.2 per 1,000 females aged 15-17, which is only marginally higher than the rate for England (41.5). The rolling quarterly rate in June 2006 was 41.1. On target for 2010 *Achievement threshold 2005/2006 = consistent with 15% reduction from 1998 baseline*

Target	Indicator & *Data source*	Lead and AD	Data supplied by	2005/06 Outcome	2006/07 Progress	Notes and actions
Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.	GP recording of body mass index (BMI) status *PCT local delivery plans* *LDPR standard collection* *(Financial year 2006/2007)*	D.Russell/Andrew Ridley V Cencora	L Gittins	**A**	**U**	Percentage of age group with recorded BMI (2005/6) = 56007/170544 (33%) Target for 2006/2007 = 45% This data is not on QMAS and requires special data collection Data collection in January to monitor progress *Achievement threshold 2005/2006 >= 75% of plan* *Underachieve >=55% of plan*
	Childhood Obesity: data quality *LDPR standard collection (as at September 2006)*	I Basnett E.Trenchard-Mabere	E.Trenchard-Mabere	**N/A**		Percentage of children with height and weight recorded 2005/2006 = 51.82% (Year R only) New indicator – measures the percentage of primary school children in year R and year 6 with height and weight measured in the last year - Target >=80%
Priority 2: Supporting People with Long –Term Conditions						
To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/2004 baseline) through improved care in primary care and community settings for people with long term conditions.	Community matrons and additional Case Managers *LDPR standard collection* *PCT local delivery plans* *(as at March 31st 2007)*	C.Alexander J Milligan	C Edmonds	**F**		Indicator has changed – now in two parts to include number of case managers Currently 18 Case managers, no community matrons *Achievement threshold 2005/2006 >= 75% of plan* *Underachieve >= 55% of plan*
	Emergency bed days *PCT local delivery plans (2006/2007)* *Secondary uses service (2006/2007 Q1 – Q3 only)* *HES*	J. Burden S. Herne	B. Garner	**A**		Data source for this indicator has changed Month 6 figure 114,139 No update
	Number of very high intensity users *PCT local delivery plans* *LDPR standard collection* *(Financial year 2006/2007)*	C.Alexander J Milligan	C Edmonds	**A**	**U**	62 Children + 243 Adults (305) *Target for September 2006 = 313, Dec = 393* *Indicator measures number of VHIUs under the care of a community matron or case manager. Performance assessed against plan*

Target	Indicator & *Data source*	Lead and AD	Data supplied by	2005/06 Outcome	2006/07 Progress	Notes and actions
Priority 3: Access to Services						
To ensure that by 2008 nobody waits more than 18 weeks from GP referral to hospital treatment.	Data collection for referral-to-treatment waiting times *New data collection January 2007 to March 2007*	J.Burden C.Wood	C. Wood	**N/A**	**N/A**	New data collection The number of months (January to March 2007) where the PCT collected and submitted waiting times data on the full referral-to-treatment pathway for patients registered with GPs within the PCT.
	Waiting times for diagnostic tests *DH diagnostic waiting times & activity collection (March 2007 monthly return)* *DH quarterly census of diagnostic waiting times (As at March 31st 2007)*	J.Burden C.Wood	C. Wood	**N/A**	**U**	Indicator has changed to include all 15 diagnostic tests currently being reported October 17% waiting longer than 13 weeks. *Indicator measures the percentage of patients waiting 13 weeks or longer.* *Expectation that all patients are seen within 13 weeks by March 2007*
	Inpatient waiting times milestones for the 18 week referral-to-treatment target *Monthly monitoring return (as at March 31st 2007)*	J.Burden C.Wood	C. Wood	**N/A**	**U**	New indicator – measures the percentage of patients waiting less than 20 weeks for elective inpatient admission Currently 93.24% No update *Expectation that >=97% of patients are seen within 20 weeks by March 2007*
	Outpatient waiting times milestones for the 18 week referral-to-treatment target *Monthly monitoring return (as at March 31st 2007)*	J.Burden C.Wood	C. Wood	**N/A**	**A**	New indicator – measures the percentage of patients waiting less than 11 weeks for a first outpatient appointment Currently 97.32% No update *Expectation that >=97% of patients are seen within 11 weeks by March 2007*
Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.	Drug misusers sustained in treatment *NDTMS (NTA)* *PCT local delivery plans (Financial year 2006/2007)*	J. Burden D.Summers	G. Elias	**A**	**A**	Current performance 66% LDP target achieved (65%). The DAT are however aiming to increase retention rates to 70% in line with the national average. (2005/06 performance = 70%)

Target	Indicator & *Data source*	Lead and AD	Data supplied by	2005/06 Outcome	2006/07 Progress	Notes and actions
	Number of drug misusers in treatment *NDTMS (NTA)* *PCT local delivery plans* *(Financial year 2006/2007)*	J. Burden D.Summers	G. Elias	A	A	September performance 1375 (plan = 1300) LDP target achieved (1300). Local stretch target is 1508. The DAT partnership is on track to meet the stretch target. New prevalence data indicates 3600 problem drug users in the borough. Capacity issues are being raised. *Indicator measures performance against plan*
Priority 4: Patient/User Experience						
Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys. The experience of black and minority ethnic groups will be specifically monitored as part of these surveys.	Experience of patients *Healthcare Commission Patient survey*	A. Ridley A Mirza		N/A		Indicator withdrawn in 2005/06 but re-instated for 2006/07. Further details awaited Survey activity only available: TH 39.7% response rate, Average =51%
Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by supporting them to live in their own home by 1% annually in 2007 and 2008, and increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	Community equipment *Special data collection* *(Financial year 2006/2007)*	R. Schaedel C. Squire	C. Squire	U	A	YTD = 97% Indicator measures the percentage of equipment delivered within 7 days *Achievement threshold 2005/2006 >= 95%* *Underachieve >= 85%*

Target	Indicator & *Data source*	Lead and AD	Data supplied by	2005/06 Outcome	2006/07 Progress	Notes and actions
Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by supporting them to live in their own home by 1% annually in 2007 and 2008, and increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	Older people's mental health: assessment of needs and services *Special data collection (as at March 31st 2007)*	J Burden	P Collier	**N/A**		New indicator - PCTs assessed on the existence and content of an up to date local assessment of older people's mental health needs and services Part 1 – yes response to all three questions Part 2 – data being sourced
Achieve year on year reductions in methicillin resistant Staphylococcus aureus (MRSA) levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available	Infection control *Special data collection (as at March 31st 2007)* *Special data collection (since March 31st 2006)*	C. Alexander	C. Alexander	**A**		Construction of this indicator is under review

Section 4: Improvement Reviews

The programme of improvement reviews assesses the quality of healthcare and action in respect of public health with reference to the developmental standards. Performance is assessed from a range of different starting points, including in relation to particular domains (such as safety), particular population groups (such as children) or particular conditions (such as heart failure). These reviews are mainly concerned with experiences of patients and the public across and between healthcare organisations, and between healthcare and other public services. For 2006/2007, assessments from improvement reviews will no longer form part of the annual performance rating, but will instead be used as ongoing assurance against standards, and to identify where targeted assessments could be necessary. The reviews will be known as service reviews, and for 2006/2007, there will be three reviews carried out; diabetes, race equality and substance misuse. In addition, results from the assessment of heart failure services, carried out during 2005/2006, will be published early in 2007. All PCTs will have their performance assessed against a set of criteria published for each review. The performance for each criterion, and the overall score, is measured on a scale of one to four:

- level 1 – performance that does not meet minimum requirements or the reasonable expectations of patients and the public;
- level 2 – performance that meets minimum requirements and the reasonable expectations of patients and the public;
- level 3 – performance that goes beyond minimum requirements and the reasonable expectations of patients and the public;
- level 4 – performance that goes well beyond minimum requirements and the reasonable expectations of patients and the public. A leader in this aspect of performance.

Substance Misuse Improvement Review

The review in 2006/2007 will assess the quality of:

- services to reduce harm (known as harm reduction services) – to reduce the transmission of blood borne viruses and drug related deaths
- commissioning or systems for managing services – to ensure that services meet the needs of their population and are managed to deliver the best possible treatment to people who use substance misuse services

The review will assess these themes within the context of local drugs partnerships, such as drug action teams, which will include primary care trusts and may include services provided by mental health trusts. The sources of data that will be used for the review are:

- national drug misuse minimum data set
- treatment plans for 2006/2007

- a national survey of people who use substance misuse services, led by the NTA
- bespoke data collected from local drug partnerships or equivalent structures specifically to inform the review
- regional NTA performance management reports for 2006/2007
- bespoke data collected from regional NTA offices

The submission date for the bespoke data collection element of this review was 1st December 2006.

Improvement Review of Diabetes

This review will be looking at how well the NHS supports people with diabetes to care for themselves. This will include:

- how well key aspects of care are recorded and kept up to date
- the content and timeliness of reviews of people's care
- how programmes of care have been tailored to the needs of people
- what educational support people have received
- how people have been supported to care for themselves in hospital
- what strategies and infrastructures are in place that will help services to support people to care for themselves

There is also a national survey of people with diabetes which has been undertaken recently, results from which are expected in the near future.

Review of Race Equality

Information related to this review is expected shortly.

Heart Failure Review

Data collection for this review was completed in June and focussed on effective delivery of heart failure services. The assessment considered the extent to which the local community responds to the needs and wishes of the population served by meeting the following criteria:

- effectively diagnosing patients with suspected heart failure
- providing patients with evidence-based treatment consistent with NICE guidelines
- monitoring patients effectively to ensure optimum treatment and quality of life
- having adequate and effective multidisciplinary services in place
- having effective care processes in place
- providing patients and carers with adequate education and support
- reducing avoidable hospital admissions, bed days, mortality and improving patient experience

Results are currently being analysed prior to release for ratification, expected early in 2007.

Conclusions

The November report shows that overall the PCT is performing well against the two quality domains included in 'Getting the basics right'. The PCT is able to report that it has a high compliance score against the core standards; and, whilst there are some gaps in performance against existing targets, performance is encouraging. There is mixed progress in relation to the new targets, but this is difficult to quantify given the recent changes to the indicators.

The Board is asked to:

- **note and comment on the information in the report**

Anne Thompson
Associate Director of Integrated Governance
December 19 2006

TOWER HAMLETS PCT: ASSURANCE FRAMEWORK 2006/07
January 2007

Key Priority 1: Ensure the effective use of financial resources Lead Director: Stuart Saw								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
1.1 Achieve a minimum level 3 assessment from Auditors local evaluation	THPCT achieved a level 2 score for 05/06. The October Audit Committee and the November Board agreed an ALE action plan to move from a score of 2 to a score of 3 for 2006/07. This has been submitted to NHS London as part of the PCT performance management arrangements for the current year. The key risk is that the actions identified in the agreed plan will not be delivered.					(Related to all risks) Many of the action points in the ALE plan have already been completed and delivered. A piece of work has been commissioned for December 2006 from the PCT internal auditors. This will look at all the action points on the action plan. Each action point is RAG risk assessed with only one red target – SLA sign-off	Reports & minutes to PCT Board, PbC exec, demand management sub-group, PCT exec team Reports included in monthly finance and performance reports Outputs from the Head of Internal Audit - pending	The action plan has been reviewed and agreed with the External Audit manager. The minutes of the October Audit Committee which agreed the plan The minutes of the November Board which agreed the plan. Update reports to the Audit committee and the Risk Management sub-committee plus Board report updates.	Key papers still to be delivered to January board on Estates and backlog maintenance. The target for 06/07 SLA sign-off was 31st March 2006. The PCT has already failed this action point in the plan. The main SLA with BLT was not signed off formally until August. THPCT has not performed	Outstanding action papers for individual outstanding actions to come to January board Review process for 07/08 SLA process in line with the NHS London Operating Framework. Agree a milestone plan to sign-off with BLT	SS - Jan 2007 SS/JB – December 2006
1.2. Develop a five year financial strategy	Lack of transparency for operating framework and overall NHS London financial position – requiring additional top-slices for example or impacts on weighted capitation based funding					Review 06/07 and 07/08 budgets, decommission all pick-ups or investments not representing value for money Alignment to commissioning strategy	Five –year financial strategy to be presented to January board. Measurable outcomes for investments. PCT in financial balance as measured on a number of bases	Finance reports Board Budget Papers January 2007 5 year financial strategy paper. Monthly NHS London FIMS monitoring reports	Lack of operating framework for London post 2006/07	Assume worst-case scenario and plan accordingly. 1st cut summary budget for 07/08	SS – November 2006 SS – December 2006
1.3 Deliver the agreed capital programme David Butcher	Lack of local authority planning consent					(Related to all risks) Monthly officers meeting (senior THPCT managers, chaired by CEO) Bi-monthly Board sub-committee Regular finance & estates meetings to review progress	Minutes for all meetings Monthly financial reports for the capital programme.	Minutes for meetings (March 2006) Monthly capital reports are included in the monthly Finance reports which go to the Executive Team meetings Monthly FIMS reports to NHS London showing capital position.	None identified	N/A	N/A
	Decant facilities not available on Mile End site because of delays in completion of work for ELCMHT								None identified	N/A	N/A
	Additional funding from brokerage & incentive payments not available or top-sliced								None identified	N/A	DB/SS June 2006
1.4 Ensure delivery of the PCT Gershon efficiency savings programme Martin Cusack	Targets not set in due time					Targets issued to managers in June 2006, based on decisions of the Gershon group	Targets contained in the papers of the Gershon group (24/5) & signed off by executive team	Notes of Gershon group & monthly monitoring data (May 06)	None identified	N/A	N/A

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TOWER HAMLETS PCT: ASSURANCE FRAMEWORK 2006/07
January 2007

Key Priority 1: Ensure the effective use of financial resources Lead Director: Stuart Saw								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
	Failure to achieve control of agency & bank spend					Work of the monthly establishment review group	Monthly monitoring information & notes of meetings	Notes of Gershon group Monthly finance & performance report	Gershon savings targets for agency savings are unlikely to be delivered		MC/SS – December 2006
	Procurement projects do not deliver estimated savings Stuart Saw					Meetings of Gershon group & monthly progress reports	Notes of Gershon group planning meeting & subsequent monthly meetings	Notes of Gershon group planning meeting Monthly finance & performance report Annual savings target is on course to be achieved	None identified	N/A	Andrew Skinner/SS January 2007
1.5. Achieve recurring financial balance	Lack of transparency for operating framework and overall NHS London financial position – requiring additional top-slices for example.					Strategic financial plan including sources & applications for financial resources. There should be a linkage to quanta of Commissioned Activity. These should be based on historical and prospective trends. Lastly there should be a clear section on CIP's – Cost Improvement Programmes. This should include the impact of Demand management schemes for which there is tangible evidence.	Monthly financial reports including balance sheet & cashflow Monthly FIMS monitoring returns to NHS London Completion of the 07/08 NHS London Financial Operating Framework showing financial balance over the three year period to 2008. Financial elements of the Fitness for Purpose – FFP – exercise showing financial balance.	Board reports Formal FFP Outputs	None identified	N/A	SS – ongoing
	The costs of actual activity at Payment by Results (PbR) tariff exceed the PCT financial resources.					Coherent demand management plans linked to practice based commissioning	Monthly activity data for acute SLA monitoring with key risks flagged to the Risk Management sub-committee	Performance monitoring Formal FFP Outputs confirm that THPCT is considered 'low risk' in failing to meet financial balance targets over the next two years.	Fit for purpose activity monitoring from BLT Lack of maturity of PbC roll-out	Monthly performance monitoring with BLT Adherence to formal freeze/flex dates Escalation of data problems to London SHA Use of ELCIS to validate activity data Use of LES and incentives to develop PBC.	SS – ongoing

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Key Priority 2: Deliver national performance requirements Lead Director: Stuart Saw and Douglas Russell (and individual Directors for specific targets)								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
2.1 Ensure delivery of full compliance against the core standards	Organisational turbulence diverts attention away from standards					Named manager to co-ordinate delivery of full compliance Installing performance accelerator and developing monitoring to ensure compliance	Post filled Product installed and tools developed	Board reports (monthly)	Installation of product incomplete	Monitor and ensure robust use of systems and tools. Making submission to London wide clinical governance meeting on mapping from SHA to new SHA	DR Currently showing full compliance
	Unexpected SUI revealing breach					Robust 1st year documents SLA for safety management and assurance	Action plans embedded in quality	Governance reports, statement of internal controls and HCC scoring SHA assessment of governance process	Action plans are not robust	Ensure systems and processes are reviewed regularly to ensure quality and strengthen action plans	DR Plans reviewed quarterly and included in performance report. No substantial breaches to date.
	High staff turnover & loss of organisational memory					Posts filled	Team working to address issues and needs Comprehensive induction	Board reports, HR and service reports	Failure to address key issues Poor uptake of induction	Prioritise team working to resolve gap Ensure Induction process	DR Low staff turnover
	Engagement of Independent Contractors					Ensure adequate contractual arrangements and SLAs	Process in place to ensure controls	Contracts and SLAs in place	Incomplete/inadequate contractual arrangements	Monitor all contractual processes and ensure compliance with process required	DR Balanced Scorecard adopted. High attendance at launch in December 2006
2.2 Continue to deliver existing targets	Lack of understanding of targets by leads					(All risks) Monthly performance report Monthly data collection mechanism in place Leads identified for all targets with director level involvement to ensure accountability	Traffic-light performance report showing status Monthly data returns from leads Positive outcome for Annual Health Check	SHA performance report (April 2006)	Lack of transparency for target construction & thresholds for some targets Understanding of targets by leads Lack of formal agreement on adoption	Training for leads & review of targets Liaison through SHA performance group Consulting with LMC Formal agreement	SS – June 2006 & ongoing Updated target indicators published November 2006, currently on target for fully met.
	Provider-based targets mapped to PCT										
	Limited investment for expansion of targets										

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TOWER HAMLETS PCT: ASSURANCE FRAMEWORK 2006/07
January 2007

Key Priority 2: Deliver national performance requirements Lead Director: Stuart Saw and Douglas Russell (and individual Directors for specific targets)								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
2.3 Strengthen performance in the new targets	Lack of data construction for most targets, therefore no effective basis for monitoring					Trajectory on LDP Refresh LDP with meaningful scores Revisit ownership Early visit of targets	Monthly performance reports Adjusted LDP trajectories Action plans flowing from hard to meet trajectories	SHA	Delayed action plans due to lack of clarity on ownership Data construction remains poor	Ensure clarity of ownership Develop progressive action plans to ensure improvement in data construction	DR Updated target constructions published November 2006. A number of changes and additions therefore continued uncertainty over thresholds for achievement. Data now available at practice level for all practices.
2.4 Ensure strong performance in the 2006/07 Improvement Reviews	Lack of detailed advance information of assessment framework					Effective links between Finance/performance and Governance/risk management	Agree input and support from key players Develop working group to improve links	Improved review scores	Breakdown in communication chain between key players	Ensure development of working group and prioritise areas of action.	DR Lead identified for each review and works with reps from relevant organisations to ensure effective input.
	Provider-based assessments mapped to PCT					Effective links between Finance/performance and Governance/risk management	Agree input and support from key players Develop working group to improve links	Improved review scores	Breakdown in communication chain between key players	Ensure development of working group and prioritise areas of action.	DR Lead identified for each review and works with reps from relevant organisations to ensure effective input.
	No corporate sign-off and/or incomplete, inaccurate data					Reorganisation	Performance management Implemented	Corporate sign off	Data remains incomplete/inaccurate	Ensure implementation of performance management	DR Responses agreed at data scrutiny group before submission.
2.5 Strive to achieve positive outcomes in the patient surveys undertaken by the Healthcare Commission in 2006/07	Methodology unrepresentative					Generate publicity about success Provide positive stories on engagement	Promote responses in community Strengthen patient involvement	PPI reports	Need for wider engagement of local community	Develop proactive approach to community engagement	DR

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Key Priority 3: Strengthen the commissioning role of the PCT Lead Director: Jeremy Burden								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
3.1 Develop a strategic framework for commissioning for improved health outcomes in Tower Hamlets over the next 10 years	Lack of management capacity to deliver on FFP gaps					Fitness for purpose will support it's development PEC ass strategic commissioning board of the PCT	Planning and development of framework Improved ratings PEC sign off commission in plan in December 2006 in line with NHS London commissioning timetable	Rated green on Fitness for Purpose Draft commissioning plan to PEC and Board on 7th December	None	Promoting uptake of services	JB Drafts taken to Board and PEC September through October Version 3 taken to PEC and Board on 7th December
3.2 Ensure the delivery of the Tower Hamlets demand management plan	Failure to deliver plan by commissioned services in line with agreed SLAs					Working group established Demand mgt plan re-worked in light of Fitness for Purpose	Monitoring via the demand mgt sub committee	Monitoring reports to demand mgt group Impact of demand mgt via Board and PEC reports	Delivery partly dependent on commissioned providers	Collective ownership of plans and delivery against outcomes	Out patient element of demand management on target. Non elective under performing
3.3 Ensure that Practice-based Commissioning is implemented effectively in Tower Hamlets Jeremy Burden/Andrew Ridley	Failure of practices to develop business plans					Practices supplied with common template Member of staff identified to support business plan development Financial incentives	Written business plan for all practices Variations from plans discussed at quarterly contract monitoring visits	Practice Business Plans and monthly data monitoring of activity			AR Business plans all developed. PCT and practices now supporting implementation of plans.
	Failure of PBC executive to function properly					Group includes 4 executive directors Additional support available if needed.	Minutes of PBC executive meetings Corporate monitoring data reviewed at PBC executive with support from Primary Care directorate	Monthly budget monitoring information (05/06) Minutes of PBC Executive and supporting "technical Group"	(GIA) Incomplete information from data warehouse	Monitor and improve Information from data warehouse	AR PBCE meeting monthly; well attended and beginning to function smoothly
	Failure to manage change as a result of the above					Service re-design plans reviewed at PBC executive and PEC	Minutes of PBC executive meetings Corporate monitoring data reviewed at PBC executive with support from Primary Care directorate	Monthly budget monitoring information (05/06) Minutes of PBC Executive and supporting "technical Group"	(GIA) Incomplete information from data warehouse	Monitor and improve Information from data warehouse	AR Evidence suggests that new services, e.g. CAS are having an impact on hospital activity.

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Key Priority 3: Strengthen the commissioning role of the PCT Lead Director: Jeremy Burden								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
3.4 Develop further joint commissioning arrangements with LBTH (Standard C22)	Failure to progress with current plans to have agreed arrangements by March 07					Recruit project manager to develop plans Project Board between PCT and LBTH in place with agreed work streams and identified leads	Project Board minutes Work stream minutes	Reports to Exec team Updates to Joint Corporate meeting between PCT and LBTH	Unable to recruit Project Manager	Prioritise recruitment of project manager	JB Funding for project manager secured. Post now being reviewed following work to date Work streams ready to report initial comments to project board
3.5 Strengthen the role of local people and service users in the commissioning process (Standard C17)	Inadequate P & P involvement					Change our approach and approachability to encourage user involvement	Proactive measures to engage local community and service users. Engaging a wider group and better representative group of patients/users of PCT services Plan to use other existing forums at the local authority including Citizen's Panel	PPI reports New set of patient experience metrics in SLAs with providers	Inadequate support for PPI forum	Better support for PPI forum Alignment of PPI forum with commissioning	JB/AM
	Failure to progress with current plans					Recruit project manager to develop plans	Project manager is recruited	PEC papers	Unable to recruit Project Manager	Prioritise recruitment of project manager	JB
3.6 Working with the new London SHA and the London PCTs, develop and implement the London commissioning model (Standard C22)	Lack of cohesion and planning for 07/08 Uncertainty of relationship with new SHA					Establish early relationship with key players	Evidence of established relationships	Minutes of meetings	Difficulty in establishing and developing relationship due to the nature of new and broader role of SHA	Proactive engagement of key players	JB Framework now in place
3.7 Implement an appropriate and effective commissioning process for the PCT's directly provided services Andrew Ridley	Lack of prioritisation					Overall commissioning strategy to include directly provided services	Completed overall commissioning strategy to include directly provided services	2007/08 PCT Commissioning Intentions clearly identify provider services of priority review/development	(GIC/GIA) Overall commissioning strategy	Develop strategy	AR and JB Priorities for work with provider services identified within PCT commissioning intentions for 07/08

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Key Priority 3: Strengthen the commissioning role of the PCT Lead Director: Jeremy Burden								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
	Insufficient capacity to implement					Re-designed directorate structure to create capacity	Roles re-designed to include explicit responsibilities Clear process for commissioning directly provided services	New Directorate Structure in DPCCC fully implemented November 1st. All provider services now transferred.	(GIA)		AR New Directorate Structure in DPCCC fully implemented November 1st. All provider services now transferred.
3.8 Significantly improve the information available to the commissioning process (Standard C23)	No change					Data warehouse and Emis web MIDAS report to all practices	ITC strategy PBC monthly reports Monthly information report that supports the Board balanced scorecard	Data warehouse information Monthly reports to PEC, Board & CMT	Systematic use of data by users	Review of use of information as part of performance management regime	JB
	Lack of public health input to the commissioning process Lack of integration between public health intelligence and other information streams in the PCT					Agreed programme of public health support to commissioning	Agreed programme of public health support to commissioning	Public Health reports Public health input into commissioning plans	GIC Programme of public health input to commissioning not yet agreed	Clarify public health information requirements for commissioning Clarify communication channels between public health and the other 2 commissioning directorates Reprioritise public health intelligence programme within the directorate	JB / IB

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Key Priority 4: Improve the health of the local population & reduce health inequalities Lead Director: Ian Basnett								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
4.1 Improve the health of children and young people (Standard C18)	Lack of data to monitor LPSA target for reduction of adolescent obesity					BMI monitoring for school children in years 1 and 6.	Data on BMI for children in years 1 and 6.	Data for year 1 collected and has now been submitted	GIC data for year 6 was not collected in school year 2005/06	Year 6 data now being collected and data collection should be complete by April 2007	September 2007 IB / SB / ETM Year 6 data was not collected due to misinterpretation of guidance, to be collected by April 2007 Year 1 data has been submitted
	Failure to meet Healthy Schools standard					SLA with Healthy Schools Team Monitoring by multi-agency steering group	Quarterly progress reports. Local Healthy Schools Plan	Annual Performance Assessment (APA)** (June 2006)	None	N/A	IB / ETM
	Outbreaks of measles, mumps or rubella if immunisation coverage targets not achieved					PCT immunisation steering group / action plan.	Data on childhood immunisation rates	Data being collated directly from primary care	GIA due to technical problems with Child Health Interim Application (CHIA)	Regular feedback to primary care to allow follow up of poorly performing practices, targeted campaign in community	IB / LD / CB
	Reduction in teenage conceptions not sustained					Teenage pregnancy strategy / action plan	Data on teenage conceptions (annual). Quarterly data	Data from DoH / TPU** (February 2006)	None	N/A	IB / PI Quarterly data in Sept 05 was 42.7
4.2 Continue to develop comprehensive and effective smoking cessation services (Standard C22)	Failure to meet 2006/07 target of 1800 quitters					Smoking cessation strategy (including increase in numbers of trained level 1 and 2 advisers.) LAA delivery plan.	Quarterly reports to DoH / SHA.	Quarterly reports to DoH/SHA	None	LAA Delivery Plan completed. Smoking Cessation Recovery has been written to address poor performance	IB / SB / TM At second quarter only 25% of target has been achieved.
	Persisting inequalities due to unequal uptake of smoking cessation service					Health Equity Audit to identify inequalities in uptake of smoking cessation service.	Report on Health Equity Audit as part of Tobacco Control Strategy	Report to Living Well CPAG	GIC Data analysed but report not written	Health Equity Audit to inform service development	IB / SB / TM Health Equity Audit data has been analysed and is being used to increase smoking cessation service provision where there are gaps

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Key Priority 4: Improve the health of the local population & reduce health inequalities Lead Director: Ian Basnett							Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
	Failure to secure funding for NRF Health Trainers Programme					Robust bid to NRF	Approval of bid by Tower Hamlets Partnership (July 2006).	NRF monitoring	None	N/A	IB / SB Bid successful and work underway to implement programme (tendering process, training, coordination)
4.3 Develop a borough wide strategy for physical activity and healthy eating (Standard C22)	Failure to secure commitment of key partners					SLA with Healthy Lifestyles Team. Multi-agency weight management Strategy. LAA delivery plan (incorporating strategy)	Sign off of strategy by Tower Hamlets Partnership Sign off of delivery plan by LAA Cross-sector group.	LAA delivery plan finalised.	GIC Multi-agency weight management strategy not yet finalised	Agreement of multi-agency weight management strategy by …..	IB / SB LAA Delivery Plan has been submitted More work needed on physical activity strategy
4.4 Improve take up and coverage of screening programmes – specifically breast screening and cervical cytology (Standard C23)	Failure to meet local target of increasing coverage of Breast Screening from 38% to 60%					Robust 3 year screening plan agreed with CELBSS including timely communication of when women are to be called. Pilot project with DNA women using new digital equipment. Recommendations from literature review of effective interventions.	CELBSS three year screening plan. Quarterly monitoring data from CELBSS (uptake) and three year coverage data (available annually). Evaluation report from DNA project.	Coverage up to March 2006 confirmed as 51.5% (improvement on coverage up to March 2005 but still below national target of 80%)	None	DNA project offering new appointments	IB / ETM / KE 3 year screening plan agreed DNA project has commenced and is showing good results Draft good practice guidelines have been written and will be piloted with sample of practices Plans to develop LES in 2007 for implementation November 2007
	Failure to achieve 80% coverage of cervical screening programme (from 73%)					Recommendations from literature review of effective interventions.	Data on uptake and coverage	Coverage data from QARC**	GIC Recommendations not fully implemented	Implement recommendations Target practices with lowest uptake.	IB / KE / SS Draft good practice guidelines have been written and will be piloted with sample of practices

Notes on terminology etc are on page 18

Key Priority 4: Improve the health of the local population & reduce health inequalities Lead Director: Ian Basnett							Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
4.5 Improve the primary and secondary prevention of cardiovascular disease and diabetes in primary care (Standard C23)	Failure to improve prevention and management of CVD and diabetes in primary care					LAA delivery plan. Diabetes Specialist Nurses targeting poorly performing practices. Primary care directorate developing balanced scorecard to assess quality of care. Smoking cessation services. Obesity care pathway	Data on relevant HCC targets performance monitored monthly	Assessment of progress in CHD and Diabetes LITs Updated CEG guidelines National Diabetes audit data	GIC Practice level balanced scorecard to be launced (see 5.1). Obesity care pathway to be developed in Jan 2007 following NICE guideline release.	Agreement of LAA delivery plan (31st August) Target action at poorly performing practices.	IB / SB LAA delivery plan submitted CEG guidelines distributed
4.6 Improve the detection of suspected cancers in primary care, with urgent referral for further investigation within 24 hours (Standard C23)	Delayed GP referrals contributing to breaches of 62 day target (from GP referral to first definitive treatment)					Monthly reporting of delayed referrals from BLT. Follow up of GPs not sending urgent cancer referrals within 24 hours.	Reporting at Cancer LIT meetings and BLT performance review meetings	Reporting at Cancer LIT meetings (bi monthly) and BLT performance review meetings (quarterly) BLT reporting weekly on GP referrals	None	N/A	IB / ETM / KE No breaches in Tower Hamlets patients since June 2006, providing no more breaches could achieve target. (but still breaches in patients referred from other hospitals)
	Inappropriate GP referrals					New proformas for referral of suspected cancers incorporating NICE guidelines	Weekly reporting of GPs not using new proforma and not faxing within 24 hours by BLT	Weekly reporting of GPs not using new proforma and not faxing within 24 hours by BLT	None	Publicise new urgent cancer referral proformas to GPs. Provide briefing / training on appropriate referrals through PLT and other fora. (September – December 2006)	IB / KE / BQS Training has been delivered Use of proforma has improved

Notes on terminology etc are on page 18

Key Priority 5: Continue to improve the quality of primary & community care services Lead Director: Andrew Ridley								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
5.1 Continue to improve the quality of general practice in Tower Hamlets through the introduction of a performance assessment process and further improvements in the Quality and Outcomes Framework	No agreement for balanced scorecard					(All risks) Discussion at PEC, LMC and Board Practice based assessment reports & action plans for 'C' rated practices	Minutes from PEC, LMC & Board meetings Action plans for 'C' rated practices with deadlines Minutes of Performance committee Performers list	Balanced scorecard formally agreed at LMC and Board Launch and implementation from Nov 2006	None identified	N/A	AR Good progress with formal LMC agreement to implementation of BSC.
	Inability to act on the result from balanced scorecard								None identified	Awaiting assessment of practices	AR All practices being formally assessed during Q4 – too early to predict results and therefore required actions.
5.2 Working closely with LBTH, the LAPs and other partners, begin to develop the primary and community care networks as outlined in the Health and Well-being Strategy (Standard C22)	Lack of co-operation between partners					Associate Director/Primary Care Development Manager relationship with practices Enhanced services commissioning process	Minutes from contract visits Centralised practice file held in Primary Care building Enhanced services plan & group	Inter-practice referral agreements (copies held by Primary Care) Evidence of practices working with other agencies (SLAs held by Primary Care) Minutes from Isle of Dogs Network	None identified	N/A	AR Moderate progress eg: Isle of Dogs network developing well; some practices inter referring for enhanced services. More practices engaged in LAP process.
5.3 Implement the Tower Hamlets strategy for older people and people with long term health conditions (Standard C22)	Insufficient data to track progress in implementation					Indicators to monitor progress	Indicators reviewed at Long Term conditions project board	Minutes from monthly long-term conditions project team meetings (may 06)	(GIC/GIA) Set of indicators to track progress/monitoring of indicators		AR Good progress on Long Term Conditions, as highlighted in the annual report. Good progress on older peoples strategy, though more data development required.
5.4 Increase our focus on targeted interventions for people with long term conditions who are also in receipt of incapacity benefits	Delay in roll out of "Pathways to work"					A Plan and indicators to support progress	None identified	A commissioning or delivery plan	None identified	N/A	AR/MC – Expressions of interest for NE London roll out of Pathways to Work just announced. PCT reviewing its potential roll.
5.5 Progress the development of priority capital schemes, as outlined in the Health and Well-being Strategy	Inadequate planning, including strategy and business plans					Strategy & business cases	Copy of strategy Business case for each scheme	Strategy Business cases for Barkantine and Queen Elizabeth developments	(GIC) Business cases for remaining schemes	Framework for all schemes in draft form Completion aim for Dec 06	AR/DB – a draft business case for all schemes has now been considered by the Capital Sub Group of the Board

Notes on terminology etc are on page 18

Key Priority 5: Continue to improve the quality of primary & community care services Lead Director: Andrew Ridley								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
David Butcher/Andrew Ridley	Potential for poor project management: schemes may not be delivered on time and/or to budget					Critical path developed for each scheme Process for monitoring against critical path	Copy of critical path for each scheme Terms of Reference & minutes of project team for each scheme Monitoring reports for each scheme	Project team minutes for Barkantine & Harford street projects	(GIC) Copy of critical path for each scheme Terms of Reference & minutes of project team for each scheme Monitoring reports for each scheme	Critical path developed for each scheme Project Teams & Terms of Reference developed for each scheme Monitoring process developed	Outline SOC now i n place for all schemes with critical path. New Programme Management Board to meet in January 07 to review all schemes, including project management arrangements.
5.6 Develop an Urgent Care Strategy that simplifies and improves care and reduces inappropriate A&E attendance	No agreement across health economy					Process for developing strategy Completed strategy	Minutes & papers from Urgent Care network board Event to launch draft strategy – 25th Oct Consultation on service reconfiguration options for Whitechapel (includes A&E, WIC & OOH)	Minutes of Urgent Care network board (April 06) Draft Strategy in place	(GIC) No urgent care strategy	Final strategy	AR – High degree of consensus achieved at annual urgent care event. Written strategy now being discussed at UCN Board.

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Key Priority 6: Improve the provision of mental health & substance misuse services Lead Director: Jeremy Burden								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
6.1 Begin to implement the Tower Hamlets Adult Mental Health Strategy (Standard C22)	Lack of capacity and resources					Implementation overseen by Adult Mental Health Partnership Board Feed into PCT commissioning plans	Papers from board meetings Commissioning Intentions	Minute from meetings	Current financial climate Lack of general improvement in the quality of services provided	Robust engagement with providers Clear specifications for any new investment into mental health services	JB Robust dialogue with all partnership members on strategy. Commissioning plans for 2007/08 highlight new investment into mental health services on the back the strategy
6.2 Continuing support to our primary care model with the recruitment of a primary care consultant psychiatrist	Unable to recruit primary care consultant					Funding agreed with Royal college Support arrangements agreed	Royal College approval	Royal college approval	No Gaps	N/A	JB Interviews on 11 December 2006 Now recruited
6.3 Ensure the delivery of a comprehensive and co-ordinated model of primary and community mental health services aligned with the transfer of mental health services from St Clements Hospital to Mile End in late 2006 (Standard C18, C22)	Uncoordinated and fragmented					Community Psychology managing services	Monitoring	Partnership board	Failure to develop better coordinated model	Performance management	JB
6.4 Increase the number of drug users receiving treatment and who are successfully sustained in treatment	Incomplete data collection and non-recognition by NTA of true picture					Internal data validation by the DAT	Dialogue with the NTA Balanced scorecard reports	Improved partnership Balanced scorecard reports update November 06)	Lack of capacity	High level engagement and scrutiny	JB Target met but ongoing work to meet stretch targets and improve retention in line with national average

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Key Priority 7: Make measurable progress in meeting targets related to equality & diversity Lead Director: Martin Cusack								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
7.1 Develop an Equalities and Diversity strategy, with detailed action plans and measurable targets to monitor progress (Standard C13)	Strategy not completed or agreed by the E&D Sub-Committee and Board					Strategy to be signed off by E&D Sub Committee and Board E&D Planning Group held on a monthly basis	Minutes of sub committee held in March. CMT meeting April. Strategy out for consultation at present E&D Planning Groups held monthly and minutes available	Minutes of sub committee considered by Board on regular basis	None	None	MC Quarterly reports to Board
7.2 Increase the percentage of PCT staff employed from the local community	Not able to recruit staff due to lack of funding					Board has agreed targets. Included in Corporate Objectives 2006/7	Minutes of E&D sub committee January 06, March 06	Board reports	None	None	MC Quarterly reports to Board
	Priority to be given to at risk staff in London for all vacancies					London wide management of change policy	Communication from London transition team	None	Have to comply with London policy.	To review all opportunities to recruit locally.	MC March 07
7.3 Increase the number of people we employ who have disabilities or long term health conditions and improve support for those staff	Lack of availability of suitable applicants					Equality and Diversity sub committee reports January/March 06	Minutes to Board May 06	Minutes of sub committee considered by Board on regular basis	None	None	MC Quarterly reports to Board

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Key Priority 8: Develop our staff, employment practices & organisation as a whole to ensure the PCT is an employer of choice Lead Director: Martin Cusack								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
8.1 Develop the skills and capacity of our workforce to deliver a broad range of high quality primary and community care services Caroline Alexander/Douglas Russell (Standard C11)	Reduction in training budget from SHA					(All risks) Enhanced education, training & development (ETD) group Service re-design plans include workforce development Flexible approaches to training delivery Regular meetings with SHA 100% achievement of appraisal & PDP Ongoing development of KSF	ETD programme of meetings and workshops ETD reports to PEC Notes of meetings with SHA Reports to executive team & Corporate Management Team Notes of KSF strategic group Notes of long term conditions workforce development group Notes of Urgent care workforce development group	ETD report (April 06) Notes of KSF strategic group (March 06, Oct O6) Notes of long term conditions workforce development group (May 06, July 06) Notes and paper tabled at corporate management team (June 2006)	(GIA) No regular report to executive team	Report frequency to be agreed and begin asap - six monthly next report to corporate management team due in Jan 07	CA – July 2006 & ongoing
	Capacity to maintain continuity of care while re-designing services										
	Lack of coherence between training plans										
	Capacity to facilitate change										
8.2 To develop the PCT as a model employer based on the outcomes of the Staff Survey	No corporate action plan					(All risks) Agreed corporate & directorate plans to be produced by end June 2006 Work of HR executive group	Report to Chief Executive & Board via Corporate Management Team (July 2006) Model employer & staff survey included in corporate objectives Staff survey included in director objectives Improved response rate and responses to 2006/07 staff survey	Minutes of executive team and corporate management team (April 06) Publication of Corporate Objectives (May 06)	None identified	N/A	N/A
	No directorate action plans								None identified	N/A	N/A
	Not allocating sufficient resources to implement plans								None identified	N/A	N/A
8.3 Implement new arrangements for the Directorates, PEC, PbC	Implementation of PbC not effective (see 3.3)					As 3.3	As 3.3	As 3.3	As 3.3	As 3.3	As 3.3

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Key Priority 8: Develop our staff, employment practices & organisation as a whole to ensure the PCT is an employer of choice Lead Director: Martin Cusack								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
to support the strengthened commissioning role of the PCT and agree a development plan following the Fitness for Purpose review Alwen Williams	Failure to meet key criteria in Fitness for Purpose review					Appropriate level of resources committed to process Included on agenda of Executive team, CMT & Board Board development session to review effectiveness in relation to Fitness for Purpose Lead Director training	Minutes from meetings Outcome from Board development session Positive outcome from Fitness for Purpose assessment & diagnostic review Action plan following review	Positive outcome from Fitness for Purpose assessment & diagnostic review	(GIA) Detailed discussions at meetings	Major item on agenda for CMT and PEC in June	September 06 for completion of process Positive outcome from Fitness for Purpose assessment & diagnostic review
8.4 To develop communications to ensure improvements and new developments are recognised, and communicated, by staff, independent contractors and our partners and that improvements in services are frequently and accessibly communicated to the local community and national opinion-formers Jeremy Gardner/Alwen Williams	Negative national publicity adversely affecting the credibility of the local message					Relationships with local partners/media/community organisations Communications Strategy	Positive articles in media and partner organisations' publications Feedback from 2-way brief Results from staff survey on communications	None at present	None identified	N/A	N/A

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Key Priority 8: Develop our staff, employment practices & organisation as a whole to ensure the PCT is an employer of choice Lead Director: Martin Cusack								Board Reports			
Key Objective	Principal Risks (include classification of risk)	Risk Status Q1	Q2	Q3	Q4	Key Controls	Assurances on Controls	Key Positive assurance (** External/Independent)	Gaps in Control or Assurance (GIC) or (GIA)	Corrective Action	Responsibility Target Date Progress
8.5 Strengthen the PCT's preparedness for emergency and business continuity planning Ian Basnett (Standard C24)	Occurrence of major incident before major incident and business continuity plans have been fully updated and tested					Robust major incident and business continuity plans Appointment of operational emergency planning officer to support lead Director	Presented updated major incident and business continuity plans to Board (September 2006)	Presented updated major incident and business continuity plans to Board (September 2006)	GIC Updated major incident and business continuity plans finalised Operational emergency planning officer appointed	External consultant currently working with Heads of Service to support development of business continuity plans and updating of major incident plan. Tested updated plans with Major Incident Team (Directors and designated deputies) in September/October Identified operational emergency planning officer Briefing and training for staff at all levels in the organisation (in progress)	IB/ PI September 2006 Major incident and business continuity plans approved at Board meeting in September Training of staff has commenced Operational Emergency planning Officer has been identified
	Occurrence of pandemic flu before plan has been completed and tested					Robust Pandemic Influenza Plan First draft of joint plan to be in place by January 2007	Presentation of Pandemic Influenza Plan to Board (April 07) Testing of draft joint plan in February 2007	Formal ratification of joint plan by LBTH cabinet and PCT Board following testing of draft plan	GIC Pandemic Flu Plan not yet complete (due 31 July)	Presentation of Pandemic Influenza Plan to Board (April 07) Broaden membership of multiagency Influenza Pandemic Committee (IPC) to include senior representation from LBTH Adult Social Care and Children's Services. Convene PCT task group for detailed operational planning. Briefing and training for staff at all levels in the organisation. Testing of pandemic flu plan with Major incident team.	IB / PI / LD April 07 Have agreed to produce joint Pandemic Flu plan with LBTH Workshop with senior representation from LBTH, BLT, ELCMHT and PCT has been held and process for agreeing joint plan by January 2007 agreed Draft joint plan ready for comment in Dec 06 (due January 2007

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Notes on terminology etc

Column	Notes on contents
1	**Key Objectives** take account of corporate and directorate level objectives. Key objectives should be strategic, SMART, be balanced across the organisation and cover the 7 domains outlined within the Standards for Better Health Care. This column also indicates the lead director for an objective, where this differs from the overall lead for the relevant priority. Where relevant, the objective is cross-referenced to the relevant Standards for Better Health
2	**Principal Risks** are what could prevent key objectives from being achieved. Key risks should be true risks (rather than consequences), and so cannot just be the converse of the objective. Risks should be classified using the same categories as the corporate risk register i.e. injury or harm; finance/stewardship; reputation; transformational; litigation; clinical quality; environment; performance.
3 (see note)	**Risk status (red, orange, yellow or green).** This shows the 'traffic lighting' applied to each risk, and seeks to help the Board 'weight' the amount of attention that it directs in reviewing entries on the Assurance Framework. The risk status is updated quarterly and, where no update is received, is automatically graded as 'red'. Risk status should be assessed using the agreed risk matrix (see Appendix)
4	**Key Controls** are factors that are in place to mitigate the principal risk(s) and assist in securing delivery of the relevant key objective. Key controls should be robust and specific, and properly match the associated key objective(s).
5	**Assurances on Controls** are sources of evidence that the key controls are effective. Assurances should be matched with specific key control(s) wherever possible.
6 (see note)	**Key Positive Assurance** assessment seeks to measure the level of assurance with which it can be determined that the key controls are mitigating the principal risks identified. The assessment also specifies how/where the PCT has evidence showing that principal risks are being managed reasonably. Descriptions should provide sufficient details to identify specific documentary evidence, e.g. dates of meetings, publications, reviews etc. External or Independent assurances are generally given more weight than internal sources.
7	**Key Gaps in Control** indicate where the PCT has failed to put key controls in place, or where the PCT has failed to make key controls effective.
7	**Key Gaps in Assurance** indicate where the PCT is failing to gain evidence that key controls are effective.
8	**Corrective action** shows what will or is being done to address the gap(s) in control or assurance.
9	**Responsibility, target date and progress** show: the director (or senior manager) responsible for appropriate and timely implementation of corrective action(s); the expected date by which actions should be completed; and 'progress' gives an update on the achievement of each action plan point.
N/A	**Generally, Assurance Frameworks** should map key objectives to principal risks, key controls and assurances explicitly. Assurance frameworks should be embedded and dynamic, providing regular Board information and not viewed as year-end exercises.

Note. The risk status does not necessarily mirror the positive assurance assessment. For example, it is possible that work may be well on track (or ahead of plan) to develop controls or address a risk, and hence management may determine that the risk status be assessed as 'green'. However, because that work is not complete, the positive assurance assessment may be 'limited assurance', with actions identified to complete the relevant work.

Tower Hamlets PCT Risk Matrix

RISK RATING

- LOW
- MODERATE
- HIGH
- SIGNIFICANT

For the element being assessed on a score of 1-5

a) Decide the potential consequences

b) Decide the probability of failure

c) Multiply the two numbers

d) Compare the score obtained with the "score range" table

			Likelihood				
		Rating	1	2	3	4	5
		Failure Descriptors	RARE	UNLIKELY	POSSIBLE	LIKELY	CERTAIN
		FREQUENCY	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
		PROBABILTY	Less than 1% <10%	1 – 5% 10 – 24%	5 – 20% 25 – 49%	21 – 50% 50 – 74%	Greater than 50% 75% +
Potential Consequences	Rating	Descriptor	A Objectives / Projects	B Harm / Injury	C Actual or Potential Complaints / Claims	D Service / Business Interruption	E Staffing and Competence	F Financial	G Inspection / Audit	H Adverse Publicity / Reputation	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not
	1	INSIGNIFICANT	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality.	No Harm Impact prevented (IP): Any incident that had the potential to cause harm but was prevented. No Harm Impact not prevented (INP): Incident occurred with no harm to patient or staff.	Locally resolved complaint.	Loss / interruption more than 1 hour.	Short term low staffing level temporarily reduces service quality (less than 1 day).	Small loss < £1000	Minor recommendations Minor non-compliance with standards.	Rumours.					
	2	MINOR	less than 5% over budget / schedule slippage. Minor reduction in quality / scope.	Patients required extra observation or minor treatment and caused minimal harm, to one or more persons. Staff did not need debriefing or injury resulted in 0-3 days off sick or unable to fulfil normal duties.	Justified complaint peripheral to clinical care.	Loss / interruption more than 8 hours.	Ongoing low staffing level reduces service quality.	Loss more than 0.1% of budget £1000 - < £10K	Recommendations given. Non-compliance with standards.	Local media – Short term. Minor effect on staff morale.					
	3	MODERATE	5-10% over budget / schedule slippage. Reduction in scope or quality.	Patients require moderate increase in treatment, and which caused significant but not permanent harm, to one or more persons. Staff: Resulted in over 3 days of sick Staff needed debriefing.	Below excess claim. Justified complaint involving lack of appropriate care.	Loss / interruption more than 1 day.	Late delivery of key objective / service due to lack of staff. Minor error due to poor training. Ongoing unsafe staffing level.	Loss more than 0.25% of budget £10K - < £100K	Reduced rating. Challenging recommendations. Non-compliance with core standards.	Local media – Long term. Significant effect on staff morale.					
	4	MAJOR	10-25% over budget / schedule slippage. Doesn't meet secondary objectives.	Patients incident that appears to have resulted in permanent harm to one or more persons. Staff: Resulted in major injury (as defined by Health & Safety Executive(HSE).	Claim above excess level. Multiple justified complaints.	Loss / interruption more than 1 week.	Uncertain delivery of key objective / service due to lack of staff. Serious error due to poor training.	Loss more than 0.5% of budget £100K - <£500K	Enforcement Action. Low rating. Critical report. Major non-compliance with core standards.	National Media less than 3 days.					
	5	Critical / Death	More than 25% over budget / schedule slippage. Doesn't meet primary objectives.	Patient died as a direct result of the incident. Staff died as a direct result of the incident.	Multiple claims or single major claim.	Permanent loss of service or facility.	Non delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training.	Loss more than 1% of budget £500K +	Prosecution. Zero Rating. Severely critical report.	National media more than 3 days. MP Concern (Questions in House).					

CONSEQUENCE		LIKELIHOOD	RISK RATING
MAJOR		LIKELY	
4	X	4	SIGNIFICANT

ICT Deployment report for Tower Hamlets PCT

Introduction

2006 has been a difficult year for NHS Connecting for Health in London. The past 12 months has seen the much publicised replacement by BT Capital Care Alliance of its original IT supplier; General Electric, with a set of offerings for the Acute, Mental Health, Community and Primary Care setting, based on the Cerner (Acute) Rio (Mental Health & Community) and INPS (Primary Care) products. Despite this, 2006 has seen significant deployment activity with Tower Hamlets PCT, based on the business case previously approved by the Board.

The ICT business of the PCT is managed via the ICT Committee, which is a sub-committee of PEC and chaired by Dr Kambiz Boomla.

Highlights

Through intensive and active engagement with NHS Connecting for Health and BT, Tower Hamlets PCT has made significant progress with the National Programme for IT and in many areas is the leading or amongst the leaders within London for its ICT developments and deployments;

We are leading the way in getting the London solution for acute hospitals (Cerner) to be deployed in PCTs. The benefits of this are that THPCT can maintain the continuity of care and medical records with those of an acute Trust. We are among the first at getting digital radiology images to the community hospital clinicians and hope to extend this access to GPs in 2007.

We are part of a national pilot to transfer medical records electronically between GPs when patients move addresses and hence GPs.

We are the only Care Community (with the local acute trust, mental health trust and social services department) to have deployed the electronic application for the Single Assessment process (eSAP). This is a significant step forward for patients and their carers as it will reduce the number of times they will have to give the same information to different health and social care professionals.

We are one of the few PCTs in the country to be implementing Emis Web, which will enable our practices to become GPSoC (System of Choice)compliant, and will provide an application for integrating the clinical records of the PCTs provider arm with their records held in GP Practices. This means that GPs and community teams will be able to share information but also make better decisions with their patients and families about their care.

We have consistently been in the top 2 PCTs in London for Choose and Book performance. Over 80% of local practices are currently achieving the national target of 50% for the number of referrals made using choose and book. We anticipate that the remaining 20% will continue to improve over the coming months.

We are a national pilot site for dentistry and will be the country's first pilot use of Choose and Book for Dentistry in 2007.

Based on our Emis Web deployment we are one of the few PCTs in the country developing a data warehouse linking acute hospital activity with GP patient records.

And finally we will become a pilot in 2007 for Networking and Infrastructure with NHS Connecting for Health London, N3 and Microsoft, as we seek to develop a networking infrastructure suitable for NHS London.

This leading position is maintained by the PCT's active involvement with the programme structures of NHS Connecting for Health London, with active membership in the following; Primary Care Programme Board, eSAP Board, Primary Care Reference Group, Chia Programme Board, and the local Care Community Board.

This has been reflected in several high profile visits; by the Prime Ministers Development Unit, with an invite to Downing St, separate visits to Chrisp Street GP practice by Kevin Jarrold CIO NHS London, Patrick O'Connell Managing Director BT Health, Paul White incoming CEO of BT Connecting for Health London and a visit to Tower Hamlets by the Taiwanese Health Department.

Summary Deployment details

Acute Care Setting

Cerner – Acute PAS
The Bancroft Unit at Mile end currently use the Barts and the London NHS Trust PAS system, which is due to be replaced by the Cerner product in late 2007. ICT have produced a CCN (contract change notice) which has been presented to BT by NHS Connecting for Health London to allow the BLT deployment to be extended to the PCT provided Elderly Services at Mile End, thus ensuring continuity of the shared clinical record and associated clinical notes and coding.

PACS & Radiology Information System (RIS)
PACS is the Picture archiving solution used to replace the use of traditional x-ray film with computerised images, while RIS is used to record reports relating to diagnostic images.

Barts and the London NHS Trust went live with these in Oct 06, and access to this is now available for Mile End clinicians – ICT are looking to extend this access to GP's in 2007.

Primary and Community activity

Child Health Interim Application (CHIA)
Chia was deployed in 2006 – there is now a business case developed for its future within the PCT (please see separate Board item).

Electronic Prescribing service
This functionality allows the ability to produce prescriptions electronically within GP surgeries and the ability to transfer them electronically to pharmacies, and has started to be implemented within Tower Hamlets.

GP2GP
This functionality will allow the electronic transfer of GP notes between GP surgeries when patients move. Tower Hamlets PCT are part of a National Pilot for implementing this in 2007, having tested the software in 2006.

e-SAP

This is an interim product to provide support for the single assessment process (SAP) within London. It allows collaboration and sharing of information between all interested parties including social services. Tower Hamlets Care community (ie Barts and the London Trust, East London and City Mental Health Trust, London Borough of Tower Hamlets and the PCT) was the pilot implementation of this application going live in June 06.

Emis Web
During 2006 we have migrated from our Emis PCS solution for GP and community services to the integrated Emis Web product. During 2006 we have started to deploy to Health Visitors, District Nursing and School nursing, and have a roll out plan for other services, starting with CAS and Speech and Language in 2007. The key here is the potential to create an integrated record for primary care, uniting both the GP and provider arm activity into a single clinical record, with the additional benefit of providing PCT wide activity reporting. Both BT and NHS Connecting for Health have had formal visits to one of our GP practices to view this solution, which currently offers more than the national programme.

We are also carrying out remote access trails for Health visitors using laptops.

RiO solution for Community Health
Currently no deployments for Rio are planned by the PCT, this solution provides much of the functionality that Emis Web does for community services, however it does not integrate with the GP record.

Choose and Book
This is a system which allows patients to choose a provider for their first outpatient appointment. Tower Hamlets PCT has been a consistent high performer within London for the use of Choose and Book by its GPs, generally being the 2nd best in London.

There is a DES target for GP's to achieve at least 50% of referrals through the Choose and Book system, and currently 30 out of 38 practices are meeting this.

Dentistry
Tower Hamlets PCT is a Dental Modernisation pilot site, and is leading the way in implementing Choose and Book for private NHS dentists. The pilot has implemented 4 new systems in private dentists within Tower Hamlets and in 2007 will start to implement Choose and Book between these practices and the Community Dental Services and the Dental Hospital at Whitechapel.

Information Reporting

In 2006 we have also developed the information reporting function of the department with the following highlights

Practice Based Commissioning
A report is produced monthly for each practice.

Balanced Scorecard
This has been redeveloped and is now produced and managed by the Information department

Midas and Performance Accelerator
Two new IT applications have been developed
Midas – a web based tool allowing viewing of hospital HES data and reports
Performance Accelerator – a web based tool allowing the monitoring of the PCT's governance and performance management framework.

Data Warehouse
With the implementation of Emis Web in 2007, we are looking to create the foundation for a data warehouse based on the GP data sets of the 38 practices within Tower Hamlets, which are currently being uploaded to Emis Web, with the hospital data sets returned by the acute systems. The potential of such a system is enormous.

IT Infrastructure

ICT has continued to invest in and develop its IT infrastructure for the PCT, leading the way with using N3 for local applications, and developing solutions for London in conjunction with N3 and NHS Connecting for Health, our main concern is the slowness of the links between sites, and we are actively testing solutions to improve this. We will become a pilot in 2007 for Networking and Infrastructure with NHS Connecting for Health London, N3 and Microsoft, as we seek to develop a networking infrastructure suitable for NHS London

Remote Access
ICT has developed a solution for providing remote access to email and files for laptops, and we will be rolling this out in 2007, we are also looking to use this to provide access to applications, such as Emis for health visitors and GPs etc

Look ahead to 2007

The key challenges for 2007 for Tower Hamlets PCT will be to maintain and improve its leading and active roll in the National and London wide deployments of the National Programme for IT.

Some key areas for deployment are:

- Full roll out of Emis Web
- Deployment of Cerner Acute System
- Dental Choose and Book
- Continued development of information reporting to support performance management.

The Board is asked to note this report.

Final DRAFT

version 8
October 2006

TOWER HAMLETS

LONG TERM CONDITIONS

ANNUAL REPORT

SEPTEMBER 2005 – SEPTEMBER 2006

CONTENTS

Executive Summary

Within the last twelve months the scope of the Long Term Conditions (LTC) Programme has changed considerably. It has moved from a small core of projects centred on Diabetes, Heart Failure, chronic obstructive pulmonary disease (COPD) and the Expert Patient Programme to become a programme of ten, inter-connected work streams. Each work stream was selected either because it was a major driver for emergency admissions or attendance at A&E or because it was a key enabler of change.

To reflect the new emphasis, the LTC Board has also been reconfigured to include a wider range of stakeholders. The work of the Board has also been re-focused around monitoring progress against an agreed Benefits Realisation Plan (BRP).

The report summarises outcome data and progress in 3 main sections:

a. Progress against national Public Sector Agreement (PSA) and Quality and Outcomes Framework (QoF) targets
b. Cumulative progress on the more established workstreams – COPD (now broadened to deal more generally with Respiratory), Heart Failure and Diabetes
c. Baseline setting for the newer workstreams – Palliative Care, Chronic Pain, Children, Older People, Self Care, Urgent Care, Workforce.

Overall the health economy is making steady progress towards its main targets and there is a considerable amount of redesign activity under way to move things further forward. However, there are 6 key risks which need to be addressed over the next 12 months

a. Admission rates for COPD remain relatively high and are the single largest contributor to total emergency bed days (EBDs) at Barts and the London NHS Trust (BLT). Greater emphasis needs to be placed on effective, proactive admissions avoidance strategies in the community.
b. The PCT currently has no community matrons and, because of this, is at risk of failing to meet both its PSA target to have 12 by end March 2007 and to be managing 433 high intensity users by the same deadline.
c. Risk factors for Stroke are not being optimally managed in primary care. This is an important area to address as both Stroke and Transient Ischaemic Attack (TIA) are significant contributors to emergency bed days and have a major impact on morbidity and mortality for local people. Proposals to support prompt intervention in TIA are also worth considering in the Commissioning round.
d. A high proportion of patients with Diabetes are either not having an annual review or their annual review is not being recorded.
e. Ambitious stretch targets have been set in the Local Area Agreement (LAA) for the numbers of people attending self management courses. The growth required is not achievable without additional resource.
f. Monitoring of EBDs needs to be more systematic, in order to ensure that reductions are maintained and we are able to distinguish whether EBDs at speciality level are being driven by admission rates or lengths of stay. Total EBDs also need to be plotted against estimated total population to

establish a true picture of performance e.g. if the total remains steady but the population has grown that is a measure of success.

It is therefore recommended that the health economy takes the following steps

1. **Supports investment in a community respiratory team designed to support practices and community nursing teams develop more robust admissions avoidance and create more seamless care with hospital services.**
2. **Supports the development and evaluation of a pilot community-based pulmonary rehabilitation programme.**
3. **Accelerates implementation of the LTC skill mix review to identify and put in place the first wave of community matrons.**
4. **Evaluates the impact of the Enhanced Services for High Risk Heart Attack and Stroke and Diabetic Annual Reviews.**
5. **Explores the potential for more effective early intervention for patients with TIA.**
6. **Ensures practice performance management visits address the issues of performance against QoF indicators for stroke and diabetic review recording.**
7. **Increases investment in the Expert Patient Programme in line with capacity required to meet the Local Area Agreement target.**
8. **Ensures that monitoring of emergency bed days is regularly undertaken by provider and by specialty, measured against latest estimates of borough population.**
9. **Implements the communications plan agreed by the LTC Board to ensure that momentum is maintained and duplication of effort is avoided.**

1. Introduction

In November 2005, a new strategy for Long Term Conditions was approved by the Borough Long Term Conditions Board. This highlighted ten key areas for action, selected on the basis that they met at least one of the following criteria

a. Affect large numbers of people within the local population
b. Are major causes of A&E attendance or unplanned admission to hospital
c. Evidence suggests that changes in the delivery of care could achieve better outcomes
d. There is the potential to use resources more effectively
e. Not adequately addressed through other means e.g. a Local Implementation Team.

As a result, the programme now covers the following workstreams

Disease Groups
Heart Failure, Respiratory, Diabetes, Chronic Pain, Palliative Care
Population Groups
Older People, Children
Enablers
Self Care, Workforce Redesign, Urgent Care

Each workstream is also charged with common themes of reducing health inequalities – particularly ensuring access and appropriate care for people from BME groups, people with mental ill health and people with learning disabilities. The programme of work is summarised in Appendix 1.

To reflect these changes the LTC Board was also revised, with the most important changes being increased engagement with the voluntary sector and East London and City Mental Health Trust (ELCMHT). In addition, the focus of the meetings has changed to ensure that monitoring takes place against an agreed Benefits Realisation Plan (BRP) and set of core outcome measures. This will be key to influencing the health economy investment strategy. A summary of current investments is included in Appendix 2.

2. General Progress

This section will summarise three key areas – the performance of the local health economy in delivering against national targets, the key conditions which contribute to unplanned use of hospital services and indicators of LTC management in primary care.

2.1 Delivering National Targets

The health economy is expected to achieve targets set as part of the Public Sector Agreement (PSA) framework. These emphasise the need to

a. reduce the use of urgent care services by people with LTCs
b. ensure the workforce has effective case management arrangements in place
c. establish mechanisms to identify and monitor people who are high users of services

Dimension	Mar 06 Local Delivery Plan (LDP) milestone	Mar 07 LDP milestone	Mar 08 target
Reduce number of emergency bed days (EBDs) across all providers by 5% by end March 2008	Target number of EBDs: 123,890 Actual : 120,926	120,173	118,884
Ensure sufficient Community Matrons and Case Managers are in place to case manage people with complex needs Case Managers	Target no of community matrons: 8 Actual : 0 Actual : 16	12	14
Ensure plans are in place to identify and case manage Very High Intensity Users (VHIUs) of services	Target no of VHIUs : 233 Actual : 247	433	1087

The most important PSA target is that of emergency bed days (EBDs) as this is the one on which the PCT is likely to be most closely performance managed. East London Common Information Service (ELCIS) data suggests we have exceeded our target. However, our data cannot currently be reconciled with Health Care Commission (HCC) data. The discrepancy is likely to be due to the fact that ELCIS data is based on information where the coding is regularly updated, whilst the HCC have a defined cut off date for their analyses. ELCIS are working with the PCT to verify performance.

Our main risks on the emergency bed days target are:

a. it is too early to say whether the reduction is part of a steady downward trend
b. because there are a plethora of different demand management initiatives in place, it is impossible to identify the specific strands which may have contributed to the reduction
c. We have achieved different levels of reduction across our main providers – it is important that there is sustained change at both BLT and ELCMHT.

Trust	**Year end 2003/4**	**Year end 2004/5**	**Year end 2005/6**
BLT	83,550	88,859	84,591
ELCMHT	32,006	25,458	27,122
Other	8,364	9,310	8,576
THPCT	1,357	937	637

To mitigate against these risks, it is important to ensure that:

a. regular reporting of emergency bed days by provider continues on a monthly basis and that year on year progress is monitored by the LTC Board and other stakeholder groups
b. we disentangle to what degree the reduction in EBDs is due to reduced admissions or reduced lengths of stay as this will enable us to pin point more precisely whether it is demand management, secondary care sector efficiency or a combination of the two which is responsible.
c. Commissioning and Performance Management functions within the PCT address the issue of EBDs as part of SLA monitoring, particularly with Barts and the London.

2.2 Key Contributors to Use of Emergency Bed Days

The Excel spreadsheet included as Appendix 3 shows the top ten contributors to the EBD total over a period of 4 years by Healthcare Resource Group (HRG). Although there is some variation each year and areas where coding is poor, the 3 main consistent contributors are respiratory disease (7.68% of total emergency bed days for 05/06) ischemic heart disease & heart failure (1.87%) and Stroke/CVD (1.13%). COPD is particularly important as it has been the single greatest contributor to Emergency Bed Days for 3 of the last 4 years. Last year COPD alone accounted for 5.4% of all the emergency bed days at BLT and was also the principal cause of emergency readmissions.

In the period 2004/06 the median length of stay for COPD has stayed stable at around 5 days, which is around the national average. In the same period, numbers of spells have increased marginally which suggests that the issue is more likely to be increasing numbers of admissions rather than longer stays in hospital. The enhanced service for COPD has only been up and running for a maximum of a year in some practices and significantly less in others and therefore it is unlikely to have had a significant impact at a borough level. However, the EBDs data suggests that the emphasis needs to be firmly on demand management and admissions avoidance.

2.3 Managing LTCs in Primary Care

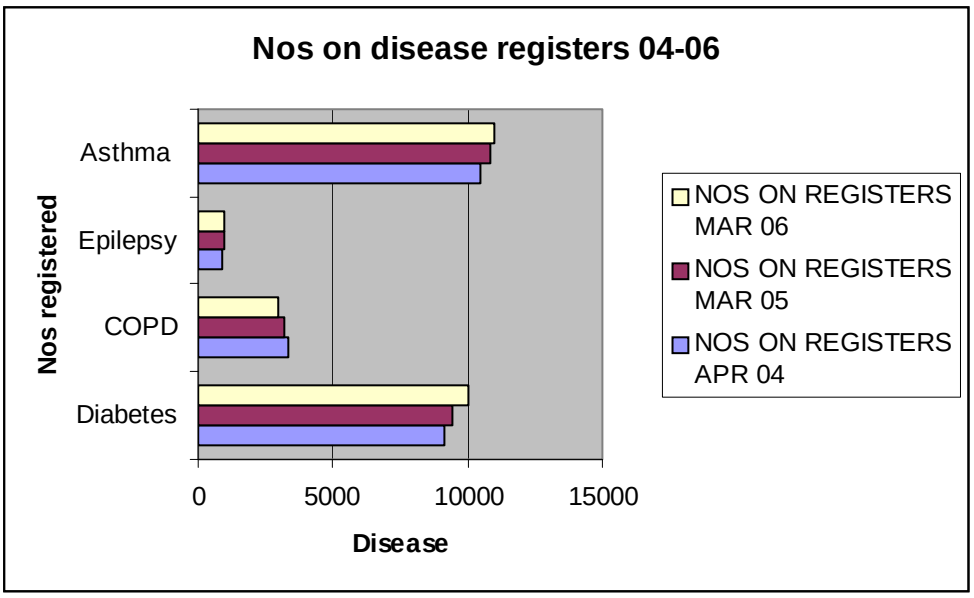
Improving the diagnosis and routine management of people with long-term conditions is a major theme in both the Quality and Outcomes Framework (QoF) and Enhanced Services. This is primarily being achieved by establishing disease registers; call, recall and review systems and improving the recording and management of risk factors such as smoking status and immunisation history.

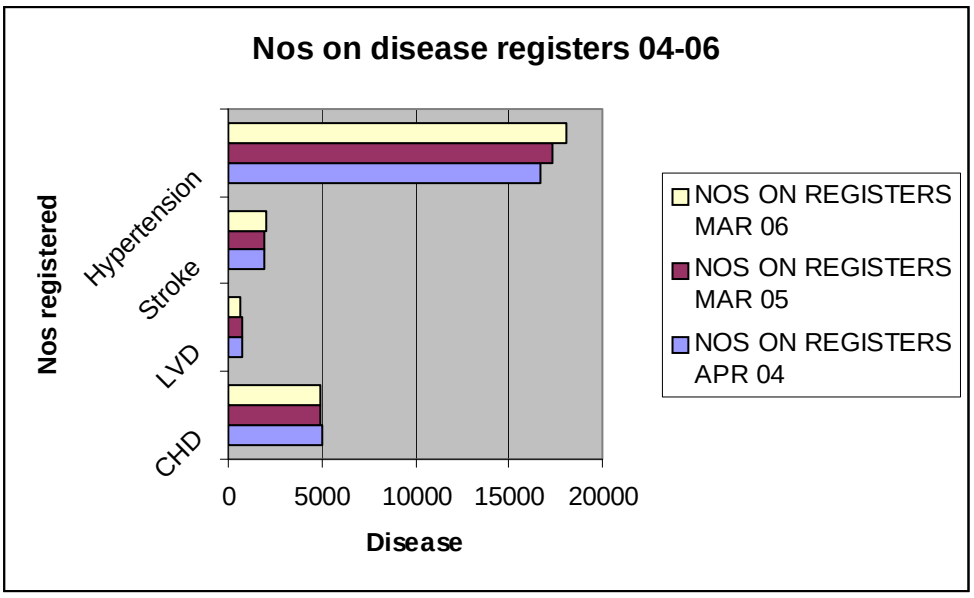
Analysis of the Quality Management and Analysis system (QMAS), the database which captures self-reported data from GP practices, shows that practices are reporting a year on year increase in compliance with QoF clinical indicators of good practice. Please see Appendix 3 for a detailed report on the changes at practice level for Diabetes, COPD, Mental Health and, coronary heart disease, (CHD) and Hypertension.

In addition, most practices are reporting increases in the numbers of patients identified and recorded on disease registers. The exceptions are CHD, Left Ventricular Dysfunction and COPD. It is unclear why numbers have dipped in

these areas but the level of decrease is not significant. In some instances it may also reflect cleaning of the data following more accurate diagnosis.

In future reports we will tabulate trends in QoF points against spells, bed days and median lengths of stay for key healthcare resource groups (HRGs) at Barts and the London.





The 2004/05 Annual Report produced by the Clinical Effectiveness Group (CEG) at Queen Mary College is able to provide a richer analysis of the clinical indicators of long term conditions care, using MIQUEST searches. A copy of the full report is available and CEG data is used to support some of the workstream sections. However, there are some key messages worth flagging up here.

a. Analysis of prescribing data tends to show steady improvement in implementing best practice in prescribing behaviours. For example, at least 80% of patients on Tower Hamlets CHD registers have been prescribed aspirin. As this is cheaper to buy over the counter than on prescription, this is likely to be an under-estimate of aspirin use.
b. Recording of risk factors such as ethnicity, smoking status and blood pressure is also improving. In the case of ethnicity, this may have been helped by the introduction of a local 'patient profiling' enhanced service.
c. In terms of risk, improvements are needed in the following areas
   - 35% of people on local stroke registers have poorly controlled serum cholesterol and 20% have a blood pressure (BP) above 150mm Hg. As Tower Hamlets has comparatively high age-adjusted prevalence for stroke, high smoking rates and significant numbers of emergency admissions, this is an important issue to tackle.
   - Over 40% of diabetic patients in Tower Hamlets do not have any information recorded with regard to the place of their annual review. If we assume half of those patients have not had a review that equates to over 1500 people potentially missing a thorough annual health check. A local enhanced service has been established to reward practices for undertaking and recording annual reviews. The PCT should closely monitor performance against the specification over the next 12 months and support roll out to as many practice populations as possible.

3. Progress on Workstreams

3.1 Diabetes

There are currently approximately 10,010 diagnosed diabetics in Tower Hamlets, a prevalence approaching 5%. As well as its impact on quality of life, diabetes has a profound impact on both morbidity (significant numbers of people suffer from co-existing circulatory disease and renal disease) and mortality, with an average 20 years life lost for people with the disease.

Over the last year, The Diabetes Group has achieved the following:

1. The Diabetes Centre at Mile End has made significant strides in developing a stronger medical and nursing outreach support service to local practices. At present, 4 locality based clinical nurse specialists and a consultant diabetologist operate a system of practice visits, telephone / email advice and 'virtual clinics'. Of 79 patients seen by the diabetologist this way, 54 have made significant improvement in diabetes control. Practices' increased confidence to manage their patients is born out by the drop in referrals from approximately 20 a week to around 6 a week. This is also underpinned by the gradual roll out of two local enhanced services (LES) – LES 2 which currently supports 73% of practices to carry out a thorough annual review. In 3 years the proportion of patients having a review done in primary care has risen from 40% to 75.5% (CEG 2006). LES 7 currently enables 59% of local practices to initiate insulin, with Clinical Nurse Specialist support. Thirty practices have also completed an online assessment tool – 'Diabetes E', designed to identify relative strengths and weaknesses in their diabetes management.
2. Equipping community based professionals with the skills to manage the majority of diabetes care has been facilitated by the appointment of a dedicated Diabetes Nurse Educator. This role has been key to initiating 3 local training programmes
   - 122 staff have commenced DEPTH "Diabetes Education for Professionals in Tower Hamlets", which incorporates the Warwick Certificate in Diabetes Care (CIDC).
   - 40 people commenced Warwick Intensive Management of Type 2 Diabetes, designed to train staff in insulin initiation for LES 7.
   - City University Diabetes Care Course, a basic qualification for nurses and paramedics
3. The Diabetes Nurse Educator has also led the roll out of patient education courses - DIANA "Daily Insulin Adjustment to Nutrition and Activities" for type 1 diabetes, and HAMLET "Hands on Approach to Lifelong Empowerment Training" for type 2 diabetes. Since April 2006 4 DIANA courses have been delivered with 31 participants completing (a completion rate of 83%). During the same period 88 patients have completed English and Bengali versions of HAMLET, a 76% completion rate. Special courses are run to support diabetics during Ramadan and Hajj.
4. In partnership with Moorfields Eye Hospital, the retinal screening service has met the National Service Framework target to offer screening to 80% all known diabetics. 70% of patients have taken up the offer. Access has also been improved by the establishment of satellite service for retinal screening at Spitalfields Practice, E1.

In the next year we will focus on

1. **Developing a robust patient pathway for diabetic patients and strengthening links with those services with high proportions of diabetic patients such as Renal and Stroke.**
2. **Ratifying the diabetes strategy and producing a costed and prioritised implementation plan**
3. **Offering targeted support through the Diabetes Lead, Diabetes Centre staff, PCT Medical Director and primary care managers to the ten practices with the lowest QoF scores.**
4. **From December 2006 the Diabetes Nurse Educator will roll out the Warwick CIDC and Roehampton University Masters in Diabetes.**
5. **Working in partnership with ophthalmology at BLT to provide a second choice for screening in accordance with patient choice.**
6. **Increasing throughput of patients into DIANA and HAMLET courses and signposting patients into generic Expert Patient programme courses and support groups. Evaluation of the impact of self management courses will also be undertaken.**
7. **Implementing Clinical Psychology-led motivational interviewing training for staff managing people with Diabetes.**

3.2 Heart Failure

Heart failure is a common end result of other cardiac conditions and currently affects approximately 1400 patients in the borough. Nationally, the prognosis for heart failure is poor with survival rates one year post-diagnosis only 60%. However, at a general level there are indications that care for heart failure patients is improving – admissions for people with a primary diagnosis of heart failure have decreased 340 in the period Feb 05-Jan 05 to 262 in the following year. Similarly lengths of stay at BLT have fallen from an average of 13.9 in 2003/4 to 10.2 at the end of March 2006 and readmission rates have also decreased slightly from 21% in 2004 to 18.4% in 2005.

In the last year, work has concentrated on

1. Creation of a cohesive cross organisation specialist nursing structure which will underpin more seamless care for patients. Within the team managed by the Nurse Consultant are two new community nurse specialists (CNS). The CNS play a crucial role in supporting practices to implement an enhanced service currently operating in 27 local practices. Patients attending BLT Outpatients are followed up at home to prevent readmission and provide close links with GPs and practices nurses to develop management plans for these patients, including titration of medication.
2. There have been several education initiatives launched with the aim of improving the skills of community based staff to manage heart failure patients. This included training for 39 GPs and practice nurses in order to enable them to be accredited to deliver the enhanced service.
3. Diagnosis of heart failure is confirmed by an echocardiogram (echo). Waiting times for echo vary significantly across the three BLT sites, with particularly long waits for Outpatients at St Bartholomew's Hospital. In order to address this, the Trust has recruited 10 additional echo technicians and a technician training coordinator, as well as purchasing two new Echo machines for the Barts site. Funding for a new machine at LCH was also approved.
4. Three working groups have been set up to develop a heart failure patient pathway, including end of life care and referral to cardiac rehabilitation.
5. In line with the emphasis on ensuring the mental health needs of patients with chronic conditions are identified and addressed, the heart failure service is also piloting a basic depression screening tool.
6. The main cardiac rehabilitation programme does not currently take heart failure patients. Building on the expertise of the CNS and Nurse Consultant, a specific heart failure rehabilitation course has been piloted, with a second course planned for October.

Over the next year, work will concentrate on the following:

1. **Finalising and publicising a whole system patient pathway.**
2. **Roll out of the enhanced service, including improving the numbers of referrals from practices to the community heart failure nurses.**
3. **Maintaining reductions in the number of admissions and readmission for Heart Failure and Length of Stay across sites.**

4. **Ensuring equity of service for provision for echocardiogram across the 3 BLT sites.**
5. **Development of a "One Stop Diagnostic Heart Failure Clinic" with an individual management plan for each patient, shared with the key professional responsible for their care.**
6. **Opening up referral from the community into the "Education and Exercise Programme" to benefit all patients with a diagnosis of Heart Failure.**
7. **Working with the Princess Royal Trust for Carers Tower Hamlets to pilot enhanced support services for carers of people with end stage Heart Failure.**

3.3 Respiratory

Tower Hamlets has the highest age adjusted prevalence of COPD in London at 1.88% and higher admission rates than the rest of the capital. Better data collection achieved via the enhanced service for COPD suggests that around one third of all sufferers are in the moderate to severe category and will need more input from health and social care services. Respiratory Disease as a whole accounts for 12-13% of all local deaths in the borough.

The Respiratory work stream began in 2005 and has been able to achieve the following

1. The overall framework for the COPD pathway across specialist, primary community with and social care has now been completed and agreed. The pathway remains high level and detail on specific parts such as the end of life will require further development. The pathway will be formally launched in November. Mapping the inpatient care pathway began in August 2006.
2. 27/37 practices are now commissioned to provide the enhanced service for COPD. Quality audits undertaken by the Clinical Effectiveness Group at Queen Mary College (CEG) report improvements in a number of quality indicators e.g. use of action plans, referral to pulmonary rehabilitation, and assessment of carers. The enhanced service has been particularly successful in engaging practices in providing both structured care for patients and promoting practice based education.
3. The Community spirometry service has increased the proportion of patients with COPD having spirometry from 13% in 2004 to 48% in 2005 (CEG) and is now around 75% according to QMAS. Twenty practices have PCT-provided spirometers, with 8 others using their own. This service is supported by clinical lead and a dedicated technician.
4. Training programmes for community-based staff (including AHPs and social services) were commissioned with the support of the Long Term Conditions workforce development group. Seventy eight health and social care staff attended and provided very positive feedback on the impact of training on their understanding of respiratory disease and their ability to manage and monitor it.
5. Three COPD Expert Patient Programmes courses were run for Bangladeshi men, a high-risk group because of their smoking activity. Three future courses are planned for 2006/07
6. £100k has been obtained from Neighbourhood Renewal Funding to roll out Asthma Action Plans and redesign Pulmonary Rehabilitation. Current data suggests that only 2-5% who would benefit from rehabilitation are currently accessing it, with long waiting times and high drop out rates for the hospital programme. The enhanced service has increased the number of referrals to rehabilitation but as this has not been matched in an increase in capacity, waiting times may grow. It is hoped that additional LAP funding will enable the pilot Pulmonary Rehabilitation programme to be expanded borough wide.
7. The Respiratory group has agreed the specification for a community based respiratory team to support primary and community care in admissions avoidance and facilitated early discharge, initially focusing on COPD. If funded, this will also support mentoring and experiential learning for generalist staff and research across the patient pathway

8. There has been a highly successful re-design of services for the assessment and provision of oxygen of domiciliary oxygen as part of a national change. This has included the development of new pathways, the establishment of an oxygen assessment centre and the systematic follow up for patients prescribed oxygen in their own homes. The relationship between the clinical lead and general practices has been central to this implementation.

Over the next year, efforts will concentrate on:

1. **Fleshing out the detail of the care pathway to take on board potential changes in the role of community teams, better use of intermediate care and more proactive end of life care. Audit mechanisms also need to be established to monitor the implementation of the pathway and its impact on patients and carers.**
2. **Completing the business case and securing funding for the Community Respiratory Team.**
3. **Continued support for the enhanced service and ensure as many non-accredited practices as possible are delivering it by September 2007.**
4. **Piloting Asthma Action Plans in 8 practices by July 2007 and roll out to the remainder by August 2008.**
5. **Designing and piloting a community based pulmonary rehabilitation programme, with the aim of reducing waiting times and increasing throughput.**

3.4 Palliative Care

There are approximately 1200 deaths in Tower Hamlets each year. Over 50% occur in people aged 75 and over. Data collated by the NE London Cancer Network shows that around 71% of all deaths happen in hospital – average compared to other boroughs in the NE sector, but high compared to other parts of London. This tends to reflect national research which shows that people living in more deprived parts of the country are less likely to be able to achieve their preferred place of care (Higginson, 1994). Information on cause of death from 2004 confirms that cancer (28%) and cardiovascular disease (27%) are the most prevalent causes, accounting for over half of all deaths between them.

In 2004/5, 152 Tower Hamlets adults were inpatients at St Joseph's Hospice and 233 received support via the hospice community caseload. The table below shows that relatively few people with common long-term conditions access specialist palliative care either via an inpatient stay or the community caseload and that the emphasis is still very much on cancers.

Disease	% Inpatients	% Community Caseload
All Cancers	88	96
Neurological Disease	4	1
Renal Disease	3	2
Respiratory Disease	2	>1
Cardiovascular Disease	1	0
HIV (main provision is via other routes)	>1	0

In future we hope to be able to include data for other specialist palliative care providers, including those providing services for children.

In terms of impact on use of services, data prepared by the King's Fund shows a clear relationship between terminal illness and the top 1% of hospitalised patients. Dependent on the age group, between 2 and 40% of the most frequently admitted patients died in hospital during the same year. The trend is directly related to age – with the over 75s having the highest risk. This has a massive impact on use of bed days. Working backwards from public health mortality files, ELCIS have calculated that Tower Hamlets residents dying between April 2004 and April 2006 used approximately 62,319 emergency bed days in their last year of life. Assuming a basic bed day costs around £200, this generates a cost of nearly £12m over two years.

There is therefore much room for improvement in terms of

a. ensuring patients are able to achieve their preferred place of care
b. enabling patients with conditions other than cancer to benefit equally from the expertise of specialist palliative care services
c. Supporting proactive management of patients in their end of life phase in order to avoid repeated attendance and admissions to hospital.

Between October 2005 and September 2006, the Palliative Care workstream has achieved the following

1. A Borough wide group of NHS, social care and voluntary sector has been established to drive forward a collaborative approach to improving end of life care.
2. A local enhanced service based on the Gold Standards Framework has been funded by the PCT. Twenty practices spread across the four localities have been commissioned and are currently receiving intensive support from the PCT's new service improvement lead for Palliative Care, Tracy Cunningham. This is backed by an audit template which will collect data from EMIS on the impact of the enhanced service.
3. Protected learning time slots have been agreed to deliver advice to commissioned and non-commissioned practices on implementing best practice tools for end of life care and Prognostic Indicators Guidance. The first PLT session was attended by over 60 local health professionals.
4. The Carers Trust and PCT have obtained a King's Fund Grant to pilot an enhanced support service 'Care Plus' for carers of people with long term conditions, initially focusing on heart failure.
5. Amendments have been made to the handover documents used to notify out of hours services of palliative care patients and the system for notifying the coroner of out of hours deaths.
6. Out of hours GPs and nurses will be able to access medication such as opiates via an emergency bag held in A&E at the Royal London Hospital.
7. Specialist palliative care funding has been allocated to support roll out of the Liverpool Care Pathway at Barts and the London.
8. A collaborative programme of benchmarking against NICE standards for adults with cancer has been launched by the PCT and BLT.

Over the next twelve months the group aims to

1. **Complete an end of life care strategy for the borough to support redesign and investment. As part of this, a consultation event with local people will take place on 25th October.**
2. **Continue roll out of the enhanced service and education programme for local practices.**
3. **Use the enhanced service audit template and NICE benchmarking to gather more detailed information on numbers of palliative care patients, their needs and outcomes.**
4. **Implement 'Care Plus' in collaboration with Social Services, St Joseph's Hospice, BLT and the new community heart failure nurses.**
5. **Re-model the Clinical Nurse Specialist post at St Joseph's to ensure it offers optimal support to generalist teams in the community.**
6. **Agree a core data set to be collected and reported for specialist palliative care.**
7. **Collaborate with other London PCTs and the Local Authority to implement appropriate recommendations of the London wide Childrens' Palliative Care Review.**
8. **Begin implementation of the Liverpool Care Pathway in the community.**
9. **Develop the end of life part of the COPD care pathway.**

3.5 Chronic Pain

International research suggests that around 10% of the population suffer from chronic pain at any one time. It is the 3rd most common reason for consulting a GP and people with chronic pain tend to consult their GP at 5 times the normal rate. This results in approximately 5m consultations each year. In addition, it is a common cause for people to drop out of the workforce and become dependent on benefits. In two wards (Bethnal Green and Bow, Poplar and Canning Town) alone there are an estimated 14,000 people dependent on incapacity benefit or severe disablement allowance.

In 2004/5, there were 423 referrals of TH residents to the specialist pain team at Barts and the London. Only 121 were from local GPs (seen within 13 weeks), with the remainder coming from other hospital consultants. For this latter group, the waiting time to see a consultant can be a year. On top of this, patients may wait a further year to access the intensive Pain Management Programme, designed to teach coping and self-management skills. These relatively small numbers mask a larger problem in terms of the patient pathway – by the time someone has been referred to a pain specialist they are likely to have had several GP visits and referrals to other specialties such as Neurology or Orthopaedics. In reality this means patients may take two years to obtain specialist advice and support, missing the optimum time to intervene and reduce the impact of pain on the person's life.

In terms of the impact on use of urgent care, conditions such as sickle cell and abdominal pain are significant causes of frequent use of A&E and unplanned admission to hospital in the 15-64 age group.

Focus groups held with patients in Spring 2006, found that they were keen to see the following improvements

a. Quality of care
   - better explanations of their pain and what causes it
   - having someone who listens and takes their pain seriously
   - advice on lifestyle such as diet and exercise
   - more opportunities to come together with other patients, share experiences and learn from each other
   - use of prayer and meditation to support people with painful conditions

b. Quality of outcomes
   - better use of medication to relive pain
   - holistic approaches to help i.e. help for clinical problems and wider issues such as mobility problems, financial worries etc arising from their illness
   - better support for mental health problems

c. The emphasis has therefore been on
   - improving the pathway for patients to ensure that they see the most appropriate professional in the shortest possible time

- Responding to patients' wish for a holistic service, sensitive to their needs.

In the last year, work on chronic pain has focused on the following areas

1. Undertaking a mapping exercise of the primary, secondary and voluntary sector services for people with pain, their referral routes, entry and discharge criteria.
2. Holding a series of rapid appraisal events with 80 local people to explore their experience of living with pain and produce a prioritized list of the improvements they would like to see in local services.
3. Organising the first borough wide multidisciplinary stakeholder event on pain to agree the three priority areas for development – introducing a community based assessment and triage service, modelled on a successful Southampton service ; developing formal and experiential training opportunities for staff to increase their confidence and competence in managing pain; developing community based self management programmes for patients.
4. Successfully bidding for £250k Neighbourhood Renewal Funding to take forward the three priority areas described above.
5. Appointing the key leads for the programme – Elaine Munday (Programme Manager), Dr Jayne Gallagher (Consultant Lead, BLT), Dr Anwara Ali (GP Lead), Dr Nick Kendall (Education Lead) and Professor Martin Underwood (Evaluation Lead).
6. Successfully bid to become part of a national pilot of 'PPP' – an expert patient programme aimed specifically at people with chronic pain.

In the next twelve months the workstream will

1. **Establish a bio-psychosocial model of care centred on a community Pain Assessment and Triage Team (PATT), attached to the musculoskeletal Clinical Assessment Service, with clear care pathways, referral and prescribing guidelines and in-built screening for co-existing mental health problems.**
2. **Appoint clinical and lay tutors to teach on the 'Persistent Pain Programme' self management course. The course will consist of seven modules over seven weeks, with advice in pacing, relaxation, use of medicines and setting baselines. It will be hosted by Social Action for Health and aimed initially at patients from Black and Ethnic Minority backgrounds. We anticipate that the first course will commence before the end of 2006.**
3. **Agree core competencies for assessing and managing pain and mapping current formal education provision. The education group will produce recommendations for commissioned and locally delivered training and pilot at least one protected learning time session for primary and secondary care professionals. It will also explore the potential mentoring and training remit of the PATT and mechanisms to spread specialist skills more widely through in-service programmes.**

3.6 Children.

In other parts of the country, long term conditions work tends to focus on the links between ageing and the risk of developing chronic illnesses. Much of the emphasis is therefore placed on managing long term conditions in people aged 65 and over. However, there is a significant evidence base which suggests that for inner city boroughs like Tower Hamlets, long-term conditions affect all age groups, including children. An analysis of the key population groups at risk of admission (Kings Fund, 2005) found that 15.5% of the patients most at risk of regular hospitalisation were in the 0-17 age group. In terms of the conditions driving their use of hospital services, asthma and epilepsy were the most significant.

Asthma

Prevalence figures for asthma are difficult to obtain in children due to diagnostic uncertainty and overlap with other diseases. Across the UK a conservative estimate would be that approximately 12% of children have active asthma with 25% having had a label or treatment for at some point (BLF 2006). It would appear that whilst the prevalence in Tower Hamlets mirrors the national average, the negative impact of asthma on the child and family is compounded by the socio-economic deprivation, ethnicity and poorly developed self management skills, (Griffiths et al 2001). Despite local clinical guidelines, health professionals report a lack of lack confidence and skills in managing children with asthma, particularly in the under 5s. The impact on health care utilisation is difficult to establish but at the extreme end where children are actually admitted data for 2005/06 indicates a total of 234 spells and 350 bed days (ELCIS 2005). Work needs to be undertaken to more accurately quantify the numbers of attendances in A&E, the Walk In Centre and GP practices.

Current work:

1. A childrens' asthma group with key representation from health, social care and education has been established with agreed terms of reference and membership.
2. A scoping exercise is currently under way in order to map current services, service development activity and research in order to inform a gap analysis
3. A core data set which incorporates data from community, primary, secondary care and education is being established in order to benchmark and provide data for evaluation

Developmental work for the coming year will centre on:

1. **Holding a childrens' benefits realisation planning event with stakeholders in November. This event aims to provide a project plan with defined outcomes and responsibilities.**
2. **Training and education for community staff to support the development and implementation of agreed care pathways.**
3. **Strengthening work with schools/wrap around care to reduce the numbers of days lost in school for children attending A&E or admitted to hospital.**

4. **Applying for funding for a project from Asthma UK to increase self-care skills in children from BME groups and their parents. If successful, the project would use more innovative techniques such as drama workshops and offer training in local venues such as Children's Centres.**

Epilepsy

Epilepsy is a generic term encompassing a wide range of epileptic disorders and syndromes, with variable prognoses. According to local government figures there are approximately 47,500 epileptic children between the ages of 0-15 years of age, with a further 14,000 between 15-19 years of age in the UK. The Royal College of Paediatrics and Child Health estimates a prevalence figure of approx. 1 in 20 children and young people which would amount to approximately 308 children in Tower Hamlets living with epilepsy.

Research published in the British Medical Association Journal in 2002 found that there is an increased prevalence of epilepsy in areas of socio-economic deprivation, and that this is an important risk factor in the development of epilepsy. This study that was undertaken in London, found that the incidence of epilepsy in the most deprived fifth of the study population was 2.3 times that in the least deprived fifth.

On average, there are approx 80 full consultant episodes per year at Barts and the London where the primary diagnosis was epilepsy. This will not include where a secondary diagnosis of epilepsy, perhaps following a trauma, was made. The average length of stay for these children with a primary diagnosis of epilepsy is 5.3 nights.

There is currently no epilepsy nurse specialist for children either at BLT or in the community. Nor are there specific community services for children with suspected or confirmed epilepsy. This means children are only treated in an acute setting. There is also very little written information in languages other than English.

This year, work has focused on

1. Establishing a multidisciplinary, multi-agency subgroup of health and education professions to drive the service improvement programme.
2. Agreeing a date and format for a benefits realisation planning event, along the same lines as the one planned for asthma.
3. Delivering an initial training session on Buccal Midazolan, a new drug which can be given orally to a child who is fitting/seizing. This session was attended by health visitors, school nurses, the community childrens' nursing team and practice nurses.

Over the next year the epilepsy workstream plans to:

1. **Implement a clear referral pathway across community, primary and secondary care.**
2. **Improve the support network for children and families with epilepsy in the community. There is currently one meeting for families every 2-3 months, but it not well advertised or attended. This is an important factor in addressing the isolation that some families and children can experience.**
3. **Ensure literature is available to all families in appropriate languages and formats.**
4. **Continue training of core staff including school nurses, practice nurses, Community Childrens' Nursing Team and health visitors in recognising the different types of seizures and administering the appropriate medication.**
5. **Recruit an epilepsy nurse specialist, able to instigate nurse led clinics where parents and children can provide life style, medication and self care advice.**

3.7 Older People

The Older People's workstream is designed to ensure that the LTC Programme dovetails with more general work led by the Older People's Partnership Board. This year the focus is particularly on enabling the LTC programme to capitalise on new developments which offer potential benefits in terms of enhancing the model of care, moving services into new community locations and harnessing the potential of technology to deliver proactive care and 24/7 monitoring of vulnerable people.

Older Peoples Service Review

A review of services for older people and rehabilitation was undertaken during the period November 2005 – May 2006. This was overseen by a multi-agency steering group, including the voluntary sector. The review process involved service mapping, stakeholder events, and service user consultation. A specific service development plan was drawn up to summarise the proposed service developments. Key areas of focus are to review the single point of access, streamline services (including intermediate care) and improve the patient pathway for access and assessment.

Link Age Plus

The London Borough of Tower Hamlets has successfully secured over £1m funding from the Department of Work and Pensions and Neighbourhood Renewal to fund 'Link Age Plus'. The initiative will fund the creation of four older people's centres spread across the borough offering a single point of entry or signposting into a range of health, local government and voluntary sector services for anyone over 50. The Centres will be based at the Sundial Centre, Sonali Gardens, Apian Court and St Matthias Community Centre. The menu of services and opportunities each centre provides will depend on local needs, but current activities include complementary therapies, exercise classes, lunch clubs and social events. In future this may extend to provide benefits advice, carer support services, advice on training and employment and opportunities to get involved in local volunteering. Progress on Link Age will be overseen by a steering group which reports to the Older people's Partnership Board. A formal evaluation of Link Age Plus is also being commissioned from the Centre for Voluntary Action Research at Aston University.

Supporting Care at Home

The Commission for Social Care Inspection Performance Assessment Framework monitors councils' performance on the number of people aged 65 and over receiving intensive support at home. At present the Borough has a home care programme which supports131 per 1,000 people aged 65, the third highest rate in the country. However, as the population ages, greater efforts will need to be made to sustain this performance. Three areas will be particularly key in delivering this – ensuring there are effective systems in place to identify people at risk, a health and social care workforce skilled in providing routine, proactive care and technology to monitor the most vulnerable.

a) Identifying People at Risk

The single assessment process (SAP) provides a comprehensive health and social care assessment which can be used to identify people with at risk of admission to hospital or residential care. Currently 228 staff across health and social care are trained in using eSAP, between them they have generated 1003 basic contact or overview assessments.

b) Workforce Development

The Enhanced Home Care service is an example of how health and social care staff working in a collaborative team are able to offer effective, proactive care to older people in their own home. Two nursing staff, a pharmacist and an occupational therapist work with a team of home carers to develop their skills to carry out basic tasks (e.g. continence care) and enable them to identify the early signs of deterioration such as breathlessness. The PCT and LBTH have agreed to pursue this kind of integration at a more general level and it has been agreed that both will work towards creating joint locality based health and social care teams. An Integration Project team for Older People and LTC has been established, jointly led by the Associate Director for Older People's Services in the PCT and the Service Manager, Adult Services LBTH. The group is charged with determining how the new teams would be operationalised.

c) Telecare

At present 1450 older people in the borough have some form of telecare in their home. This is usually in the form of an alarm system linked to the Local Authority call centre. Tower Hamlets has been awarded a Preventative Technologies Grant of £410,000 for 2006-08 which will be used to identify the most appropriate infrastructure to put in place to enable older people identified as at risk of admission to residential care and / or hospital to live independently in the community for as long as possible. The approach is therefore not simply to buy more equipment, but also to ensure that there are efficient systems in place to provide 24/7 contact and response services. In the early part of 2006, a study was commissioned from two independent consultants to identify how the telecare grant could be used to strengthen existing support services for older people such as the Care Alarm scheme and identify the principal providers and types of telecare equipment currently available. A newly created Telecare Board has agreed to use part of the funding to appoint a Project Manager; in order to appoint someone with sufficient experience, a brief was circulated to eight consultants and three bids were received.

For the 2007/08 the key workstream areas of work will focus on.

Older Peoples Service Review

The multi-agency steering group will continue to meet quarterly over the next year to monitor progress. Work is focussing on

1. **Extending the single point of access, and working towards integrating/streamlining a number of services to improve the patient pathway for access and assessment.**

2. **Working to improve outreach and discharge processes and follow-up procedures,**
3. **Maximising the utilisation of resources and avoid preventable admissions, i.e. through joint working with Urgent Care service Very High Intensity Users group.**
4. **Services for older people are continuing to monitor that they are fit for purpose and explore potential for increased joint working across care pathways i.e. a continuing care review, review of intermediate care and exploring for working in different ways with community organisations and housing providers Peabody Trust, ELCMHT, and Social Services to develop services at Shipton House, associated with the Link Age developments at Sundial Centre.**

Link Age Plus

Over the next year, leads will agree the menu of Long Term Conditions services which could be provided in Link Age Centres, particularly how the venues may be used to promote self care and early intervention for people at risk of admission to hospital or care facilities. For example, it may be possible to use the centres for venues for generic and disease specific Expert Patient Courses, cardiac and pulmonary rehabilitation maintenance programmes.

Supporting Care at Home

a) SAP – the emphasis will move to rolling out e-SAP and ensure that staff expected to implement e-SAP have adequate training and support. Induction packs and half day courses will be available for all new starters.

b) The Integration group has developed a number of potential models for future service integration around community based services, which will be debated at the next meeting. The preferred model will be presented as a proposal to the Integration Programme Board for approval in October 2006.

c) Enhanced Home Care Service. There are plans over the next year to increase the number of home care staff and nursing staff/AHPs working together to support the delivery of integration at a workforce level and enhanced the sharing of knowledge and skills. Key areas of expansion are to develop and implement a policy that will allow home carers to dispense medication with the support and mentorship of community nursing, and to improve skills in basic foot and pressure area care.

d) Telecare - Over the next year, the group aims to recruit the project manager and any additional specialist support and complete an options appraisal for the provision of telecare services. Services will be commissioned in time for the 07/08 financial year and an interim evaluation will inform how the service is mainstreamed.

3.8 Self-Care

Providing patients and carers with the knowledge, skills and confidence to manage their condition is a key tenet of national policy on LTCs because it has potential benefits for both service users and service providers. There is strong evidence that pulmonary and cardiac rehabilitation, for example, lead to improved clinical outcomes for patients and a better quality of life as well as reducing the likelihood of further admissions to hospital. In order to recognise the importance of this, a self-care work stream was established in December 2005.

Key achievements in the last 9 months have been

1. Previously the only self-care activity monitored by the LTC programme was the Expert Patient Programme (EPP). The Self-Care group has agreed to extend the scope of what we include in a self-care programme to ensure that monitoring of activity and outcomes takes place in areas such as smoking cessation, disease specific programmes such as the Diabetes courses described earlier and formal rehabilitation programmes. This new focus has been formalised in a Tower Hamlets Self Care Plan, which also incorporates a set of key milestones and targets.
2. The Neighbourhood Renewal Fund EPP pilot ran from January 2005 to March 2006. 16 courses were delivered, 5 in Bengali and 2 in Somali. 194 participants started and 134 completed. This is an average completion rate of 69%. From the EPP courses 9 lay EPP tutors were recruited and trained. While successful in some respects, the pilot reached a limited number of local residents. The PCT will move to a commissioned model for EPP by April 2007 where organisations will be invited to bid to provide both generic and condition-specific courses. As a first step towards this, a formal service level agreement (SLA) has been put in place with current providers, which will provide much more detailed information on activity and outcomes. The SLA will see 25 courses delivered by the end of the financial year. At the end of September 2006, 6 EPP courses have been delivered with 52 people completing, with another 4 courses in progress.
3. Steps have also been taken to ensure that the quality of EPP courses is consistently high. Tower Hamlets PCT and its voluntary sector providers has enrolled in ‘Stepping Stones to Quality’, a national pilot which embeds quality assurance and benchmarking for courses and course tutors.

In the next year, work will focus on the following

1. **A PCT self care coordinator will be recruited by mid November. This role will act as a local champion for self care, as well as having operational responsibility for organising the tendering and contracting process, collating activity and evaluation data, quality assurance and ensuring there is active awareness raising and communication with the public and potential referrers.**
2. **A specification for EPP courses will be completed by the end November and organisations will be invited to tender by January 2007, with service level agreements in place by March 2007.**

3. **Exploring how new primary care mental health services and roles could improve self-management and patient support, especially in relation to managing the underlying anxiety experienced by a proportion of high intensity users.**
4. **Strengthening engagement with the community link pharmacist, locality pharmacists and the Local Pharmaceutical Committee to raise awareness and increase referral to self care courses.**
5. **Ensuring the core skills necessary for staff to support self care are identified and factored into education commissioning plans. At present e.g. smoking cessation, motivational interviewing and Cognitive Behaviour Therapy have all been highlighted as key.**
6. **Expanding the capacity for the voluntary sector to act as the main providers of self care by recruit at least 6 further EPP tutors by the end of 2006.**
7. **Ensuring that self care is built in to care pathways as they are developed i.e. COPD, childhood and adult asthma, heart failure and chronic pain.**

3.9 Urgent Care

Nationally, two thirds of people who are admitted with a medical emergency have an LTC as a cause for their admission. It is anticipated that because of these strong links between LTC and Urgent Care, all work streams have the potential to contribute to the aim of reducing A&E attendances and unplanned admissions to both hospital and institutional care. The Urgent Care work stream itself has initially focused on identifying better ways to manage people who are regarded as high intensity users of A&E, understanding the non clinical reasons why people attend A&E and expanding access to alternatives.

Managing High Intensity Users

Case Managers

As part of the London Older People's Collaborative, TH PCT piloted a small number of Pathway Coordinators designed to identify over 75s at risk of regular A&E attendance or admission. Following a positive evaluation, the posts were converted into six case managers, jointly funded by the PCT and Social Services. Experience gained during the first year has led to a number of changes being made to the way the team operates.

A team leader, Kath Sylvester, has been appointed to provide mentoring and supervision for the team, implement changes to procedures and also ensure that evaluation data is being collected. Previously case managers were targeting those aged 65 and over with very high rates of attendance at hospital. Using PARR (a predictive risk tool) it became clear that this had led to younger high intensity users being missed and patients being taken on with needs beyond the scope of the team's experience e.g. long term alcohol users with a history of non-engagement. The team now accept people aged 50 plus and are better able to identify the patients they can turn round. A review of the current caseload in April 2006 has seen more appropriate clients referred - currently 4 case managers are in post with a case load of 83 patients. The new focus has also led to improvements in discharging patients from the service.

A case monitoring system has been introduced to ensure people's needs are addressed in a timely way, previously some patients waited several weeks between referral and first contact.

As part of Practice Based Commissioning, GP practices have been sent data which identifies patients who have attended A&E or the Walk In Centre more than 4 times in a six month period. Each practice is given a menu of suggestions on how to manage these patients, which includes referral to the case managers. The team leader is now following up on the reports and developing a stronger relationship with the practice teams.

Hospital Avoidance Team (HAT)

The Hospital Avoidance Team were originally funded to ensure there was a regular primary care presence within the A&E Department. The role of the team is to identify and follow up patients attending A&E on a regular basis who have conditions which could have been dealt with by other teams in other settings. For the majority of patients the HAT will intervene for a short period of time e.g. helping a patient to register with a GP or referring them into self management. However, a smaller number are case managed if that is felt appropriate and there is no obvious existing team to provide this service. As a

small team of community nurses based in A&E the team has suffered from being pulled between secondary and primary care, resulting in difficulties establishing a profile in A&E and with local practices.

Identifying Non Clinical Reasons Behind A&E Attendance

The PCT commissioned Dr Foster to identify the key characteristics of people attending A&E at the Royal London Hospital between January 2004 and January 2006. Analysis of 200,838 records highlighted a number of key points

- the general profile of people attending A&E is young with the two most prevalent age groups being 0-4 (mostly male) and 20-29 (mostly female)
- the greatest users by ethnicity are Bengali and White British residents
- geography plays a major part in that people living in E1 postcodes are more likely to attend than people living in other parts of the borough.

Building on this initial work, focus groups have been held with A&E staff and local minority ethnic communities. The latter was led by, Social Action for Health and involved over 200 local people – principally of Bengali and Somali origin.

The messages from both sets of participants are highly relevant to the LTC programme:

- Anxiety is a major factor in influencing people to use A&E. Professionals felt strongly that there was a significant number of attendances for minor conditions which could be dealt with by patients and carers with the necessary self care skills and confidence.
- Young Bengali people described not wanting to take chances with their health and therefore they are a major target group for education messages about how and when to use urgent care.
- Administrative processes are also extremely important in influencing where people seek care, the availability of appointments and professionalism of A&E reception staff were cited as major reasons for choosing that route for care
- Effective signposting is crucial as patients are confused about the most appropriate place to seek help. On a positive note those who had used alternatives such as a nurse practitioner or local pharmacist were happy with the care they received.
- Overwhelming support for single entry access to urgent care services

Developing Alternatives to A&E

Walk In Centres (WiC)

Over time the WiC has seen an annual increase of approximately 16.5% each year. In the last twelve months this has risen to 30%, with an average of 135 patients attending each day. This is largely due to more efficient streaming of patients (particularly children) from A&E. However, performance remains high and currently 99.9% of patients are seen within 4 hours. In order to cope with the rising demand the WiC staff have received systematic training on topical issues (e.g. diagnosing sick children) and the service has enhanced the Nurse in Charge role, the roster and room allocation and relationships with A&E nursing.

The Liverpool Street Commuter Walk in Centre opened just before Christmas and although it is relatively close to the Barts Minor Injuries Unit there has been no noticeable impact on their activity. This remains stable at approximately 25-35 patients a day. The Canary Wharf WiC was also opened in June 2006.

Extended hours

The PCT has also invested heavily in commissioning 25 local practices to provide additional appointments in the evening and at weekends. The initiative is particularly designed to improve access for people unable to attend standard appointment times e.g. people in full time work or education. A further six practices are undertaking preparatory work to enable them to participate in future waves. Data collected by the PCT Primary care Directorate shows that in the first quarter of the 06/07 financial year, extended hours provided an additional 3,576 GP appointments and 649 nurse appointments were delivered by the scheme, out of a target of 3840 and 818 respectively.

An evaluation of the pilot programme was undertaken in January, with 8 of the original 11 participant practices and 155 service users responding. On the whole the service appears to be a reaching its target population – over 50% of respondents stated they would not have been able to make a traditional appointment slot, with 2/3 of this group citing work as the main reason. Some practices reported initial problems ensuring adequate staffing and administrative time to run the extra sessions. However, the opportunity for flexible working and overtime was often welcomed by locum and reception staff.

NHS Direct

Work is currently underway to review the services provided by NHS direct to Tower Hamlets residents by the PCT.

Pharmacy First

43 Local Pharmacies are now taking part in a scheme called Pharmacy First, where they provide advice free of charge without an appointment on a range of minor ailments such as headache, cough, sore throat, back pain, skin rashes and heartburn. If a medicine is necessary and the patient does not normally pay for prescriptions they will be provided with medication for free. The patient registers once with reception staff at their GP practice, they are then given a form to take to the participating pharmacy. After registering, patients can access this service from the pharmacy they are registered with at any time, without the need to go to their practice first. Since the scheme began in June 2005, 21,782 patients have registered with the service.

Over the next year, the plans are as follows:

Urgent Care Redesign

Tower Hamlets Urgent Care Strategic Framework is currently being written with a first draft to be completed by November 2006. The strategy will reflect both the Tower Hamlets Improving Health and Well-being Strategy and the recently published national guidelines from the DOH- 'Direction of Travel for Urgent Care – a discussion document'. The 4 core principles of the strategy are that services users receive t*he right treatment, at the right time, in the right place, by the right person*. In order to achieve the vision indicated by the '*4 rights'* there are 3 strands of work that need to be implemented:

1. **The development of an integrated Urgent Care Centre for ambulatory care based at the Royal London Hospital. The Urgent Care Centre will combine A&E minors, the Whitechapel WiC, and GP OOH services to improve access to care, avoid unnecessary delays and admissions, reduce patient confusion and the 'bouncing' of patients between A&E and the WiC.**
2. **A 24/7 primary care service, expanding the existing Out of Hours service into an in hours service providing a single point of contact for a range of services.**
3. **The provision of locality based urgent care centres/services utilising newly developed Health and Social Care facilities to provide this.**

Communication with the Public

1. **Local publicity campaign supported and delivered by the PCT and Dr Fosters which is targeted at local residents to inform them of current alternatives to A&E as described above.**
2. **To establish an Urgent Care Patient Group which will support the development of the urgent care model of care the strategic framework.**

Developing Alternatives to A&E

Extended Hours

1. **Continue evaluation of the service, to include monitoring of actual versus target provision, uptake by patients and cost per patient seen compared to standard hours appointments.**
2. **Develop an agreed approach and criteria for long term funding for the programme.**

Pharmacy First

1. **Continue to review the conditions covered by the scheme and undertake a formal evaluation of its impact.**
2. **Ensure IT systems are in place to enable pharmacists to process their payments electronically.**

Managing High Intensity Users

Case Managers

1. **To review funding for the social care funded members of the team.**
2. **As part of the integration project, leads are identifying how case managers may be added into the skill mix of locality based health and social care teams.**
3. **Further work will take place to establish which PARR indicators which will be used to identify the patients most suitable for social care case management.**
4. **We will evaluate the impact case management has by utilising the data warehouse to track numbers of practice / home visits and use of urgent care services pre and post intervention.**

HAT

1. **In line with the organisational arrangements for Tower Hamlets PCT the HAT team will move into the Provider Development Directorate to sit within Older People and Rehabilitation services. The team may be formally absorbed into Intermediate Care, to enable the service to have a stronger 24/7 presence in A&E. This would address the current issue of referrals to intermediate care tending to drop over the weekend.**
2. **The team also needs to continue work begun this year to strengthen links with local GP practices, particularly those with high numbers of patients attending for conditions which could be managed in the community.**
3. **Evaluation of HAT criteria for referral, activity and outcomes will take place along the same lines as the case managers.**

3.10 Workforce

One of the fundamental elements of the LTC strategy is to reduce reliance on hospital and institutional care services by strengthening the capacity of community services to deliver the majority of routine health and social care. Implementing this is reliant on the PCT and LBTH ensuring that staff have the capacity, skills, information, supervision and equipment to enable them to provide a safe and effective service. The LTC workforce development sub group was established in September 2005 to take this forward.

Many trusts were driven by the PSA target to create community matrons very rapidly. In other areas, the target was achieved by redefining some district nurses as community matrons. THPCT resisted this as we believe that improving the way the workforce in the community manage long term conditions requires much more fundamental redesign and that simply creating a new layer of community matrons

a. introduces cost without necessarily securing added value
b. does not address the broader skill mix and clinical leadership required in each locality
c. will not command the confidence of the existing workforce, particularly GPs.
d. Misses opportunities to work more closely with social care colleagues to create more integrated teams.

Our approach has therefore been to commission a formal skill mix review. This has been undertaken by the School of Nursing and Midwifery at City University, in collaboration with clinical and managerial leads from the PCT and social services. The report outlining a proposed model of care that would best meet local need has been completed and is currently being consulted upon across the organisations that were involved. This model is based on national and local evidence and staff and service user feedback about their experience of services locally. The Department of Health are interested in the approach we have taken and we are currently waiting to hear whether they will be able to offer the PCT resources to enable the work to be implemented more rapidly.

Over the next year the workstream will

1. **Run a series of consultation events with LTC service users to ask them for their views on the skill mix proposal by December 2006**
2. **Identify the care needs of a selected population at tier one, tier two and tier three based on the new model of care proposed by Professor Procter in order to design the skill mix required for that population using the new model of care by March 2006**
3. **Identify whether EMIS templates can be developed to categorise patients into each tier and prompt referral into particular care pathways / case management / self care etc**
4. **Develop outcome measures to ensure that we are measuring the impact of a new skill mix and to assess value for money and impact**

on patient experience and clinical outcomes that can be used to identify the impact of the change by January 2006

5. **Develop a skill mix implementation plan by December 2006.**
6. **Develop an education and development strategy that builds on existing plans and that supports generic and specialist skills development and the change management element of the implementation plan – by February 2006**
7. **Implement our LDP target of 12 community matrons by March 2007.**

4. Key Risks and Priorities for Action

Failure to sustain decreases in Emergency Bed Day use at Barts and the London NHS Trust remains the single greatest risk to the programme, particularly in financial terms. The difficulties associated with this have been described on page 6. However, the health economy is reaching the end of its period of growth money and is likely to face further top slices in 2007/8 as part of the drive to achieve financial balance in London.

With this in mind, the list of priorities for action and investment has been restricted to a small core of essential activities.

Risk	Actions	Leads
1. EBD total fails to decrease in line with PSA milestones	Quarterly data should be produced for the EBD total by provider, plotted against total population. ELCIS analyses need to distinguish at specialty level between numbers of spells and length of stay as the key driver. Progress towards EBD milestones for BLT and ELCMHT need to be incorporated into the performance management meetings with each provider.	Bruce Garner Jeremy Burden
2. Admission rates for COPD remain above London average	Investment in a community respiratory team designed to support practices and community health and social care teams to exercise proactive admissions avoidance in and out of hours and create more seamless care between home and hospital. Support implementation and evaluation of an NRF funded pilot community based physiotherapy-led pulmonary rehabilitation programme to improve function, confidence to self manage and reduce the risk of de-conditioning.	Sally Herne & Jill Goddard Ange Price
3. Community matrons are not in place by end	Accelerate the implementation of the workforce skill mix project to identify and develop	Caroline Alexander

March 2007 and the milestone for managing high intensity users is not achieved	a core of community matrons with a defined caseload. Bid for support from the Department of Health. Ensure active engagement of mental health and social care partners.	
4. Risk factors for stroke are not managed in primary care	Evaluate the impact of the enhanced service for high risk heart attack and stroke practice by practice. Ensure performance development meetings with practices address QoF and enhanced service performance in relation to stroke. Assess options for improving early intervention in people with TIA	Andrew Ridley Douglas Russell Primary Care Assistant Directors (Ads) and Primary Care Managers (PCMs) Sue White & Patrick Gompertz
5. Diabetic reviews are not implemented or recorded effectively	Evaluate the impact of the enhanced service for diabetic annual reviews practice by practice. Ensure performance development meetings with practices address QoF and enhanced service performance in relation to diabetes.	Andrew Ridley Douglas Russell Primary Care ADs and PCMs
6. Throughput of patients to self care initiatives fails to match LAA targets	Increase investment in the Expert Patient Programme and ensure raising the profile of the service with both patients and potential referrers is a core part of the Self Care Coordinator's role.	Russell Don Sally Herne
7. Lack of communication leads to duplication of effort or loss of momentum for the programme	Ensure universally accessible LTC website is up and running Produce regular Annual Report Ensure regular presentations and reports to key stakeholder groups	Russell Don Sally Herne Dean Field Jeremy Gardner Susan Cunnington-King, BLT

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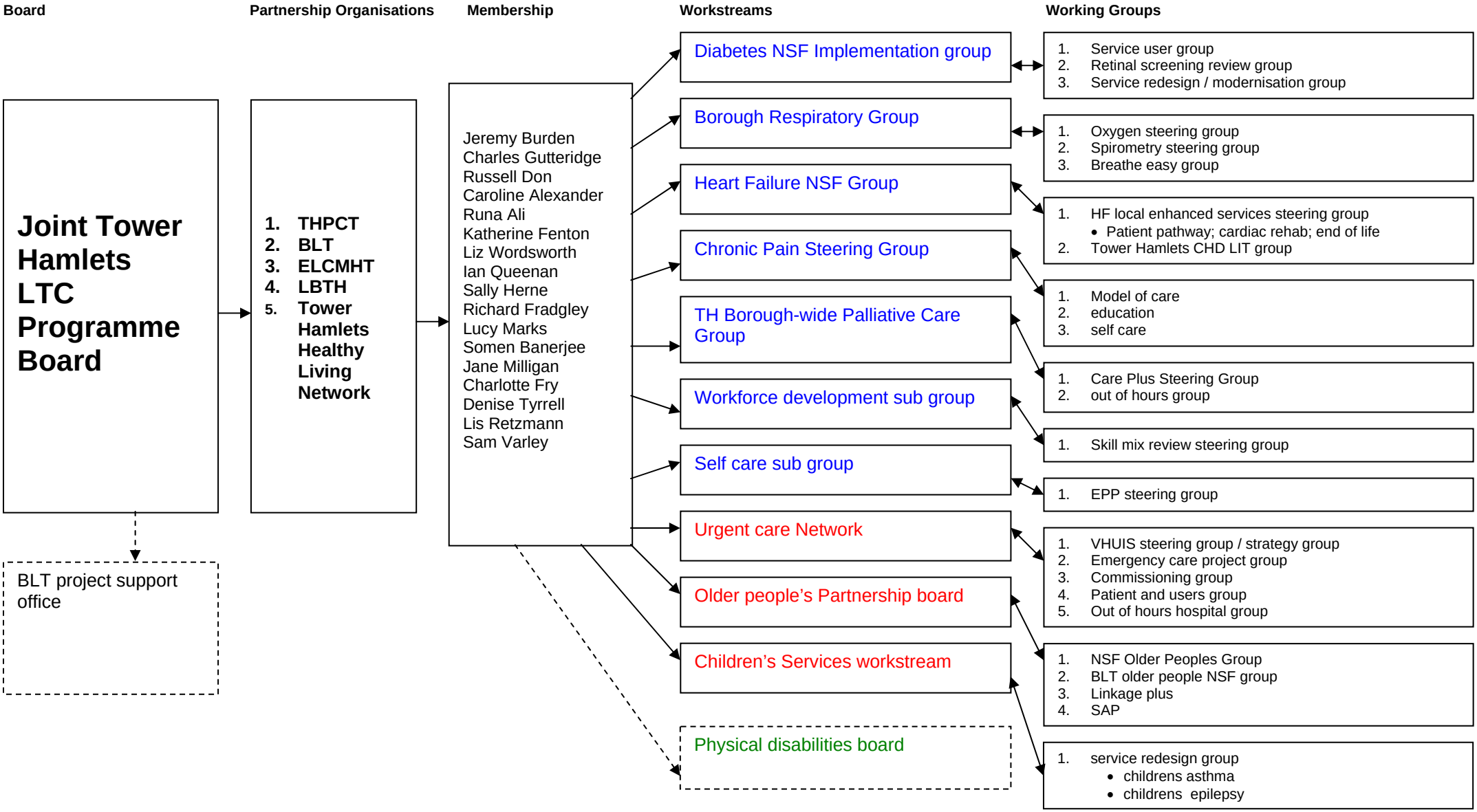
Appendix 1: Organogram of the LTC Programme

Joint Tower Hamlets Long Term Condition Programme Board and Workstreams



Appendix 2

Investment in Long Term Conditions 2006/7

Initiative	Source of Funding	Budget 2006/7
COPD Enhanced service including costs of 1 Lead Clinician	PCT Enhanced Services	155,000k
Heart Failure Enhanced Service including costs of 2 specialist nurses	PCT Enhanced Services	130k
High Risk Heart Attack and Stroke Enhanced Service including costs of 2 specialist nurses	PCT Enhanced Services	135k
Diabetes Annual Review and Insulin Initiation Enhanced Services	PCT Enhanced Services	246k
Anticoagulation Enhanced Service	PCT Enhanced Services	80k
Gold Standards Framework Enhanced Service including costs of 1 Lead Clinician	PCT Enhanced Services + NE London Cancer Network	56k 35k
Depression Enhanced Service	PCT Enhanced Services Including some graduate mental health workers	260,000k
Expert Patient Programme SLA and infrastructure costs	PCT mainstream budget	123k
Roll out of Asthma Action Plans	NRF	25k over two years
Redesign of Pulmonary Rehabilitation	NRF	75k over two years (possible expansion)
Redesign of Chronic Pain Services	NRF	252k over two years
Case Managers	Joint Funding PCT and LBTH	130k (PCT element)
Hospital Avoidance Team	PCT	120k
Stop Smoking Services	PCT	56k
Primary Care Mental Health Services	PCT	313k

Young Stroke Services	PCT	96k
Diabetes Nurse Specialist	PCT	42k
Health trainers	NRF	151k
Youth Peer Educators	NRF	54.9
Promoting Positive Mental Health (LAP 3 only)	NRF	50k
Weight Action Group (LAP 3 only)	NRF	35.8k
Physical Activity Promotion (LAP 7 only)	NRF	21.5k
User led mental health centre (LAP 5 only)	NRF	332.6k
Smokers clinic (LAP 3 only)	NRF	27k

Appendix 3 – Performance against the Quality and Outcomes Framework 2004-6

"clinical data summary report.doc"

"clinical comparisons.xls"

Appendix 4 - Top Contributors to Emergency Bed Days 2002-2006

"top contributors 2002-6.xls"

Tower Hamlets NHS
Primary Care Trust

Chief Executive's Report January 2007

1. Independent Report of the care and treatment of Mrs Mariam Miles

I chaired the launch of this report into the care and treatment of Mrs Miles, who had been convicted of the manslaughter of her husband in July 2004. Mrs Miles had been receiving treatment for mental illness at the East London and the City Mental Health Trust and the report makes a number of recommendations aimed at strengthening the quality of mental health services in Tower Hamlets. A joint action plan between the PCT, East London and the City Mental Health Trust and the London Borough of Tower Hamlets has been agreed, and this describes improvements already delivered improvements and future work to be done. A full copy of the report is available.

2. Fitness for Purpose

The final letter following the Board to Board meeting is appended to my report for this month. Board members are asked to note that we will be in Wave 3 of the Development Programme which will start at the end of January 2007. This will be completed by the end of March 2007. The end product of the Development Programme will be the implementation of Development Plan which will address any capability gaps ensuring we are fit for purpose.

3. Healthcare for London: A Framework for Action

This key piece of work on developing a vision for London's Healthcare was launched in December 2006. Professor Sir Ara Darzi has been commissioned to develop a strategy to meet the health needs of Londoners over the next five to ten years, and an initial document setting out the framework and models of service is expected in early spring with the final strategy expected in summer 2007. There is an associated website www.healthcareforlondon.nhs.uk has been set up where members of the public and healthcare staff can get further information. A fuller briefing is appended to this report.

4. Primary Care Trust Collective Working Arrangements

These arrangements, appended to my report, are being put in place to support the London PCTs in working together and discharging some of the key responsibilities effectively. The need for PCTs to work closely together in the future is well recognised, and this will be underpinned by a partnership agreement that will make explicit what this will mean in practice. The agreement confirms the commitment to work together to achieve common objectives. Proposals for the infrastructure to support collective working are expected shortly.

5. Healthcare Commission visit

The PCT will be hosting a visit from Anna Walker (Chair of the Healthcare Commission on January 19 2007. This will give us the opportunity to showcase some of the PCT's services and discuss the key issues with regard to our ratings (as raised with Lesley Rogers at the informal Board meeting in December 2006).

6. Barts and the London NHS Trust

The Department of Health have agreed that the Trust will be included in the Wave 5 Foundation Trust status process. The Trust will be presenting their application to our March 2007 Board meeting.

7. Annual Staff Survey 2006

Early indications show that we have exceeded the Healthcare Commission target for survey returns and an early report will be brought to the March 2007 Board meeting for consideration.

8. In the Pink

The PCT is one of two NHS organisations to have been included in Stonewall's Top 100 Employers for Gay People in Britain listing. The list is compiled by measuring against nine policy and practice gay friendly criteria including monitoring sexual orientation and diversity training that incorporates sexual orientation. In getting into the top 100 it shows that we do more than just tick boxes in this area but are able to demonstrate our commitment to equality and diversity.

9. People

Ian Wilson retired as Interim Chief Executive of the London Borough of Tower Hamlets on December 31 2006. Ian had worked in the Borough for the last decade and led the transformation of the council's social services into one of the best in the country. In recognition of this he was awarded a CBE in the New Year's Honours list. Martin Smith whose substantive post is Director of Resources will take over the Interim Chief Executive responsibilities until a substantive appointment is made.

Following Paul White's departure from Barts and the London Trust, the recent recruitment process to appoint a new CEO was unsuccessful. John Goulston (Director of Finance) will assume Chief Executive responsibilities until a substantive appointment is made.

10. Fresh Start

The PCT has launched a campaign to encourage people to give up smoking.

The Fresh Start campaign includes advertisements on buses, Channel S TV, beermats, and in local newspapers. Posters will be in all PCT and hospital trust service areas, GP practices and pharmacies. The advertisements show real local people who have made a fresh start by giving up smoking. Each has a simple message on why that person gave up smoking – for the sake of their family, for example.

Smoking contributes to the death of 500 people per year in Tower Hamlets and we have one of the highest smoking rates in the country. Success in helping people to give up smoking is also one of our key targets.