Commissioning Strategy Plan
2010 – 2015
Chief Executive's foreword

When it comes to health Newham has the greatest challenges, the most exciting opportunities and the most aspirational vision. In 2009 we presented a highly ambitious Commissioning Strategic Plan that reflected, addressed and built on all these different facets of our local NHS.

One year on we have achieved some major successes: transforming maternity services; working in partnership to deliver health outcomes; exceeding stop smoking targets; extending primary care access; and opening new GP practices. We have been able to define and refine the tasks ahead of us so our path to becoming a World Class Commissioning organisation is completely clear.

For NHS Newham the key to achieving excellence is to build a strong and lasting relationship with all our stakeholders, so that we can truly say that the Newham community has ownership of health and local health services. We have engaged our community at every step in defining our priorities and monitoring delivery. “You said, we did” has become our mantra.

Newham’s communities aspire to NHS services that make them full partners in ownership of their health and health services, rather than passive recipients of services. Developing Polysystems gives us this opportunity.

As part of its implementation of the NHS Constitution, NHS Newham consulted more than 1500 local residents on the Constitution Rights and Responsibilities. BME communities in particular challenged NHS Newham to make commissioning accountable to local communities, involving them in setting organisational goals and performance standards.

NHS Newham was commended by the Secretary of State for Health for this engagement exercise, and the PCT will be responding to this challenge by embedding patient and public engagement in all aspects of the Newham Commissioning Cycle.

Our approach has been completely honest and open. We have acknowledged that performance needs to improve, and engaged with our contractors and providers in constructive dialogue that focuses on outcomes and pulls no punches. We have recognised that we need to transform our organisation. We have developed a strong leadership team. We are building a highly professional, skilled workforce that is motivated by our goals and seeks innovative solutions to our challenges.

Our relationships with our partners have always been strong but we certainly aren’t resting on our laurels – we are continuing to develop integrated commissioning with the London Borough of Newham (LBN) and our approach to joined-up service delivery has been applauded by our community. Developing Polysystems will strengthen this partnership as we integrate health and social care and our providers. We are developing our partnership across the sector with NHS Tower Hamlets and NHS City and Hackney through collaborative working, the creation of the Sector Acute Commissioning Unit (SACU) and the Health Intelligence Unit (HIU) as well as the Health for North East London Programme, and we continue to work closely with Commissioning Support for London (CSL).

While we have much to celebrate, our future still looks incredibly challenging. Our funding has never matched the needs of Europe’s most diverse community, but we know that we must work even smarter to deliver more for less. The strength of our dialogue with our local community means we already have demonstrable support for the new ways of working that we will need to adopt, to deliver best quality and address our financial challenges. We are well placed to build on this in years to come as we tackle our biggest challenge of transforming primary and community services through Polysystems.
We have the enormous opportunity of the Olympics to engage more people than ever before in our Let’s Get Moving campaign and to work with partners across the five Olympic boroughs to leave a lasting legacy through the principle of convergence.

So in presenting our refreshed Plan we present an organisation that is confident, professional and thriving, and an approach that is collaborative, community-oriented, structured and performance-focused. This way we will deliver the very best healthcare for the people of Newham.

Melanie Walker
Chief Executive

Our vision
The health of all Newham people will be better than other Londoners by 2020 and the quality of services which affect health will be as good as anywhere in the country by 2012.

World Class Commissioning highlight – manage
You said, we did – transforming maternity care
Our infant mortality rate has been extremely high. Local women told us they want more efficient maternity services that respect their dignity.

We… funded 16 extra midwives; based the midwifery service in children’s centres, providing a free walk-in pregnancy testing service with follow-up care and support; set up a local support phone service available in community languages; produced a DVD for all expectant mothers. The infant mortality rate in Newham has been falling faster than the rest of London in recent years and 93% of women said they would choose to have another baby at Newham Hospital.

World Class Commissioning highlight – engage
You said, we did – exceeding stop smoking targets
Local people said they want health improvement services that are delivered closer to their homes, and reflect their cultural identity.

We… launched our social marketing campaign, Real Support Real People, to show residents that ‘people like them’ have used local stop smoking services; trained successful quitters to support others; ran a mobile drop-in campaign, using a health promotion vehicle based seven days a week in town centres. We have exceeded our target four years in a row.

World Class Commissioning highlight – procure
You said we did – improving GP access
Our performance on access has been poor. Local people said they wanted greater choice about when they could see a GP, and the ability to ‘walk in’ to see a doctor.

We… opened the Vicarage Lane GP led health centre, with walk-in appointments available 8am–8pm, seven days a week; opened two new GP practices; worked with GPs so that now 86% offer extended hours; have begun an Improvement Foundation programme with our lowest-performing GPs.
1. Introduction

1.1. The role of the Commissioning Strategy Plan

This report is the Commissioning Strategy Plan for NHS Newham covering the five year period from 2010/11 to 2014/15. It aims to set out our strategic intent to change the health and healthcare of the people of Newham over that period. NHS Newham and the London Borough of Newham share a vision and agenda for improving health and well-being and the quality of services for local residents. This document has therefore been agreed and jointly signed off with the London Borough of Newham.

This document will not only inform other organisations of our commissioning intentions, including our providers, NHS London and other partners. It will also drive change within NHS Newham itself, structuring and focusing our performance processes and programme management structures over the next five years.

The report is divided into four key sections:

- **Vision**: describes our vision and our goals, the challenges we face and how we will prioritise our goals and resources to meet those challenges. It also shows how important equality is to us and to the values we have in Newham;
- **Context**: divided into four components the first will focus on our approach to commissioning at both borough and sector level, how we are responding to the opportunity of the Olympics through the Strategic Regeneration Framework, our approach to quality and how we manage clinical engagement in Newham. The second will focus on how we have renewed our goals, the progress we have made this year and the role of the Local Area Agreement. The third will detail our provider landscape, our achievements so far and our strategic intent. The last component in this section will detail our financial plan for the Commissioning Strategy Plan (CSP) period;
- **Strategy**: will detail how we are going to deliver our transformation through Polysystems. It will also show how we are implementing the Healthcare for London (HfL) care pathways in Newham and the initiatives we have identified to deliver our prioritised needs. This section will detail these initiatives, which will be the key drivers for the next five years of the CSP period;
- **Delivery**: will outline how we plan to implement these initiatives. It includes details of the enabling strategies that will be necessary to ensure health outcomes continue to improve across Newham.

The last section is our declaration of Board Approval to this Commissioning Strategy Plan.

2. Vision

2.1. Our vision

In Newham we have committed ourselves to an ambitious vision for our organisation;

“The health of all Newham people will be better than other Londoners by 2020 and the quality of services which affect health will be as good as anywhere in the country by 2012.”

All too often, people in Newham experience worse health and worse service access because of who they are, where they live, their education or their background. We will work with our local communities to tackle these inequalities and ensure everyone is enabled to improve their health and access the services they need.
2.2. The CSP and equality

Our Commissioning Strategy Plan is all about tackling inequalities: inequalities of service, health and the wider inequalities that affect health. By successfully implementing this plan, we will tackle inequalities for the population of Newham by:

- promoting equality, diversity and human rights. This lies at the heart of Newham’s vision to improve health outcomes and reduce health inequalities;
- implementing priority actions in our Single Equality Scheme to promote equal access, experience and outcomes;
- ensuring that equality considerations and objectives will inform all stages of the commissioning cycle. From the first stage of needs assessment in which data are segmented by equality dimensions, through to subsequent investment decisions, procurement arrangements and monitoring;
- assessing and monitoring the impact on population groups to ensure that inequalities are reduced and opportunities to promote equality and improve the quality of commissioned services are optimised.

2.3. Our core values

To deliver our vision and to lead the drive to reduce inequalities we will also focus on creating an excellent NHS Newham. One way we do that is by having clear core values. These values are to:

- Put the people of Newham’s interests, rights, safety, views and well-being at the heart of everything we do.
- Embrace diversity and promote equity of access.
- Be an enthusiastic participant in productive partnerships.
- Strive to be a learning organisation by embracing innovation and challenge, seeking continuous quality improvement and valuing staff.
- Promote openness, transparency and accountability for decisions, services and commissioning.
- Seek to commission high quality and efficient services.
- Work towards a common set of values and principles with LBN.

2.4. Our challenges

Newham is an extraordinary place. We have the most diverse population in the UK, with

- over one hundred different languages spoken,
- almost half of our population under twenty five,
- 20% of our population changing each year and
- one of the fastest growing populations in London.

Newham is also the sixth most deprived local authority area in England. We face all the health issues that go with this position, high mortality, low life expectancy and high levels of chronic illness. Our latest statistics show

- GP access survey results showing a satisfaction rate of 68% compared to an England average of 77%
- The second lowest levels of physical activity in London
- The highest under 75’s mortality rate for women in London
- The fifth highest rate for men
We also have a significant change to our financial position. Following many years of growing resources we are about to enter a spending period where the resources available to us will be severely constrained.

The big challenges we identified last year are still very relevant. They were:

- meeting the resource demands created by the population growth;
- influencing the wider determinants of health and inequalities through our work with the London Borough of Newham;
- improving the quality of primary and community care services, as this is where the greatest health gain can be achieved;
- effectively engaging with the whole population to support healthier lifestyles to prevent disease;
- moving care away from hospitals to the local community through Polysystems to improve health outcomes and financial sustainability;
- establishing and successfully implementing Polysystems as the key delivery vehicle for Newham’s healthcare.

2.5. Refreshing our goals, needs and resources prioritised

2.5.1 Identifying our needs

Starting to identify priorities from all the challenges we face is a daunting task. However, through our Joint Strategic Needs Assessment (JSNA), produced in partnership with the London Borough of Newham, we have been able to identify where we need to concentrate our energy. Our JSNA identifies trends in key health outcome areas, and using comparative data at a ward, borough, London and national level for benchmarking, assesses our achievements in addressing those trends and meeting the needs of the people of Newham.

Those needs assessments and reports that have contributed to its development inform both this strategy and related plans and programmes. A prioritisation process was undertaken to identify our ten key priorities. This involved creating informal criteria, and matching the evidence of need to these criteria. Priorities were then selected on the basis of good matches. The following criteria were used:

- The issue is an important public health problem in terms of magnitude and/or consequence.
- When benchmarked against London and England, performance is poor in relation to this issue and therefore challenging.
- Historical performance has been below expectations for this issue
- The issue is of important public concern.
- The issue is important in terms of local strategic priorities and joint working.

2.6 Understanding our population

According to GLA projections, the population of Newham is expected to increase in all age groups, but especially between 25 and 49 years old (Figure 3.5). Although the proportion of older people in Newham is relatively small, the absolute number will increase; and the need for health and social care by this age group is disproportionately high, because of the burden of illness and need for support to live independently. The predicted increases in population will challenge NHS Newham to provide healthcare at increasing levels as the demand for healthcare grows with the population. This alone would pose a significant challenge to NHS Newham; when coupled with the pre-existing health inequalities we face a significant challenge.

The table below demonstrates the significant variation between GLA and ONS population estimates. Whilst the ONS data estimates the population of Newham to be 247,600, collation of data from our GP lists indicates a registered population of 342,000.
From the JSNA we have identified five areas that relate to specific challenges in health and healthcare. These areas are:

- Early identification and treatment of cardiovascular disease and diabetes
- Improving mental well-being
- Prevention, early diagnosis and treatment of cancer
- Improving maternity services and reducing infant mortality
- Improving sexual health
- Improving access to primary and community based services

However we are aware that the ability of the people of Newham to achieve good health is about managing the wider determinants of health and requires us to influence more than just healthcare. We have identified four areas in which we need to work with our local authority partners to ensure whole systems solutions are employed to deliver health gain. These areas are:

- Healthy lifestyles
- Attainment, skills and access to employment
- Reducing teenage pregnancy
- Improving health outcomes of vulnerable children

2.6.1 Listening to the people of Newham

The Newham Health Debate started last year with over 3,000 local people giving their views in the survey and at a number of local events. NHS Newham listened to what local people said and made changes to local health services. Segmented data from the Newham Health Debate, show that patients and the public want services:

- closer to where they live
- that are more accessible in terms of waiting times
- that provide more tailored customer care
- that have a greater range of facilities under one roof, particularly phlebotomy and diagnostic services.

While patients and the public continue to challenge NHS Newham in a robust manner around access, they have rated the services we commission first in London for being ‘joined up’. The recently launched Newham Health Debate 2 will act as both a comparator and opportunity for patients and the public to contribute ideas to the emergent Polysystem development and other transformational changes to healthcare in Newham.
In addition to the Newham Health Debate, more focused and local, neighbourhood level engagement interventions, such as focus groups, have been used to drill down to identify patient-expressed need. Patient engagement is viewed as central to the commissioning cycle in Newham.

NHS Newham is the highest performing PCT in London on three key patient issues, according to survey work carried out by Ipsos MORI on behalf of NHS London.

The statements that Newham residents gave the most positive responses to were:

- My local NHS and Social Services work well together to provide a ‘joined-up’ service.
- I can influence decisions affecting local NHS services in my area.
- My local NHS is improving services for people like me.

We performed second highest on residents’ agreement with the statement ‘My local NHS is giving people more choice about their treatment and care’ and fifth highest (out of 31 PCTs) on the statement ‘My local NHS helps improve the health and well-being of me and my family’.

Listening to the people of Newham, it is not enough to aim to tackle health and its wider determinants, if the healthcare services we provide are not accessible. The people of Newham have reinforced our need to focus on:

- Improving access to primary and community based services.

2.6.2 Benchmarking against Healthcare for London

In addition to the needs of Newham’s residents, our priorities are also determined by benchmarking services across Newham with best practice care pathways as shown in Healthcare for London. We have participated in a series of facilitated workshops that reviewed each pathway in turn, and with key individuals present, were able to identify gaps between best practice and Newham practice. This work has been integral to determining our priorities for the next five years (see 4.3 Healthcare for London below for more detail).

2.6.3 Prioritising our resources

Having prioritised the health needs of the people of Newham, we will now align our resources against activities to meet those health needs. We have developed our resource prioritisation process to build on the success of last year and to align with the process that has been adopted by the sector.

Across the sector we have taken an approach that measures new investments against the criteria of quality of patient outcomes (our goals), productivity (savings and the transformation agenda) and ‘must do’ targets. Through the operating planning process we will focus first on prioritising the activities within our initiatives and then broaden the process to include all our resources.

This process will become increasingly important over the coming years as the financial situation becomes more challenging. To recognise the severity of the deteriorating financial situation we have included an eleventh need to measure everything we do against:

- To achieve financial sustainability

The goals below are therefore derived from our JSNA, our care pathway benchmarking and listening to the people of Newham. They represent the areas that we believe offer the greatest challenges to Newham and the greatest potential for health improvements as we move towards achieving our vision.
### 2.6.4 Developing goals from our vision and needs

<table>
<thead>
<tr>
<th>Need</th>
<th>Goal</th>
<th>WCC outcomes to achieve our vision (trajectories in table below)</th>
<th>Vital signs to monitor progress towards our vision</th>
<th>Additional outcomes to achieve our vision from our 2009/10 base</th>
</tr>
</thead>
</table>
• 58 Diabetes controlled blood sugar | • VSA14: Implementation of the stroke strategy  
• VSB01-S: All-age all-cause mortality rate per 100,000 population (Spearhead Group)  
• VSB02: <75 CVD Mortality rate  
• VSC23-S: Vascular risk score (Spearhead Group)  
• VSC27: Patients with diabetes in whom the last HbA1c is 7.5 or less from Quality Outcomes Framework (QOF) | • Enabling 1,400 more people with diabetes to keep their HbA1c below 7.5 (target is moving as HbA1c now to be below 7) |
| Improve mental well-being | Improve mental well-being | • 48 For IAPT services the number of people entering IAPT treatment | • VSB04: Suicide and injury of undetermined intent mortality rate  
• VSB12: Effectiveness of children and adult mental health service (CAMHS) (percentage of PCTs and local authorities which are providing a comprehensive CAMHS) | • For IAPT services the number of people entering IAPT treatment  
• Increasing by 9% the number of people in contact with mental health services reported as being in employment |
| Prevention, early diagnosis and treatment of cancer | Improve cancer survival rates to be better than London | • 23 Cancer mortality rate | • VSA08: Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral  
• VSA09: Proportion of women aged 47–49 and 71–73 offered screening for breast cancer  
• VSA11: Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments)  
• VSA12: Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)  
• VSA13: Proportion of patients with suspected cancer detected through national screening programmes or by hospital specialists who wait less | • An additional 1,840 women having breast screening per year (plus increase for population growth) |
<table>
<thead>
<tr>
<th>Improve maternity services and reduce infant mortality</th>
<th>Improve maternity services and reduce infant mortality</th>
<th>3 Infant mortality</th>
<th>VSB06: Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy</th>
<th>7 fewer infant deaths per year (20% reduction)</th>
<th>20% reduction in low birth weight babies</th>
<th>18 fewer women smoking at time of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved sexual health</td>
<td>Early diagnosis of HIV and sexually transmitted infections</td>
<td>No directly related WCC outcomes</td>
<td>VSB13: Prevalence of chlamydia</td>
<td>Screen an additional 3,600 people per annum rising to 4,000 by 2020</td>
<td>Reduce percentage of people diagnosed late with HIV by 55%</td>
<td>Increase chlamydia screening in 16–24 yrs to 25% (from 15% = c. 3,600 additional screens per annum rising to 4,000 by 2020.</td>
</tr>
<tr>
<td>Healthy lifestyles</td>
<td>Help the people of Newham to lead healthy lifestyles</td>
<td>14 Prevalence of obesity in Year 6 children</td>
<td>VSB05: Four week smoking quitters (proxy for smoking prevalence)</td>
<td>140 fewer obese children in Reception, and 180 fewer obese children in Y6 (Current = 500 in YR and 900 in Y6)</td>
<td>1 in 4 white and Pakistani male smokers to quit smoking</td>
<td>1 in 3 white female smokers to quit</td>
</tr>
<tr>
<td>Attainment, skills and</td>
<td>Improve access to</td>
<td>No directly related WCC</td>
<td>No related vital signs</td>
<td>enabling over 4,000 people to find jobs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

than 62 days from referral to treatment
- VSA15: Proportion of women receiving cervical cancer screening test results within two weeks
- VSB01-S: All-age all-cause mortality rate per 100,000 population (Spearhead Group)
- VSB03: <75 Cancer mortality rate
<table>
<thead>
<tr>
<th>Access to Employment</th>
<th>Employment in Healthcare Delivery for Local People</th>
<th>Outcomes</th>
<th>For 6% more young people to achieve 5+ A*-C at GCSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Teenage Pregnancy</td>
<td>Reduce Teenage Pregnancy</td>
<td>No directly related WCC outcomes</td>
<td>VSB08: Under 18 conception rate per 1,000 females aged 15–17</td>
</tr>
<tr>
<td>Improve Health Outcomes of Vulnerable Children</td>
<td>Improve Health Outcomes of Vulnerable Children</td>
<td>No directly related WCC outcomes</td>
<td>No related vital signs</td>
</tr>
<tr>
<td>Improve Access to Community Based Services</td>
<td>Improve Access to High Quality Primary Care and Community Services</td>
<td>32 Self-reported experience of patients and users</td>
<td>VSA06: Patient experience of access to primary care</td>
</tr>
<tr>
<td>Achieve Financial Sustainability</td>
<td>Achieve Financial Sustainability</td>
<td>No directly related WCC outcomes</td>
<td>No related vital signs</td>
</tr>
</tbody>
</table>
2.6.5 **Setting our WCC outcome aspirations**

We have to hit some challenging targets if we are to achieve our vision. The table below outlines our trajectories against our chosen WCC outcomes. If we achieve these trajectories it will go a long way towards achieving our vision.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Outcome</th>
<th>Improvement aspiration (5 years)</th>
<th>Rationale for aspiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Health inequalities (males)</td>
<td>5.9 5.6 5.5 5.5 5.4</td>
<td>APHO national guidance</td>
</tr>
<tr>
<td>1b</td>
<td>Health inequalities (females)</td>
<td>3.4 3.8 3.7 3.7 3.7</td>
<td>APHO national guidance</td>
</tr>
<tr>
<td>2a</td>
<td>Life expectancy in years (males)</td>
<td>75.8 76.3 76.8 77.3 77.8</td>
<td>Reach London trajectory by 2020</td>
</tr>
<tr>
<td>2b</td>
<td>Life expectancy in years (females)</td>
<td>80.4 80.8 81.1 81.5 81.8</td>
<td>Reach London trajectory by 2020</td>
</tr>
<tr>
<td>3</td>
<td>Infant mortality (rate per 100,000)</td>
<td>5.8 5.6 5.4 5.2 5.0</td>
<td>Reach London trajectory by 2020</td>
</tr>
<tr>
<td>17</td>
<td>Smoking quitters (number)</td>
<td>1,027 1,027 1,027 1,027 1,027</td>
<td>First two years already set nationally, last three years based on maximum rate in any one year needed to reach 10% prevalence by 2020</td>
</tr>
<tr>
<td>23</td>
<td>Cancer mortality rate (rate per 100,000)</td>
<td>121.39 115.70 111.63 107.49 103.49</td>
<td>Based on achieving the Newham trajectory by 2020 as this is more aspirational than London’s by 2020</td>
</tr>
<tr>
<td>32</td>
<td>Self-reported experience of patients and users (score)</td>
<td>71.9 73.3 74.7 76.1 77.5</td>
<td>Based on achieving the highest ranking London score by 2020</td>
</tr>
<tr>
<td>55</td>
<td>CVD mortality (rate per 100,000)</td>
<td>118.89 110.11 101.33 92.55 83.76</td>
<td>Reach London trajectory by 2020</td>
</tr>
<tr>
<td>58</td>
<td>Diabetes controlled blood sugar (percentage of patients)</td>
<td>61.9 64.0 68.0 71.0 74.0</td>
<td>Continuation from last years trajectory</td>
</tr>
<tr>
<td>14</td>
<td>Prevalence of obesity in Year 6 children, as measured by the national child measurement programme</td>
<td>24.58 24.23 23.89 23.54 23.19</td>
<td>Based on halting the rise in obesity by 2020, baseline 2006/07</td>
</tr>
<tr>
<td>48</td>
<td>For IAPT services the number of people entering IAPT treatment (number)</td>
<td>3,426 4,685 4,865 4,865 4,865</td>
<td>Based on modelling by local clinician for IAPT</td>
</tr>
</tbody>
</table>
3  Context

3.1 Strategic context

*High Quality Care for All* (2008) outlined the requirement of putting “quality at the heart of the NHS”. It set out an ambitious vision for making quality improvement the organising principle of everything we do in the National Health Service, placing a particular emphasis on the need to measure what we do as a basis of transforming quality.

Our transformation plans are informed by a number of key documents:

- *The NHS Next Stage Review* made a public commitment to creating modern, responsive primary and community services of a consistently high standard.
- *Healthcare for London (HfL)* is an ambitious ten year programme aimed at transforming the quality and outcomes of healthcare in London. Implementing Healthcare for London will result in a step change in service delivery and outcomes for patients. It is the quality strategy for London and the framework within which we can meet the productivity and affordability challenges we face.
- *Transforming Community Services* is a guidance document, published by the DH, to enable the development of community services in the context of the provider–commissioner separation within PCTs and of radically improved commissioning.
- *Putting People First*, a cross-departmental concordat to which the NHS is co-signatory, sets out the government’s commitment to independent living for all adults. It explains the shared aims and values that will guide the transformation of adult social care to ensure that older people, people with chronic conditions, disabled people and people with mental health problems have the best possible quality of life. This will be based on a personalised system of social care, with person-centred planning and self-directed support becoming mainstreamed. This will transform social care in Newham.
- *Health 4 NEL* is the North East London acute services review which provides the whole system strategic framework behind the Newham CSP. The North East London PCTs identified a need for change in the configuration of acute services. Together we are formally consulting on this set of proposals. The proposals underpin our plans to transform healthcare delivery in Newham. The details of which are articulated in the sector commissioning strategy.

If we are going to implement Healthcare for London aggressively, we need to transform our model of healthcare based on four principles:

- Care closer to home
- Prevention and well-being
- Effective management of long term conditions
- Productivity and value for money

Allied to this we have to manage demand more effectively and, with our local authority partners, develop services that ensure personalisation and choice.

3.2 Newham as a World Class Commissioner

3.2.1 *Our strategic approach to commissioning*

If we are to meet the needs we have identified we must work effectively to commission services as a World Class Commissioning (WCC) organisation. NHS Newham and the London Borough of Newham have a long history of joint and collaborative commissioning for both adults and children services also developed collaborative commissioning as part of the sector arrangements for the three PCTs of the East London and City Alliance. We have worked with other London PCTs to develop other arrangements such as CSL and Specialist Commissioning.
In order to build on these achievements we will:

- Ensure meaningful engagement with local people drives change
- Work in partnership with the London Borough of Newham.
- Extend our work with other PCTs to maximise the skills available to us to strengthen our commissioning capability
- Develop our internal systems, skills and processes.

Our organisational development plan details how we will develop our own organisation and our partnerships. The next section identifies how we are delivering a World Class Commissioning capability in NHS Newham.

3.2.2 Borough based commissioning

Over the last year we have transformed the commissioning arm of the PCT. We have designed, agreed and embedded our commissioning processes as the Newham Commissioning Cycle.

We have built on the existing capacity, expertise and strengths of our commissioning partners and the commissioning teams.

The Newham Commissioning Cycle

In 2009/10 to provide the platform for transformational service change, we have:

- Agreed our shared strategic direction (based on high level needs assessments, e.g. JSNA) through the Newham Partnership Board (the Local Strategic Partnership – LSP)
- Agreed Polysystems will be the main delivery vehicle for the joint transformation of health and social care
- Revised our joint borough based commissioning arrangements
- Ensured that clinical commissioning is an active part of local commissioning
- Strengthened the governance structures for adults and children
- Jointly agreed a set of values and key principles

Clinical commissioning is a fundamental component of all activities within the commissioning cycle. In Newham there are well established clinical leads who work closely with commissioners, particularly on the redesign and specification of services. The clinical leads are drawn from the local GP community, from the Practice Based Commissioning (PBC) consortia and stand alone PBCs. New specifications and commissioning proposals are also presented to the Professional Executive Committee (PEC) which focuses on quality improvement. Formal processes are being developed for engaging with clinicians on the ‘procure’ and ‘manage’ steps as well as needs assessment and planning of services.

We have an ambitious vision for borough based commissioning between NHS Newham, PBC and the London Borough of Newham, which includes commissioning community based care and treatment very differently within the Polysystem model. A particular strength of Newham
Commissioning is our range of engagement strategies. These strategies ensure we listen to our residents, clinicians and other key stakeholders and apply what we learn into our commissioning decisions. To further strengthen our commissioning approach for Polysystem based care, we are structuring clinical and professional commissioning to involve a wide range of professionals. These will include Practice Based Commissioners, social care professionals and the wider local authority in determining commissioning intentions. The intentions will be based on needs assessments for each Polysystems’ geographical area. Future commissioning structures will also adapt to encompass the concept of individuals commissioning some services for themselves with personalised budgets. This is an approach which will take commissioning into a new arena.

3.2.3 Sector based commissioning

The ICSP outlines how we will work collaboratively with our ELCA partners to implement Health for NEL. More information and detail is available in the ICSP. We will continue to work with the newly established health intelligence unit (HIU) to ensure that we systematically analyse and review health intelligence data to inform us of the progress and impact of implementing our transformations.

In particular the sector acute commissioning unit (SACU) will bring greater leverage, economies of scale and enhanced commissioning expertise to effectively drive productivity, performance, quality and redesign within acute hospital provision. NHS Newham has adopted a close performance management relationship as well as collaborative working with the SACU managing director and commissioning team. The SACU will enable us to:

- improve acute sector productivity;
- apply comprehensive claims management protocols and systems (linked to the development of the sector health intelligence unit);
- ensure acute sector performance improvement – vital signs;
- ensure acute sector quality improvement – Commissioning for Quality and Innovation (CQUIN);
- reshape the acute sector as shifts to care outside hospital occur – close working will be required year on year to accurately size contract volumes between SACU and NHS Newham;
- redesign acute pathways ensuring interlink to community care closer to home – shorter length of stay, prevention of admission, easy access to clinical advice for primary care health professionals;
- implement the Healthcare for London pathways and the Health for North East London (H4NEL) reconfiguration.

There are also sector arrangements in place for the commissioning of mental health services from our main provider, East London Foundation Trust (ELFT). This improves our commissioning strength by sharing expertise, reducing duplication and bringing greater leverage for improved productivity and quality of services. It also consolidates commissioning intentions with our main provider and streamlines monitoring and evaluation of the contract.

3.2.4 The Olympics and the Strategic Regeneration Framework

The Strategic Regeneration Framework (SRF) brings together the regeneration of the physical area of the five Olympic host boroughs, and the socio-economic regeneration of the communities who live within it, and is driven by the hosting of the Olympics and Paralympics in 2012.
Because these are the most deprived communities in England, the SRF has as its organising principle that over a 20 year period conditions for the people who live in the host boroughs will improve to the point where they can enjoy the same social and economic conditions as Londoners as a whole. This is the principle of convergence.

The SRF will work by improving the co-ordination and delivery of socio-economic interventions linked to the Olympic Games legacy of physical transformation and raised aspiration. The SRF will provide sub regional strategic leadership to address barriers to improvement and harness the opportunities available through the sub region’s improved connectivity, housing offer, public realm and economic growth.

NHS Newham, through the Chief Executive, provides leadership at a pan-London level to the health and well-being elements of the SRF. This is a once-in-a-lifetime opportunity to tackle the endemic poverty and disadvantage experienced by people in Newham and East London.

Through the SRF, we will work with the other Olympic and Paralympic boroughs and their PCTs and partners to improve recruitment and retention practices, including apprenticeships and work experience offers, and in-work training. With employment and training providers, the five PCTs will support the key employment and training interventions relevant to each disadvantaged group in order to identify and plug the gaps in provision for marginalised groups which includes disabled people, and people with chronic health conditions and mental health problems. We will also work with sports and leisure partners to improve the take-up of local physical health opportunities by people who are currently inactive.

For more details on the specific targets and how we plan to deliver them see the Strategic Regeneration Framework.

In addition to the commitments made in the SRF we are also committed to a legacy of the Olympics being transformed primary care for the people of Newham. This will be delivered through our drive to implement Polysystems and has already begun through the approval of the Olympic Polyclinic business case by NHS London which will provide 5,000 m² of health and community space (3,700 m² for health and 1,300 m² for the Community Development Trust) by 2013.

3.2.5  Our approach to quality

Improving the quality of care in Newham is central to everything we do in NHS Newham. We aim to improve patient safety, the patient experience and clinical and cost-effectiveness through the commissioning cycle and all our interactions with patients and providers.

Our quality plan integrates the seven quality components and three quality domains, as detailed in the High Quality Care for All report, and NHS Newham’s World Class Commissioning Cycle. This approach will be embedded across NHS Newham to ensure that improving quality is intrinsic to everything we do.

We are already driving quality improvements across Newham. For example the maternity services in Newham have improved significantly. With strong clinical engagement and leadership, capacity and access was increased, and quality indicators were developed and inserted into the acute trust contract; a Maternity Matters action plan was also developed and is currently being monitored for implementation by December 2009. This has resulted in still birth rates being reduced from 8 per 1,000 births to 5.3 per 1,000 births, in direct access to midwives, and in no complaints being received in relation to the service.

The NHS Newham Board have approved a new committee. The Professional Executive Committee – Quality Standards Improvement is the committee that will oversee quality.
3.2.5.1 **Quality, Innovation, Productivity and Prevention**

Quality, Innovation, Productivity and Prevention (QIPP) represents a coming together of existing policies and is designed to improve delivery at a time of financial challenges across the National Health Service.

NHS Newham has embraced this model and has aligned its initiatives throughout the CSP to QIPP methodology, which you will see in our initiatives where the impact on QIPP is specifically identified.

3.2.6 **The CSP and clinical engagement**

NHS Newham recognises that clinical leadership and engagement are vital to all aspects of its commissioning cycle to ensure that health and health services are improved as set out in our vision. Clinical input is needed so that plans make clinical sense and implementation is realistic. No one knows better than local clinicians what the local needs are and no one is better placed to find the innovative solutions which will improve both the quality and productivity of local healthcare.

The structural foundation of clinical leadership in our organisation is the Professional Executive Committee, where the high level priorities of the CSP were developed and refined. The PEC clinicians include local GPs, a general dental practitioner and a community nurse consultant, as well as our Medical Director, Director of Nursing and Director of Public Health. PBC group representatives attend the PEC and have regular well attended meetings with the commissioning team, where they are invited to provide input into strategy and development.

To provide more detailed input to strategic planning, NHS Newham has 14 GP clinical leads specialising in disease areas or aspects of service, e.g. medicines management and urgent care. Community clinicians and members of other local professional committees provide regular important non-medical expertise. These clinicians provide input into specific programmes, local and sector network and partnership boards and clinical reference groups for the development of Map of Medicine pathways. This input extends to specific developmental areas of procurement and monitoring, such as the ‘urgent care centre’ and ‘whole systems demonstrator’ project. All these forums refine the detail of strategic planning.

H4NEL is the North East London acute services review which provides the strategic framework behind the Newham CSP. This process is lead by two acute consultant clinical leads and a clinical reference group (CRG) of acute and primary care medical directors and PEC chairs. Working under the CRG are clinical teams of multidisciplinary primary and secondary care clinicians. Acute landscape changes are predicated on transformational development of primary and community services. In recognition of this, the inner and outer NE London sectors have their own clinical partnership groups and associated working groups. These groups provide multidisciplinary clinical expertise from primary, community and acute backgrounds to develop the out-of-hospital provider landscape. More information is available in the sector ICSP.

To add a greater range of clinical input to our planning, NHS Newham and its sector partner PCTs hold large workshop events to inform specific stages of development. Examples of this include the launch workshops for Map of Medicine pathways and the H4NEL workshops.

NHS Newham recognises that, as we look to the future, our plans will only succeed with increased multidisciplinary clinical engagement, both quantitatively and qualitatively. Our focus in future will be on locality based Polysystems. Each of these will be led by a multidisciplinary steering group of local clinicians, community lay members, social care and other local authority representatives. We have recently appointed Clinical Directors for each of the Polysystems.
supported by a Polysystem Manager. To facilitate increased and broader clinical engagement and leadership, we will provide access to appropriate training and mentorship and support to clinicians who provide local clinical expertise to the commissioning cycle.

3.3 Reviewing our performance and our strategic goals

3.3.1 Reviewing last year’s goals

Last year we identified seven strategic health improvement goals and five strategic health services goals which, if achieved, would go a long way towards realising the vision.

Over the last year we have made significant progress on a number of these goals. As we go forward and refresh our commissioning strategy, we have reviewed whether these goals are still relevant, and how they relate to the needs identified in our Joint Strategic Needs Assessment. In the following section we review our progress against these goals and how we will take them forward.

3.3.2 Renewing our goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>What did we do over the past year?</th>
<th>Related WCC outcome performance</th>
<th>How will we take this forward?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce heart disease and stroke mortality by 40% across the borough, focusing on communities where mortality is highest</td>
<td>We commissioned the NHS health checks (vascular risk assessment), screening 19,500 people in the first 6 months of the service. We continued to be an active partner in North East London to support the Stroke CCI</td>
<td>5.5% reduction in CVD mortality</td>
<td>Remains a priority identified in the JSNA</td>
</tr>
<tr>
<td>Reduce infant mortality</td>
<td>We have developed maternity services through our pathway redesign process and begun to introduce community maternity centres and implement our maternity strategy</td>
<td>11.8% reduction in infant mortality</td>
<td>Remains a priority identified in the JSNA</td>
</tr>
<tr>
<td>Reduce adult smoking prevalence in White British population (both men and women), and in Bangladeshi men, by at least 20%</td>
<td>We commissioned a stop smoking service that has used local non-healthcare expertise and skills in parallel with a social marketing campaign to exceed our target. Last year we helped 2,171 people to quit smoking at a lower cost per patient than the London average</td>
<td>11% increase in smoking quit rate</td>
<td>Remains a priority as part of helping the people of Newham to lead healthy lifestyles</td>
</tr>
<tr>
<td>Halt the increase in child obesity</td>
<td>We supported the implementation of the national measurement programme, conducted a joint needs assessment with the London Borough of Newham, and jointly implemented free healthy school meals in all primary schools</td>
<td>No related WCC outcome in 2009/10</td>
<td>Remains a priority identified in the JSNA</td>
</tr>
<tr>
<td>Halt the increase in incidence of sexually</td>
<td>We introduced an HIV point of care testing pilot in GPs’ surgeries, the</td>
<td>No related WCC</td>
<td>Remains a priority identified</td>
</tr>
<tr>
<td>Transmitted infections (STIs)</td>
<td>Chlamydia LES and developed our ‘Shine’ young persons sexual health services</td>
<td>Outcome in 2009/10</td>
<td>In the JSNA</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Improve the early detection and treatment of diabetes</td>
<td>We launched our diabetes programme</td>
<td>Improvement of 24% in diabetes controlled blood sugar performance</td>
<td>Remains a priority identified in the JSNA</td>
</tr>
<tr>
<td>Improve cancer survival rates to better than London average</td>
<td>We supported the healthy cancer collaborative work, undertook advertising campaigns in breast, bowel, lung and mouth cancer and provided GPs with training to identify cancer</td>
<td>6.5% reduction in cancer mortality</td>
<td>Remains a priority identified in the JSNA</td>
</tr>
<tr>
<td>All primary care premises will be in Class 1 and 2 and have adequate space to provide an extended range of services</td>
<td>We launched our PCST programme, which included a review of the existing estate and has led to the production of an Estates plan that will be taken forward as part of our Polysystems development</td>
<td>No related WCC outcome in 2009/10</td>
<td>Will be addressed through Polysystem development</td>
</tr>
<tr>
<td>All general practices and our main providers will have a patient experience score above the national average</td>
<td>We undertook our PMS review and developed an access plan to improve the experience of primary care. All our contracts now include patient experience metrics to ensure our providers improve this area</td>
<td>We are developing a measure and trajectory for 2010/11</td>
<td>This remains a WCC outcome</td>
</tr>
<tr>
<td>Quality and Outcomes Framework (QOF) scores of all general practices will be in the top 50% nationally (and exclusion rates better than the national average)</td>
<td>We undertook our PMS review and have applied rigorous contract management to QOF score performance</td>
<td>No related WCC outcome in 2009/10</td>
<td>Remains a priority identified in the JSNA as part of improving the access to high quality primary care and community services</td>
</tr>
<tr>
<td>All patients attending A&amp;E/ urgent care centre (UCC)/ out of hours (OOH) are seen and either discharged or admitted within 4 hours and local performance will be within the second quartile in the country</td>
<td>We achieved this standard throughout the year after the introduction of rigorous contracting and performance management meetings with our local provider</td>
<td>No related WCC outcome in 2009/10</td>
<td>We will continue to develop urgent care as part of improving the access to high quality primary care and community services</td>
</tr>
<tr>
<td>By 2012, staff turnover and sickness absence will be reduced to 10%</td>
<td>Staff retention for both providers and commissioning remains higher than 2008/09</td>
<td>No related WCC outcome in 2009/10</td>
<td>This will be addressed in the organisational</td>
</tr>
</tbody>
</table>
and 4.5%, and our staff will feel valued and want their families to use Newham services

<table>
<thead>
<tr>
<th>Sickness rates across both commissioning and providers shows an improvement over 2008/09 performance</th>
<th>2009/10</th>
<th>development plan</th>
</tr>
</thead>
</table>

3.3.3 **Strategic goals in the Local Area Agreement**

We are committed to the strategic goals in the Local Area Agreement (LAA) and have ensured that our goals have been reflected in the LAA priorities and aligned targets.

Investing in children and young people
- Reduced obesity among primary school age children in Year 6

Better health and well being
- Reduced mortality rate from all circulatory diseases at ages under 75
- Improved user-reported measure of respect and dignity in their treatment
- Increased numbers of adults in contact with mental health services in employment
- Improved early access for women to maternity services

We have made progress on a number of these targets through joint work with our partners. Our LAA performance report highlights the significant progress, particularly smoking and implementing measures for childhood obesity.

3.3.4 **Our work towards achieving the goals in 2009/10**

In order to deliver the significant improvements necessary to become a World Class Commissioner, there needed to be improvements in the way initiatives were implemented. The WCC assurance process had confirmed a clear path for developments targeting primary and community services, key health improvement outcomes and organisational capability to deliver.

To ensure delivery of improved health outcomes, the commissioning arm of NHS Newham adopted best practice in programme management, through the setting up of a programme management office. Outcomes based, multidisciplinary programmes were implemented which brought about a new way of working across the organisation. This enabled programme teams, subject to finance and resource availability, to achieve the goals set out in the CSP.

Following a detailed prioritisation process, 11 programmes were identified as encompassing the CSP goals, outcomes and initiatives. The agreed list of programmes was:
- Diabetes
- Primary and community services transformation
- Healthy living
- Demand management
- WCC development
- Maternity services
- Cancer
- Cardiovascular disease
- Sexual health
- Mental health
- Integrated adult and older people’s services

A systematic set-up process was designed and implemented in February 2009. By the end of May 2009, three of the highest priority development programmes had been launched, with
others progressing through the set-up process. By the end of the calendar year, governance and reporting processes had been established encompassing all the above programmes.

The WCC development programme was concerned with the development of tools and processes to enable working at a higher level of competency – for example, use of the commissioning cycle and associated processes. For NHS Newham’s development, it was not sufficient to deliver evidence of improved competency, it was essential that level 3 competencies were embedded in our everyday working.

3.4. Our providers and the journey so far

While we now face these considerable health and service transformation challenges, we have achieved much already as shown in 3.5.2 above. Over the past seven years we have invested heavily in heath and healthcare interventions. This is reflected, for example, in our success with our local acute provider in achieving the four hour A&E and 18 week referral to treatment (RTT) targets, and our success in helping the people of Newham to quit smoking.

In 2010/11 we will have a budget of £546m, the majority of which is spent across approximately 306 providers operating under varying contractual arrangements, payment mechanisms and performance management regimes. Until now our focus has been on improving the quality of our existing providers and ensuring our patients are treated effectively and promptly.

Expenditure by sector (NHS Newham Annual Report 2008/09)

To deliver the degree of transformation we are seeking across health and social care in Newham are committed to work differently with our providers and ever more closely in partnership.

3.4.1. Primary and community care

The biggest challenge and greatest opportunity, as identified by last year’s World Class Commissioning assessment and the JSNA, is to transform primary and community care. If we can significantly improve the quality of primary and community care, bringing the average in Newham up to the highest standards currently being set by the best in Newham, we can alleviate many of the health impacts that have been identified through the JSNA. It is this transformation that could have the biggest impact on the delivering our vision.

We have committed ourselves to delivering high quality primary care services as the NHS’s contribution to the regeneration and convergence agenda for East London, led by the Olympics and its legacy. NHS Newham intends to bring the focus of these interrelated policy initiatives, and the outcome of the WCC Assessment, to deliver a co-ordinated Polysystem implementation programme.
The table below details the current state of primary care, what we have achieved so far, our challenges and how we aim to meet those challenges. The table also details how our priorities meet the QIPP agenda and the enablers we believe are needed for delivery.

3.4.3 Prevention

NHS Newham is committed to prevention and has invested in a number of prevention programmes to attempt to improve the health and well-being of our population.

This year we developed managed programmes for staying healthy and for diabetes. We have begun work through these programmes to make significant improvements in these areas. Our infection control and communicable disease resilience has been strengthened and is reflected in our recently produced Winter Planning, improvements in HIV testing and the significant improvements in the outcomes for TB patients. To improve access to HIV testing we commissioned rapid point of care HIV testing. This has enabled us to deliver improved access closer to home for those at risk of HIV. In turn this has reduced unnecessary acute attendances.

Last year we identified reduced smoking as one of our key World Class Commissioning outcomes. To start to respond to this we commissioned a stop smoking service that has used local non-healthcare expertise and skills in parallel with a social marketing campaign to exceed our target. Last year we helped 2,171 people to quit smoking at a lower cost per patient than the London average. Previous service users have become advocates working within the service. This has enabled us to work towards our smoking target and exceed the national rates to meet our vision on smoking. We need to continue to invest in smoking services to ensure the long term benefits of smoking cessation are realised.

We are working with a number of agencies, including the local authority, to ensure we are influencing the wider determinants of health and to developing community based venues where people can access multiple services that support their health and well-being, community care, housing advice, job and employment support.

We currently jointly commission a number of prevention services with LBN including the exercise on referral service and the Newham Striders walking group. Through our Joint Director of Public Health we are able to ensure that health and well-being are given prominence in local decision making. Many of the aims included in the Local Area Agreement are linked to our goals; we share the delivery of these goals with partner organisations. This is reflected in our LAA ‘better health and well-being’, ‘active and inclusive’, and ‘investing in children and young people’ priorities. As we take forward our increasing investment in prevention we need to further develop our provider landscape in this area.
### Primary care development

<table>
<thead>
<tr>
<th>Market sector</th>
<th>Current provision</th>
<th>Achievements to date</th>
<th>Challenges</th>
<th>Access priorities</th>
<th>QIPP priorities</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>27 general medical services contracts (GMS)</td>
<td>We commissioned two new APMS contracts under the national equitable access of primary care (EAPC) programme</td>
<td>Newham is recognised as an under-doctored PCT. Patient access survey results are worse than last year and the lowest in London</td>
<td>Ensure urgent care provision</td>
<td>Ensure that all practices improve QOF scores to move towards the top 50% nationally</td>
<td>Develop KPIs for primary care providers</td>
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<tr>
<td></td>
<td>33 personal medical services contracts (PMS)</td>
<td>The GP led health centre contract at Vicarage Lane is supporting increased access by providing capacity to register 6,000 patients in the first year as well as providing guaranteed drop-in services to unregistered patients or patients from other practices who require treatment</td>
<td>Some practices achieve low points on Quality Outcomes Framework (QOF)</td>
<td>Undertake competitive tendering process for the practices currently being managed by us</td>
<td>Ensure robust processes are in place to achieve exception rates better than the national average</td>
<td>Effectively measure primary care activity</td>
</tr>
<tr>
<td></td>
<td>2 alternative provider of medical services contracts (APMS)</td>
<td>Over 85% of NHS Newham GP practices currently provide extended hours We supported an innovative approach to extended hours, where greater accessibility was created from the extended hours initiative by large numbers of GP practices working together under a federation of practices.</td>
<td>Inadequate telephone systems exacerbate the access problem for patients</td>
<td>Undertake a Newham-wide patient survey of current extended hours provision to better understand whether these are meeting the needs of patients and to also understand why DNA rates are high</td>
<td>Work with all general practitioners to ensure we have robust succession planning that makes optimum use of the existing salaried GP workforce</td>
<td>Develop IT solutions to ensure effective record keeping</td>
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<tr>
<td></td>
<td>2 PCT medical services contracts (PCT-MS)</td>
<td>We have 61 salaried GPs employed within general practice, most of whom find it difficult to get a partnership.</td>
<td>Newham Health Debate – patients have told us that access is a key issue</td>
<td>Ensure the inclusion of additional quality metrics to the out of hours contract regarding the management of medicines, particularly controlled drugs. Ensure that there are appropriate recruitment</td>
<td>To ensure all revised PMS contracts are signed and in place by April 2010</td>
<td>Ensure maximum use of estates</td>
</tr>
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Commissioning Strategy Plan 2010 – 2015
<table>
<thead>
<tr>
<th>With one consortium now providing extended hours including week nights and on Saturday mornings to its 106,000 combined practice population</th>
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<tbody>
<tr>
<td>An Access Improvement Plan has now been prepared to address the continuing concerns expressed by the patients of Newham</td>
</tr>
<tr>
<td>We have taken steps to improve our monitoring of the entire out of hours service with bi-monthly contract meetings and monthly attendance at the Out of Hours Board, reviewing not just activity and response targets but also governance arrangements at the co-operative</td>
</tr>
<tr>
<td>Pathways already redesigned during 2009/10 include diabetes, diabetes in pregnancy, COPD, heart failure, termination of pregnancy and anti-coagulation. Pathways agreed and waiting to be publicised are smoking cessation, processes in place regarding fitness to practice, qualifications, references and inclusion on a performers list, and that professional registration and insurances are renewed on an annual basis</td>
</tr>
<tr>
<td>We have a high level of single handed practices</td>
</tr>
<tr>
<td>We have an ageing GP population (63 GPs aged 55 years and over) and we need to develop robust succession plans</td>
</tr>
<tr>
<td>We currently manage a small number of practices where the previous GP has retired or been removed.</td>
</tr>
<tr>
<td>Considerable extra resources have been given to PMS practices and we need to be able to demonstrate additional productivity from these resources</td>
</tr>
<tr>
<td>Decommission services</td>
</tr>
<tr>
<td>Embed the principle of Map of Medicine into the Polysystem transformation programme to support the delivery of integrated care pathways</td>
</tr>
<tr>
<td>Review our IT infrastructure to ascertain whether our primary care, secondary care and third party providers are able to communicate electronically across Polysystems and share patient data in a safe, controlled environment</td>
</tr>
<tr>
<td>All general practices and our main providers will have a patient experience score above the national average</td>
</tr>
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</table>
### Dental

**NHS Newham**

- Currently contract with 30 dental practices: 29 on a GDS contract and 1 on a PDS

We have agreed a revised dental access trajectory with NHSL which will increase demand for dental services to 57.5% within the next two years.

The urgent dental telephone service operates during evenings, weekends and bank holidays across all seven PCTs in NE London.

After extensive consultation we have designed a new dental service specification to meet the needs of urgent care dental patients. After completion of the consultation we will commission dental care capable of meeting our current unmet need.

Only 50% of Newham’s population currently access NHS dentistry. This is reflected in the oral health needs assessment, which also highlighted poor oral health in the under 5s and vulnerable adults as a priority.

Of particular concern is the ability of patients to access emergency dental services out of hours and a sector-wide review has taken place to address this concern. The review showed that the current service is not meeting the demand for appointments, and identified poor dental health in children.

**Procure a new dental contract.** We will seek to procure using the new ‘personal dental services plus’ contract incorporating the 15 new KPIs.

**Work closely with other PCTs in London to ensure all dental premises are fit for purpose.**

- Complete the consultation exercise for emergency dental care and, taking into account any modifications, undertake a procurement process for a provider to deliver the new service specification.

- Ensure that local services can meet next-day appointment requirements from the emergency dental service.

- Monitor the revised dental access trajectory to ensure we remain on course to achieve an increase in demand.

**Use competitive tendering to procure the agreed business cases from the oral health work streams.**
<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>There are currently 63 pharmacies in Newham, 47 of which are owned by single independent contractors and 16 owned by national companies. As part of the contractual framework pharmacists can provide essential services, advanced services (only if essential services are fully met) and enhanced services. We are currently undertaking a pharmaceutical needs assessment to focus on the services we need to commission, how best to commission them and how current pathways of care could be stretched to allow a pharmacist to actively participate in the patient journey. If we are to successfully deliver Polysystems and Healthcare for London we will need to ensure community pharmacy is fully integrated into the development of new integrated care pathways in a way that we have not seen before.</th>
<th>To ensure successful completion of the pharmaceutical needs assessment and ensure this is linked to the Joint Strategic Needs Assessment Implementation of a training/workforce development programme for contractors and their support staff to deliver alternative services in a primary care setting.</th>
<th>Ensure all contractors are delivery against existing contracts. Identify opportunities to use pharmacies as alternative providers. Develop robust KPIs for any new services commissioned from pharmacy contractors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optometry</td>
<td>NHS Newham currently commissions 41 optometry services through The new contract for opticians remains in its infancy and we continue to develop appropriate KPIs to enable us to key to the successful delivery of our vision for Polysystems are opticians who are fully integrated into the</td>
<td>To ensure successful completion of the optical needs assessment and</td>
<td>Ensure all contractors are delivery against</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Develop robust KPIs for any new services.</td>
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</tbody>
</table>

The work on redesigning the specification has a strong quality element as we seek to ensure that we commission a dental service to deliver safe and effective care for dental services.
the following contractual mix:
- 21 mandatory GOS
- 16 additional GOS
- 4 both mandatory and additional

properly monitor the services currently being provided

We are currently undertaking an ophthalmic needs assessment to focus on the services we need to commission, how best to commission them and how current pathways of care could be stretched to allow an optician to actively participate in the patient journey

Polysystem model and are members of each Polysystem steering group

ensure this is linked to the Joint Strategic Needs Assessment

Implementation of a training/workforce development programme for contractors and their support staff to deliver alternative services in a primary care setting

existing contracts

commissioned from ophthalmic contractors
This will be a challenging agenda, but unless we take robust action to improve the quality and productivity of current primary care providers we will jeopardise our chances of successfully delivering the required shift of activity from acute settings into primary and community settings.

3.4.2 Community services

3.4.2.1 Work with the local authority

The PCT provider is integrated with the London Borough of Newham and has a well established joint management structure. This provides opportunities for joint delivery of community based health and care services. In a number of cases these are fully integrated partnerships under s75 of the NHS Act 2006 (previously s31 of the Health Act 1999), including integrated learning disability services, integrated community equipment services, home rehabilitation services for intermediate care, and a lead commissioning agreement for local nursing homes. The rest of the community services are delivered through the joint management arrangement.

The integrated and joint working has provided some benefits in delivering services which are locally sensitive, but poses significant challenges in commissioning integrated solutions from such a wide range of discrete and uni-professional services.

Where there are integrated services, such as integrated community equipment services and home rehabilitation services, these have provided strong examples of multidisciplinary working which has resulted in the prevention of avoidable admissions, improved hospital discharges, and efficient assessment and timely delivery of equipment. Integrated learning disability services have led the way in the development of self-directed support and individual budgets for social care, which are beginning to transform people’s lives. Services delivered under joint management, such as occupational therapy, neuro-disability rehab, end of life care, case management and assistive technology have evidenced improved support at home and closer to home, leading to better outcomes for service users and more effective use of resources.

Previous CSP initiatives, such as the development of community matrons, have also delivered improved case management of some long term conditions and significant reductions in admissions for this cohort of service users.

The work on delivering a new ‘front office’ for council services is crucial in transforming ‘somewhere to live’ into somewhere people can feel part of and be served by a council that works for and with them in developing a sustainable community. Part of the solution to challenges of poor or late access is to ensure that we do as much as we can to design accessible services, with as much health and social care as possible being delivered from local community settings. We have made significant investments in extended hours, reviewing primary and community care contracts in response to the views of local people.

For the past year we have also been part of a national pilot for telehealth and telecare in Newham. This pilot has been successful in supporting people’s care at home. Extension of this pilot offers us opportunities to increase self care within the home environment and in turn reduce unnecessary primary and secondary care activity.

The organisational arrangements for Newham’s community services are fairly atypical of provider health services in London: only three services are of a significant...
size (representing 35% of the 2008/09 NHS budget); a further 16 have budgets between £1m and £3m (representing 47% of the 2008/09 NHS budget); and the remainder form a long tail of small specialist services.

For the last year we have been consulting on the future of our provider services. East London Foundation Trust (ELFT) has been identified as the preferred provider. We are working with ELFT to agree a new management arrangement for provider services to drive the transformation and productivity improvements set out in this plan. Provider services will continue to be integrated with the London Borough of Newham.

3.4.2.2 Access, quality and productivity

Transforming community services in Newham, especially in the areas of enablement and rehabilitation, LTC case management and end of life care, will provide the opportunity to commission integrated multidisciplinary health and social care services within each Polysystem. We will develop integrated care pathways that remove traditional barriers and improve access, quality of care and productivity.

The service review and redesign will involve community clinicians and professionals working closely with acute, primary and social care colleagues and with expert patients, service users, carers and key stakeholders such as housing, environment and leisure services. They will design services that:

- reduce unplanned admissions
- reduce length of stay for both planned and unplanned episodes
- ensure access to health and social care enablement and rehabilitation
- deliver proactive case management and personalised care including individual health and social care budgets
- facilitate support planning and brokerage
- maximise independence and access to universal services
- deliver support to finding employment and to social inclusion
- support carers to continue to care and have a life of their own with increased breaks, and
- enable more end of life care at home.

We will use better procurement and contractual arrangements with community service providers, including the independent and third sector, to drive service innovation and improvement, increased performance and greater efficiency. For several years we have agreed a service level agreement (SLA) with our community services provider. In 2009/10 this has been developed as a contract with the provider as an arms length organisation of NHS Newham. Future commissioning and procurement will be based on outcomes and efficiency, creating opportunities for a wider range of providers, including the third sector, to enter the local market. We are working with the sector to explore the introduction of standardised tariffs for community care packages (see the ICSP for more detail).

3.4.2.3 Third sector

NHS Newham also commissions a relatively small portfolio of services from the third sector. This portfolio of £650k includes independent advocacy, counselling and therapy particularly for ethnic minority communities, healthy living projects and support for service user and carer involvement in service strategy, planning, design and monitoring. For service users who are eligible for NHS-funded continuing healthcare, services totalling £3.7m are commissioned from the private and
independent sector for people with learning disability, and £7m for children, adults and older people with disabilities, long term conditions and end of life care needs.

We are developing our excellent relationships with the Third sector to enable them to play a greater part in shaping the delivery of healthcare to key patient groups. For example we are working closely with the British Heart Foundation (BHF) to develop a better understanding of heart health within the borough and to develop improved prevention programmes. Hearty Lives Newham, a BHF funded programme, includes three BHF nurse educators who are working with community and primary care services.

3.4.3. Acute care

Our strategic intent for acute care is to shift care closer to home, where possible, to ensure those requiring acute care are seen promptly and effectively in a sustainable acute model.

3.4.3.1 Secondary services

Newham University Hospital NHS Trust (NUHT) is a district general hospital towards the south of the borough. It provides us with 63% of our inpatient work. The Trust has a standalone elective care centre called the Gateway Surgical Centre, which undertakes non-complex elective surgery. The main Trust site has an intensive treatment unit (ITU) and high dependence unit (HDU), A&E and separate paediatric A&E. There is an inpatient paediatric ward and observation unit. The Trust has a separate stroke unit which had recently gone live as a ‘designated stroke unit’. The Trust has a genito-urinary medicine (GUM) clinic based at the Greenway Centre.

In addition to acute services on the main hospital site, some outpatient services are based at the Shrewsbury Health Centre (Forest Gate), the Centre in Manor Park and the Appleby Centre in Canning Town. These include the community diabetes service, the Respiratory Early Discharge Team (REDS and the TB service. In addition to these services Barts and The London NHS Trust provide community based outpatient services for rheumatology and dermatology.

An urgent care centre was established in the A&E department in April and this is successfully treating patients who would have previously been seen in the emergency department.

For 2008/09 the Trust was rated in its Annual Health Check as:
- Fair for use of resources
- Good for quality of services

The Trust has been deemed as ‘performance under review’ in the quarter 1 Performance Framework, with finance performance and user experience identified as needing improvement.

The Trust has however exceeded the targets for 18 weeks referral to treatment and four hour A&E target, and its improvement in MRSA and Clostridium difficile rates this year has been impressive. The Trust is currently in discussion with Whipps Cross University Hospital Trust and Homerton University Hospital Trust about possible merger and reconfiguration of services.
3.4.4 Tertiary services

Barts and The London (BLT) is one of Newham’s choice providers for all services and our second largest contract. It is also the main tertiary provider to Newham residents. Specialities include major trauma, renal, neonatal intensive care (level 3 medical), cancer and cardiac including the heart attack centre at the London Chest Hospital. BLT will be the site of both the hyper acute stroke unit and the hyper acute trauma centre. In addition BLT run dermatology and rheumatology services from the NUHT site.

While BLT has an excellent clinical and service reputation it has experienced major difficulties in monitoring and achieving waiting time targets, including the 13 and 26 week wait targets. The Trust has been rated as ‘Underperforming’ in The Quarter 1 Performance Framework.

For 2008/09 the Trust was rated in its Annual Health Check as:
- Fair for use of resources
- Weak for quality of services

3.4.3.1 Specialist services

Specialist services are commissioned on a sector and pan-London basis via a commissioning consortium. These services are generally subject to risk share agreements across the PCTs to smooth volatility arising from low volume high cost services. Clinical networks are well established across the North East London sector. These include primary care and provider clinicians and cover:

- Cancer
- Cardiac
- HIV and sexual health
- Renal
- IVF, maternity and neonatal
- TB

Local boards feed into these networks and vice versa where applicable. We have a local cancer board, diabetes working group, sexual health steering group, a cardiac board, a local maternity monitoring group and a TB group.

3.4.5 Mental Health Services

East London NHS Foundation Trust (ELFT) is the main provider of mental health services for the people of Newham. The main contract with ELFT covers the inpatient wards, psychiatric intensive care, home treatment, assertive outreach, early intervention and community mental health teams as well as other services such as a day hospital and rehabilitation. We commission specialist services from providers across London through NHS Tower Hamlets on behalf of NHS Newham.

Excellent links with the London Borough of Newham result in the best use of resources across the two partners. LBN currently contributes £9.4m to adult mental health services in addition to supporting housing and employment opportunities within the borough.

For 2008/09 the Trust was rated in its Annual Health Check as:
- Good for use of resources
- Good for quality of services
3.5 Financial plan

This section sets out a financial plan that aims to support the CSP and the achievement of the vision. This is achieved by ensuring that resources are deployed in support of the organisation’s strategy, and that this is done in the most effective and efficient manner. This section is consistent with the activity and finance tables submitted separately.

This section has been written in advance of the SLA negotiations with providers, these discussions will be reflected within the operating plan. However, certain assumptions have been made in accordance with guidelines issued by NHS London and local knowledge of the financial arrangements in place for a range of commissioned services. We will need to return to a number of the assumptions made when the operating plan is developed.

We face a significant financial challenge in the NHS, combined with potential increased demand for healthcare, resulting from the sharp predicted growth in population. Our commissioning strategy must be affordable in each of the potential financial scenarios we face. The table below identifies the financial challenge we face.

![Newham Downside graph](image)

3.5.1 Recent Performance

The PCT has met its financial duties every year since 2001. Consistent expenditure themes during these years have been:

- Increasing expenditure on acute activity generated in part by a growing population but also by local acute hospitals that have significantly improved the quality of their information recording.
- Significant cost increases on people requiring long-term continuing care.
- High cost increases on HIV services

The Accounts for 2008/09 show a surplus of £6.7m, which was slightly in excess of the control target set by NHS London.

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Resource Limit</td>
<td>476.5</td>
</tr>
<tr>
<td>Revenue Expenditure</td>
<td>469.8</td>
</tr>
<tr>
<td>Under spend against resource limit</td>
<td>£6.7</td>
</tr>
<tr>
<td>Control Target</td>
<td>£6.4</td>
</tr>
</tbody>
</table>

This under spend is brought forward into 2009-10. In addition the PCT received £3.3m lodging return from 2007/08. The PCT Board approved a budget for 2009-10, the main features of this were:

- A forecast surplus of £2.985m (0.5% of turnover)
- A £24.9m increase in baseline allocation (5.4%)
- £7.1m invested in new developments and enhancements to services
- £39.4m invested in new activity created by increased demand for services including the impact of the change to treatment of the Market Forces Factor (MFF).
- £10m of lodged surplus returned, including 2007/08 return of £3.3m.

Excluding this non-recurrent funding, the PCT had a budgeted underlying deficit of nearly £10.5m. During 2009/10 it has been necessary to extensively re-work the operating (budgetary) plan baseline to take account of:

- Over optimistic forecasts of the impact of demand management schemes.
- Continued growth in secondary care activity
- Re-alignment of reserves to match re-current commitments
- Rebasing of secondary care activity in the light of successful claims management.

Although the original forecasts for demand management were over-optimistic, the processes underpinning the work have been firmly embedded within the organisation. In 2009/10, the main focus of energy on establishing data cleansing processes and accelerating claims management, resulting in an equivalent value to the original programme being delivered. Going forward, demand management is part of the transforming services process and is included within those plans.

This work has been completed based on month 6 activity and expenditure forecast, and is reflected in the CSP and WCC Financial templates submission.

3.5.2 Assumptions in plan

The CSP financial model has been run under three scenarios; Base Case, Down side and Up side. This section addresses the Base case scenario. NHS London issued the PCT with a range of assumptions to be used in developing financial projections. The majority of these assumptions have been used but the PCT has reviewed these and made suitable adjustments for a small number to reflect both local circumstances as well as best estimate of some of these growth drivers.
The key assumptions made in the base case are:

<table>
<thead>
<tr>
<th>Base Case</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource allocation growth</td>
<td>5.20%</td>
<td>2.50%</td>
<td>2.50%</td>
<td>2.50%</td>
</tr>
<tr>
<td>Prescribing growth</td>
<td>4.00%</td>
<td>6.50%</td>
<td>6.50%</td>
<td>6.50%</td>
</tr>
<tr>
<td>GP list size allocation growth**</td>
<td>1.00%</td>
<td>1.50%</td>
<td>1.50%</td>
<td>1.50%</td>
</tr>
<tr>
<td>Tariff (excluding CQUINN)</td>
<td>1.00%</td>
<td>-0.50%</td>
<td>-0.50%</td>
<td>-0.50%</td>
</tr>
<tr>
<td>Pay awards (inc NI changes)</td>
<td>2.25%</td>
<td>2.00%</td>
<td>1.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Population growth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- GLA Low- population</td>
<td>No*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

GLA Low population growth has been used to project increases in demand for acute activity, with the exception of 2010/11 where a growth rate of 2.25% has been assumed. The rationale in using a lower growth rate in 2010/11 (than GLA low) is that considerable work has been carried this year to increase claims management activity, the benefits of which are likely to result in a reduction of recorded activity as a one off re-alignment in 2010/11. The model assumes a rebasing of the 2009/10 activity to inform the 2010/11 SLA plan. The PCT believes that the implementation of HRG 4 this year has led to an artificially high growth in recorded activity this year. Working with the sector acute commissioning unit, acute providers will be even more closely monitored to ensure growth in activity is restricted next year. The age profile of the growth in population (mainly young adults) suggests that activity should be proportionately lower than a liner increase in line with GLA low growth might suggest.

There is also a significant difference between the GP list size and the GLA population estimates. This suggests growth is already built into the PCT’s baseline spend. For Mental Health and Community Health services no growth has been applied, as they are managed as block contracts. As yet no efficiency savings have been applied to these services.

The plan includes the delivery of 1% surplus throughout the planning period and provides for 0.5% contingency in each year, both in line with NHS London planning assumptions.

In addition to the assumptions above, the PCT has reviewed all the expenditure growth assumptions, where local knowledge is required e.g. continuing care provision.

3.5.3 **Forecast Position**

**Base case Forecast** - The forecast income and expenditure for the five years is shown below.
The service transformation savings have fully costed and developed from the costing of the Polysystem(s) across Newham, in support of the Olympic polyclinic business case which is presently being appraised by NHS London. The total savings deliverable through transformation has been assessed at releasing £42.6m in total. The base case CSP assumes a linear release of savings throughout the CSP period and beyond. The assumed level of savings provides the opportunity for NHS Newham to invest significantly in JSNA identified priorities throughout the CSP period.

The table below provides an analysis of the reasons for the variations in costs:

<table>
<thead>
<tr>
<th>Analysis of expenditure</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net allocation</strong></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-536.2</td>
<td>-560.8</td>
<td>-574.7</td>
<td>-588.5</td>
<td>-602.1</td>
</tr>
<tr>
<td><strong>Cost savings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficiencies:</td>
<td>7.7</td>
<td>6.3</td>
<td>6.2</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>- Other</td>
<td>8.2</td>
<td>1.2</td>
<td>1.2</td>
<td>1.4</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Net expenditure</strong></td>
<td>-528.9</td>
<td>-551.9</td>
<td>-567.2</td>
<td>-580.9</td>
<td>-595.0</td>
</tr>
<tr>
<td><strong>Projected surplus/(deficit)</strong></td>
<td>3.0</td>
<td>5.4</td>
<td>5.5</td>
<td>5.7</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Over the next four years (2010/11 – 2013/14), an additional £117m (activity growth and new developments combined) will be invested by the PCT in developing services for its population. The key areas of additional investment include acute care and Healthy Living programmes. The investment that has been identified as acute spend will be substantially delivered in Primary and Community health care sectors through the transformation agenda. Given the ethnic and age profile of Newham, significant additional investments are planned in CHD, stroke, cancer, sexual health, learning disabilities and continuing care. The investment year on year is incremental:
### Implications for the investment and savings targets

Given the assumptions in the base scenario, the overall, financial position is driven by the following:

- Growth in Income 5.2% in 2010/11, 2.5% per annum thereafter
- Population/non-pop/incidence 2.25% in 2010/11, GLA growth thereafter
- Inflation 2.25% per annum in 2010/11, 2% in 2011/12, 1% thereafter
- A transformation savings requirement of £37m in total (£26m during the planning period)
- Investment in continuing care services

The delivery of financial balance throughout the planning period is dependent on delivery of significant savings through service transformation:

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings Required (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>£7.7m</td>
</tr>
<tr>
<td>2011/12</td>
<td>£6.3m</td>
</tr>
<tr>
<td>2012/13</td>
<td>£6.2m</td>
</tr>
<tr>
<td>2013/14</td>
<td>£6.2m</td>
</tr>
</tbody>
</table>

Further savings of £11m will arise in 2014/15 and beyond. Further work will be required to determine the pace of implementation to achieve the required savings target. Savings resulting from the transformation initiatives identified in this document are set out in the table below.

<table>
<thead>
<tr>
<th>Assumptions built into pan-London affordability modelling: aggressive scenario</th>
<th>Modeled</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>allocation</strong></td>
<td>● From 2011/12: base case 0% real growth; upside 0.75% real growth; downside −2.5% real growth until 2013/14, then 0.5%</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Underlying activity growth</strong></td>
<td>● Base case activity growth of 4% (GLA low plus adjusted residual growth); upper end growth of 5.5%; lower end growth of 1.4%</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Tariff changes in the acute sector</strong></td>
<td>● NHS London financial planning assumptions until 2010/11</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>● From 2011/12, net tariff uplift of −2.2% (Cost inflation 1.45% and tariff reduction of 3.65%. Both figures are compound average growth rates)</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Reduced unit cost of non-acute sector</strong></td>
<td>● Radical measures in staff utilisation (66%), appointment times (33% reduction in primary care) and prescribing costs (10%–15%)</td>
<td>Y *</td>
</tr>
<tr>
<td></td>
<td>● Mental health</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>● GPs are paid on a fee for service basis of £50 per consultation to cover extended hours and out of hours</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Shift of acute to lower cost setting</strong></td>
<td>● Higher outpatient (55%) and A&amp;E activity (60%) shifts to Polysystem (see note 2) [where?]</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>● Activity shifted and delivered at lower unit cost: enabled by Polysystem</td>
<td>Y 18,108,919</td>
</tr>
<tr>
<td><strong>Long term conditions and case management</strong></td>
<td>● Of non-elective medicine activity, 10% of complex, 30% of non-complex and 40% of LTC cases prevented</td>
<td>Y 7,389,665</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td>● 10% of non-elective medicine costs prevented through early detection and counselling in Polysystem</td>
<td>No **</td>
</tr>
<tr>
<td><strong>Decommissioning</strong></td>
<td>● 7% of all elective procedures</td>
<td>Y 898,276</td>
</tr>
<tr>
<td></td>
<td>● 30% of outpatient, 10% of A&amp;E</td>
<td>Y 5,391,090</td>
</tr>
<tr>
<td></td>
<td>● 10%–15% of diagnostics</td>
<td>Y 1,054,240</td>
</tr>
<tr>
<td></td>
<td>● service constraints</td>
<td>Y 696,000</td>
</tr>
<tr>
<td></td>
<td>● Maternity</td>
<td>Y 3,500,000</td>
</tr>
<tr>
<td><strong>Capital and transition costs</strong></td>
<td>● Space efficiency increases to 80% (leading to total space of 1,516m²)</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>● Set up costs transition from ~ £1.0m to ~0.5m per Polysystem</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>● Transition costs reduce to 20% efficiency loss for 6 months plus 15% residual acute activity for 6 months for all activity shifting to hub/Polysystem</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Total savings</strong></td>
<td></td>
<td>37,039,190</td>
</tr>
</tbody>
</table>

*The PCT is committed to working within the sector to develop efficiency measures for Community Health Services (linked to tariff development) and Mental Health Services. For now, these are assumed to be managed through Block Contracts.*
The PCT is currently modelling the impact of the Preventive part of the Transformation agenda which should result in reductions to Non-Elective activity.

The phasing for these savings differs in the three financial scenarios:

<table>
<thead>
<tr>
<th></th>
<th>Base case</th>
<th>Upside case</th>
<th>Worse case</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>21%</td>
<td>21%</td>
<td>21%</td>
</tr>
<tr>
<td>2011/12</td>
<td>38%</td>
<td>38%</td>
<td>71%</td>
</tr>
<tr>
<td>2012/13</td>
<td>54%</td>
<td>54%</td>
<td>96%</td>
</tr>
<tr>
<td>2013/14</td>
<td>71%</td>
<td>71%</td>
<td>97%</td>
</tr>
<tr>
<td>2014/15</td>
<td>87%</td>
<td>87%</td>
<td>99%</td>
</tr>
<tr>
<td>2015/16</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The delivery of the Transformation savings is crucial to the PCT delivering financial balance during the CSP planning period. The risks associated with this are significant. Detailed work, led by the relevant directors, is underway. It is focussing on the following areas:

- Delivering acute activity within a Primary Care setting
- Management of Long Term Conditions
- Decommissioning of activity (primarily through the SACU, more details are available on the ICSP)
- Delivering efficiencies in Community Health and Mental Health with partner organisations
- Review of Maternity finances. Newham has particular needs, but is a significant outlier in funding levels, when benchmarked against other similar localities.

3.5.5 Other Scenarios
As well as the baseline assumptions above, the PCT has modelled 2 other scenarios using different assumptions over the level of future income:

- Scenario 1 (Baseline)  5.2% allocation growth in year 1 and 2.5% thereafter
- Scenario 2 (Downside)  5.2% allocation growth in year 1 and 0% thereafter
- Scenario 3 (Upside)  5.2% allocation growth in year 1 and 3.25% thereafter

Scenario 2
The results of the Downside being modelled are:

<table>
<thead>
<tr>
<th>Downside Case</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net allocation</td>
<td>531.0</td>
<td>557.3</td>
<td>559.3</td>
<td>559.3</td>
<td>559.3</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-536.2</td>
<td>-560.8</td>
<td>-573.8</td>
<td>-565.5</td>
<td>-573.8</td>
</tr>
<tr>
<td>Cost savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Efficiency savings service transformation</td>
<td>7.7</td>
<td>18.6</td>
<td>9.3</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>- Other CIP's</td>
<td>8.2</td>
<td>1.1</td>
<td>1.3</td>
<td>2.3</td>
<td>19.4</td>
</tr>
<tr>
<td>Net expenditure</td>
<td>-528.0</td>
<td>-552.0</td>
<td>-553.9</td>
<td>-553.9</td>
<td>-553.9</td>
</tr>
<tr>
<td>Projected surplus/(deficit)</td>
<td>3.0</td>
<td>5.3</td>
<td>5.4</td>
<td>5.4</td>
<td>5.4</td>
</tr>
</tbody>
</table>

The Key risks to delivering the Downside scenario, over and above the Base Case are:
• The pace at which service transformation needs to be delivered, particularly in 2011/12 and 2012/13 which is significantly greater than is required under the Base case scenario.
• There is a shortfall on the transformation savings, which under the present model produces a required CIP in 2013/14 of £19.4m. This will be delivered, generating efficiencies through the Estate, Management cost savings, and further efficiencies in acute, community and mental health services. Specific streams of work to deliver the optimum CIP’s are being established to deliver the required value. The PCT will seek to bring forward and accelerate the CIP programme, reducing pressure on the transformation programme in the earlier years.
• It should be noted that the financial deficit of £19.4m, plugged by a residual CIP programme, in entirely generated by the scale of the predicted population growth (GLA Low) in Newham creating financial pressures, particularly in the acute, community and mental health sectors. The funding scenarios do not make allowance for any differential growth in population.

Scenario 3
The results of the Upside scenario being modelled are:

<table>
<thead>
<tr>
<th>Upside Case</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net allocation</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Net allocation</td>
<td>531.0</td>
<td>557.3</td>
<td>576.7</td>
<td>594.9</td>
<td>613.7</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-536.2</td>
<td>-560.8</td>
<td>-578.7</td>
<td>-596.8</td>
<td>-614.8</td>
</tr>
<tr>
<td>Cost savings</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Efficiency savings service transformation</td>
<td>7.7</td>
<td>6.3</td>
<td>6.2</td>
<td>6.2</td>
<td>6.2</td>
</tr>
<tr>
<td>- Other CIP’s</td>
<td>8.2</td>
<td>1.1</td>
<td>1.3</td>
<td>1.4</td>
<td>0.9</td>
</tr>
<tr>
<td>Net expenditure</td>
<td>-528.0</td>
<td>-552.0</td>
<td>-571.1</td>
<td>-589.2</td>
<td>-607.7</td>
</tr>
<tr>
<td>Projected surplus/(deficit)</td>
<td>3.0</td>
<td>5.3</td>
<td>5.6</td>
<td>5.7</td>
<td>6.0</td>
</tr>
</tbody>
</table>

The upside financial scenario provides the opportunity to deliver significant investments which have been initially set aside to support the healthy living and other public health initiatives, over and above those identified in the base case scenario.
4.1 Transforming the landscape

4.1.1 Polysystems – the vision

NHS Newham is committed to the development of Polysystems as the essential means by which we will deliver the organisation’s vision of improved quality of care for all and deliver financially sustainable local health and social care services.

Newham has been divided into four Polysystems to maximise the opportunity for alignment with local authority services, and that matching present and future provider capacity with projected population growth. The Polysystem model is configured into four areas: North west, North east, Central and South.

The selection of location for Polysystem hubs was determined via a series of assessments of current and future conditions within the Borough. This includes:

- Patterns of future population growth
- Current capacity within primary and community care;
- Current condition of facilities;
- Impact of changes on patient travel times (Jacobs assessment 2008);
- Discussion with Health Scrutiny Commission;
- Cross border working with Tower Hamlets and other boroughs.

The current plans show four hubs located in the four Polysystems, with the hub in the Central Polysystem being on the site of Newham University Hospitals NHS Trust and therefore having an Urgent Care Centre. This includes one hub that is not yet built, St Lukes, which as part of a regeneration project is expected to attract s106 and London
Thames Gateway Development Corporation funding. Some reconfiguration of the site at NUHT is required and detailed plans have already been produced for this.

As we know we have some very high quality primary care in Newham, but we also have some that is not so good. Forty five percent of our 63 practices were in buildings (56) that have been classified as either category 3 or 4 (fortunately far fewer than 45% of patients are registered with these practices). Our development of hubs and spokes is allowing us to improve the quality of this estate. The Vicarage Lane development was built for example, to allow us to relocate GPs from unacceptable practice’s elsewhere, as well as increasing the availability and access to primary care.

This is why we will explore with the London Borough of Newham the possibility of utilising space on a redeveloped East Ham Town Hall site where health services could be co located with local services, a library and leisure centre.

It is also why Vicarage Lane will continue to provide high quality care after the Olympic Polyclinic becomes operational (as well as the additional c50,000 people who will be moving into the Olympic Park post the Games), and takes over as the hub for the North West Polysystem.

We will monitor the services provided at Vicarage Lane closely to see if any need to be transferred to the new Olympic Polyclinic hub during 2012. We currently planning to move unscheduled care to the Olympic Polyclinic, however early indications are that Vicarage Lane is meeting considerable unmet need as significant numbers of patients visiting unscheduled primary care are unregistered (220 of the 330 attendances each week). We will therefore monitor the situation and make a decision in 2012 informed by patient flows and volumes.

These plans will continue to be updated and reviewed in light of the consultation on Healthcare for London and the emerging future of NUHT, Homerton and Whipps Cross. These discussions will be linked to the development of Polysystems as commissioners of care and future patterns of providers for disaggregated services. We are working with the emerging sector wide Polysystem Strategy Group to develop the strategic outline case for Polysystems development. More details can be found in the ICSP.
For the North West and South Polysystems, a growth in population will be seen over time to allow for the redevelopment of these areas as part of regeneration plans and the Olympics. Population modelling suggests that as housing provision improves in the North West and South of Newham, overcrowding will be reduced in the North East and Central Polysystems.

4.1.2  
**A new system of health care delivery**

There is currently a move in the NHS towards developing formal clinical networks as a way to cut across traditional boundaries between professional groups and individual organisations. Formal networks have the potential to drive significant improvements in quality.

The Polysystems will bring together within a geographical area the health and social care professionals who know best the patients' and the general health needs of that area. The alignment of localities and services to Polysystems is the start of the journey of moving services out of hospitals to be provided closer to home, as well as redesigning community services to be provided in more innovative ways that support the delivery of primary and secondary care within the Polysystem setting.
4.1.3 Services within our Polysystems

The table below identifies the services offered within different settings within the Polysystems. Not every hub or large spoke will contain every element identified below but services will be configured to ensure patients have access as required. Where there are gaps in service, including diagnostics, which cannot be met via configuration then this will be met through commissioning by the Polysystem.

<table>
<thead>
<tr>
<th>Poly setting</th>
<th>Offering</th>
<th>Workforce</th>
<th>Estates</th>
</tr>
</thead>
</table>
| Community step down beds | Step down beds  
Rehabilitation beds  
Respite care  
Day care  
Physiotherapy  
Mental health services | Nurses  
AHPs  
HCAs  
Therapists | 6000sqm  
70 beds  
Therapy rooms  
Day care facilities |
| Location              | East Ham Care Centre (Borough-wide)                                      |                    |                       |
| Hub                   | 8-to-8 unscheduled care (minor illness and injury)  
Routine GP led care (GMS, PMS, APMS)  
Minor surgery and procedures  
Outpatient care  
Long term conditions teams  
Psychological therapies  
Paediatrics  
Integrated social care services  
Prevention services  
Dentistry | GPs  
GPSI  
Consultants  
Specialist nurses  
Nurses  
Nurse practitioners  
Pharmacists  
AHPs  
Dentists  
HCAs  
Integrated health and social care MDTs | 2000-4000sqm  
Consulting rooms  
Testing facilities  
Treatment rooms  
Paediatric areas  
Staff areas  
Gym  
Community use areas |
<table>
<thead>
<tr>
<th>Poly setting</th>
<th>Offering</th>
<th>Workforce</th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large spoke</td>
<td>Routine GP led care (GMS, PMS, APMS), Minor surgery and procedures, Outpatient care</td>
<td>GPs, GPSI, Consultants, Nurses, Nurse practitioners, AHPs, Pharmacists</td>
<td>500-2000sqm, Consulting rooms, Testing facilities, Treatment rooms, Staff areas</td>
</tr>
<tr>
<td>Location</td>
<td>North-West: Vicarage Lane Health Centre to 2013 (Phlebotomy; Audiology), Olympic Polyclinic after 2013 (X-ray; Ultrasound; ECG/Echo; Phlebotomy; POC Testing)</td>
<td>West Ham Lane (Paediatric audiology), Woodgrange Medical Practice, Shrewsbury Road Health Centre (X-ray; Phlebotomy; Dexam Scans)</td>
<td>Lord Lister Health Centre (Retinal Screening; Breath Tests; Ultrasound), Wordsworth Health Centre, East Ham Town Hall (POC Testing)</td>
</tr>
<tr>
<td></td>
<td>North-East: The Centre, Manor Park (X-ray; Phlebotomy; Retinal Screening; Ultrasound; ECG/Echo)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Central: NUHT (X-ray; Ultrasound; ECG/Echo; Phlebotomy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>South: Canning Town Square from 2012 (X-ray; Ultrasound; ECG/Echo; Phlebotomy; POC Testing)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poly setting</th>
<th>Offering</th>
<th>Workforce</th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small spoke</td>
<td>Routine GP led care (GMS, PMS, APMS)</td>
<td>GPs, Nurses</td>
<td>300-500sqm, Consulting rooms</td>
</tr>
<tr>
<td>Location</td>
<td>North-West: 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>North-East: 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Central: 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>South: 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poly setting</th>
<th>Offering</th>
<th>Workforce</th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community /home care</td>
<td>Postnatal care, District nursing, Tele-care and tele-health, Telephone and multimedia care</td>
<td>Health visitors, District nurses, Therapists</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### North West Polysystem

**Clinical Director:** Dr Subir Sen  
**Polysystems manager:** Charles O’Hanlon

#### Key facts & challenges for the Polysystem
- 24% of the population under 20
- 20% of working age claiming benefits (UK average 15%)
- Rates of child obesity range from 22-27%
- Spends £63.6m on Prescribing and Acute care per year
- 20,000 A&E attendances
- 72,000 Outpatient attendances
- 45,500 Inpatient spells
- Large population growth post Olympics

#### Outpatient activity to decommision/shut into Polysystem by 2015 (cumulative)

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub</td>
<td>21,737</td>
<td>38,166</td>
<td>46,904</td>
<td>51,119</td>
</tr>
<tr>
<td>Large spokes</td>
<td>21,737</td>
<td>38,166</td>
<td>46,904</td>
<td>51,119</td>
</tr>
<tr>
<td>Small spokes</td>
<td>21,737</td>
<td>38,166</td>
<td>46,904</td>
<td>51,119</td>
</tr>
<tr>
<td>Population in 2010</td>
<td>67,434</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population by 2015</td>
<td>95,891</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Estates

Work to date suggests that significant utilisation gains can be made in the Polysystem with existing buildings utilisation between 30 and 50%. X-rays are not currently available in the Polysystem but are available at 3 other sites within the Borough. There is ultrasound at Lord Lister and a phlebotomy service at Vicarage Lane. There are 8 dental practices in the Polysystem.

**IT**

Emis web is currently deployed across all primary care providers and RiO has been deployed amongst health and social care teams.
## North East Polysystem

**Clinical Director:** Dr Bupinder Kohli  
**Polysystems manager:** David Peck

<table>
<thead>
<tr>
<th>Configuration</th>
<th>North East</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub</td>
<td>The Centre Manor Park is an existing health centre which comprises of a mixture of community provider and primary care services. The intention is to reconfigure the use of the building to ensure it will function as a Hub from 2011 onwards.</td>
</tr>
<tr>
<td>Large spokes</td>
<td>3</td>
</tr>
<tr>
<td>Small spokes</td>
<td>10</td>
</tr>
<tr>
<td>Buildings to be</td>
<td>4</td>
</tr>
<tr>
<td>decommissioned by</td>
<td>2015</td>
</tr>
<tr>
<td>Population in 2010</td>
<td>64,491</td>
</tr>
<tr>
<td>Population by 2015</td>
<td>63,616</td>
</tr>
</tbody>
</table>
| Key facts & challenges for the Polysystem | • Large proportion of young people (28% below 20 years old)  
• 27% of all births in Newham took place in North East Polysystem  
• 10-12% of babies with low birth weight  
• Highest rate of CHD prevalence  
• The majority of the population are Asian (41-70%)  
• Lowest rates of Teenage pregnancy in Newham  
• High prevalence of diabetes  
• Spends £98.5m on Prescribing and Acute care per year  
• 26,500 A&E attendances  
• 71,600 Inpatient attendances  
• Currently 105,235 Outpatient attendances |
| Outpatient activity to | 15,074  26,070  32,058  34,846  34,937 |
| decommission/shift into Polysystem by 2015 (cumulative) | 6750 |
| Unplanned care to be provided in the Polysystem by 2015 | |

**Estates**  
The Polysystem Hub is already in existence with a number of large spokes. Reconfiguration will be required to improve utilisation at all sites to deliver transfer of services from acute sites. Two of these locations have x-ray with Phlebotomy, Retinal Screening, Doxa scanning, ECG/Echo and Ultrasound also available.

**IT**  
Emis web is currently deployed across all primary care providers and RiO has been deployed amongst health and social care teams.

---

*Hub at Centre Manor Park*
### Central Polysystem

**Clinical Director:** To be appointed  
**Polysystems manager:** Sajid Shah

#### Configuration

<table>
<thead>
<tr>
<th>Configuration</th>
<th>Central</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub</td>
<td>The Central Polysystem hub will be based on the existing NUHT site. The site will be subject to redevelopment with the addition of the new Urgent Care Centre to be operational by 2012.</td>
</tr>
<tr>
<td>Large spokes</td>
<td>3</td>
</tr>
<tr>
<td>Small spokes</td>
<td>10</td>
</tr>
<tr>
<td>Buildings to be decommissioned by 2015</td>
<td>1</td>
</tr>
</tbody>
</table>

#### Population

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>76,819</td>
</tr>
<tr>
<td>2015</td>
<td>77,626</td>
</tr>
</tbody>
</table>

#### Key facts & challenges for the Polysystem

- High birth rate
- Most diverse ethnicity within Newham
- Spends £74.8m on Prescribing and Acute care per year
- 25,000 A&E attendances
- 97,000 Outpatient attendances
- 65,000 Inpatient spells

#### Outpatient activity to decommission/shift into Polysystem by 2015 (cumulative)

<table>
<thead>
<tr>
<th>Activity</th>
<th>2010</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19,797</td>
<td>34,544</td>
<td>42,416</td>
<td>46,241</td>
<td>46,341</td>
</tr>
</tbody>
</table>

#### Unplanned care to be provided in the Polysystem by 2015

<table>
<thead>
<tr>
<th>Activity</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6,500</td>
</tr>
</tbody>
</table>

#### Estates

The gains to be made through utilisation improvements in the Central Polysystem estate are limited. A hub at NUHT will be delivered via the expansion of the Urgent Care Centre and through internal re-configuration. The PCT also intends to take advantage of opportunities for joint working with Council Front Office services and local leisure service provision through the development of a spoke at East Ham Town Hall.

#### IT

Emis web is currently deployed across all primary care providers and RiO has been deployed amongst health and social care teams.
**South Polysystem**

<table>
<thead>
<tr>
<th>Configuration</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub</td>
<td>The exact size and specification of the Hub within the South is currently under discussion and is likely to be part of the regeneration scheme at Canning Town Square (from 2012). This is close to the new L6N &quot;front office&quot; and we will ensure that users of both services will enjoy a seamless transition between both council and PCT commissioned services.</td>
</tr>
<tr>
<td>Large spokes</td>
<td>3</td>
</tr>
<tr>
<td>Small spokes</td>
<td>5</td>
</tr>
<tr>
<td>Buildings to be decommissioned by 2015</td>
<td>1</td>
</tr>
<tr>
<td>Population in 2010</td>
<td>70,975</td>
</tr>
<tr>
<td>Population by 2015</td>
<td>87,857</td>
</tr>
</tbody>
</table>
| Key facts & challenges for the Polysystem | • Highest rates of teenage pregnancy  
• 27% of the population under 20  
• 51-61% of population within wards White  
• Highest levels of deprivation  
• 20-26% of working age claiming benefits (UK average 15%) between wards  
• Rates of child obesity range from 22.7-31.86% between wards  
• Spends £66.6m on Prescribing and Acute care per year  
• 25,000 A&E attendances  
• 56,000 Outpatient attendances  
• 47,000 Inpatient spells |
| Outpatient activity to decommission/shift into Polysystem by 2015 | (cumulative)     | 13,652 | 23,740 | 29,259 | 31,776 | 31,840 |
| Unplanned care to be provided in the Polysystem by 2015 | 6,500 |

**Clinical Director:** Dr Jim Laurie  
**Polysystem manager:** Jonathan Shaw (interim)

**Estates**  
In advance of the development of the hub in Canning Town there is significant opportunity for the provision of additional services from current PCT buildings. There is no x-ray within the Polysystem currently but Phlebotomy, ECG/Echo and Ultrasound are available.

**IT**  
Emis web is currently deployed across all primary care providers and RiO has been deployed amongst health and social care teams.
4.1.4  **Delivering urgent and unscheduled care in Polysystems**

Central to providing care closer to home is the need to provide access to high quality urgent care that is understandable and accessible to the public. To achieve this we will need to integrate urgent care with primary care and ensure an 8 to 8 GP led unscheduled care offering within each of the Polysystem hubs to support the 24/7 urgent care centre at the front end of A&E at Newham University Hospital Trust.

Our urgent care centre is already operational and we are seeing the benefits. A&E attendances have been reduced between 2008/09 and 2009/10 by 8% despite an overall increase in the number of patients attending. This is a significant achievement but we plan to go further.

We are in the process of procuring a new urgent care centre for Newham on the same site. Our new service specification for urgent care will deliver 24 hour care, a GP practice on site and a changed skill mix to increase the number of doctors providing care. We plan to have this operational (assuming capital investment is required to enhance the facilities) by January 2012.

This, in conjunction with 8am-8pm unscheduled care provided in each of our Polysystems (currently operational at Vicarage Lane and planned for the other hubs) will enable us to deliver the reduction in A&E attendances and admissions that we have planned.

Our achievements to date mean that we are already delivering urgent care for £55 per episode and unscheduled care in the Polysystem hub for £44 per episode. That means that our average cost of urgent and unscheduled care given our volumes is £67 per episode, the benchmark set by NHS London. As we bring more unscheduled care on stream and increase the throughput of the urgent care centre, this average cost will drop further, making Newham’s urgent and unscheduled care significantly more cost effective than the NHS London benchmark.

The chart below shows how we will commission urgent and unscheduled care in Newham.

4.1.5  **Quality in the Polysystems**

Moving care out of hospitals is not itself going to deliver either reduced cost or improved quality: indeed, it can, if done badly, cause both to deteriorate. Service reconfiguration will be delivered
through the Department of Health QIPP methodology – Quality, Innovation, Productivity and Prevention.

Quality is made up of clinical quality, patient experience, patient safety and access. NHS Innovations points out the two essentials to consider when designing systems to fulfil these objectives: reducing the steps in a care pathway (as near to one-stop shop as possible) and improving the ‘hand-off’ co-ordination when patients do have to move between and within organisations.

4.1.6 Clinical engagement

We are bringing together local clinicians in Polysystem networks and enable them to work together to improve the way they deliver care to patients. The development of networks is fundamental to the delivery of an increased range of care packages and in terms of new ways of delivering care closer to home. New contractual and governance arrangements will enable the extension of the role of networks to employ staff and deliver key services across a Polysystem.

Polysystems will harness local clinical, professional and patient expertise to define and prioritise changes in commissioned care pathways. The powerhouse of the Polysystem will be its steering group made up of local clinicians, social care and local authority representatives. For maximum success, they will have both a commissioning and providing aspect. For the first time, we will achieve a truly locally led and driven health and well-being system, with the authority and incentives to promote the health and well-being of local people. To enable clinical commissioning to flourish Practice Based Commissioning will be aligned to Polysystems.

4.1.7 Governance

Each Polysystem is led by a Clinical Commissioning Steering Group and a Clinical Director. The Clinical Commissioning Steering Groups will produce an annual operating plan that details how it will achieve the required productivity and activity shifts within the defined timescales. The PCT will develop a robust performance framework, or scorecard, for each Polysystem that incorporates a broad range of patient experience, quality of care and productivity metrics, which includes core requirements for all Polysystems to deliver upon (e.g. a minimum number of appointments per 1000 patients for GP practices), as well as Polysystem specific cost, productivity and activity expectations.

The Steering Groups consist of 12 members:

- 5 GPs
- 2 community care clinicians
- 1 secondary care clinician
- 3 (mix of) pharmacist, dentist and optician
- 1 London Borough of Newham representative

Each Steering Group will ensure that services are delivered in settings which are accessible, appropriate and convenient to patients. This will require an innovative approach to using our estate, which will include maximising the use of rooms and working with some of our providers to relocate office bases from some buildings, so that the space can be reconfigured to provide a clinical function. It will also involve working closely with the local authority to align Polysystems with local customer access, to ensure that we all make the best use of settings of care with shared contact and access points. This will require an innovative approach to using our current infrastructure of IT, estates and workforce.
Each Polysystem has a Clinical Director who will facilitate and maximise clinical leadership and engagement within the Polysystem to deliver its objectives. A specific remit of this post will be succession planning so that by the end of their contract local clinicians are sufficiently skilled and experienced to be leaders for their Polysystem. The Clinical Director will lead on a portfolio of outpatient services to deliver 60% of care closer to home, and will ensure there are transparent processes in place for all new pathways of care.

Primary care clinicians will be supported by Clinical Directors to demand manage pathways by using clear protocols for referral for first outpatient appointments.

Working in close partnership with the Polysystem Clinical Director is a full time senior manager, employed by NHS Newham, whose objective will be to use the expertise and capacity within the Polysystem to drive change forward and deliver the challenges posed above.

By working closely with local clinicians we have established a clinical commissioning governance framework to ensure that we are able to introduce clinical commissioning that will drive the safe, effective and locally appropriate services closer to people’s homes.

The following shows the governance framework for our Polysystems.

To ensure that the vision is delivered we need to align core elements of the PCT with Polysystems, which includes governance structures, staff, resources and change programmes to ensure that the skills, expertise and effort of NHS Newham are focussed in realising the benefits of Polysystems. That aim is set out in the following diagram.
This aspiration will require NHS Newham to adapt and be shaped around the delivery vehicle which is Polysystems. The Clinical Commissioning Steering Groups will drive the commissioning intentions of each locality, performance managed by NHS Newham to deliver the service changes and improvements in health outcomes that are identified through the Joint Strategic Needs Assessment process.

The Clinical Commissioning Steering Boards will not hold and manage contracts with providers. That role would sit elsewhere, depending on the provider and the commissioning arrangements in place. For example the SACU, at sector level, will drive the changes required in our secondary care and the Mental Health Commissioning Unit will do the same for mental health. The Integrated Commissioning Transformation Board, jointly chaired by NHS Newham and LBN, will drive the changes required in our community services provision. These commissioning decisions however will be an amalgamation of the locally, clinically determined intentions from the respective Clinical Commissioning Steering Groups.

In effect therefore, the PCT would be commissioning the Clinical Commissioning Steering Groups to deliver the service changes and health outcomes that are determined by the population of Newham. We will achieve a clinically led, population focused responsive health care system.

4.1.7 Implementing Polysystems

Our approach to the development of Polysystems has been to spend a considerable part of the first year communicating and sharing locality profiles with our stakeholders and clinicians. The locality health profiles have been important for two reasons: firstly they have provided vital evidence about the current and future health needs of our local population, and secondly it has helped to identify the gaps in our current provision. Our approach to developing clinically led Polysystems has been to involve and include all independent contractors (GPs, Pharmacists, Dentists and Opticians).

The alignment of localities and services to Polysystems is the start of the journey of moving services out of hospitals to be provided closer to home, as well as redesigning community services to be provided in more innovative and integrated ways that support the delivery of primary and secondary care within the Polysystem setting.
We have reviewed 21 outpatients’ services which will be delivered outside of an acute environment from 2011. We are focusing on decommissioning in 2010. Each Polysystem Clinical Director has taken the lead on several pathways and they are developing protocols to ensure follow ups are reduced and first attendances are referred to appropriately. In the first year of our transformation, 2010, we will decommission 43,000 follow up appointments to meet the top quartile ratio (details of the specialities we are decommissioning along with the volumes being decommissioned are included in the Operating Plan).

From 2011 we will begin the transfer of outpatient services into a lower cost community setting. In line with Health for NEL recommendations the services that will shift are predominantly “Level 1 Specialties” identified by the Clinical Working Group as able to transfer to Primary Care at 50% first and 60% follow up. The table below shows the phasing of that activity over four years. Where opportunity arises we will begin this shift in 2010.

The rational for focusing on decommissioning and improving primary care in the first phase and shifting care in the second is based on the following factors:

- Availability/reconfiguration of space to deliver services within existing buildings
- Successful negotiation of local care packages with clinical commissioners
- New hub development (where planned)
- Information technology/specialist equipment i.e. diagnostics
- Availability of providers/workforce or delivery of training to skill up existing staff

<table>
<thead>
<tr>
<th>Specialty</th>
<th>O/P 1st shifted to Polysystem</th>
<th>O/P F/up shifted to Polysystem</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
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<tr>
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<td>General Medicine</td>
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<td>Orthodontics</td>
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<tr>
<td>Paediatric Dentistry</td>
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<td>1148</td>
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<td>187</td>
<td>50</td>
<td>100</td>
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</tr>
</tbody>
</table>

The following changes during 2010 will underpin this transformation:
We will implement Integrated Care Pathways that embody best practice of treatment, case management and onward referrals starting with those that cover the long term conditions with highest local prevalence.

Information will be provided to Polysystems which details and benchmarks quality, activity and price so that the changes discussed above can be planned and implemented.

EMIS web will be rolled out and will include links to RIO and the NUHT EPR so that with proper access level control patient information can be shared between the clinicians within a Polysystem, and with their external providers and the PCT.

The Polysystems will be supported by transformational change programmes, and by planned communications and a community engagement campaign (including social marketing) which will consult and inform residents of Newham about the proposed changes and increase their ability for self care and for satisfying and appropriate use of local health services.

We are developing referral protocols to ensure the decommissioned activity is not repeated elsewhere but managed appropriately within primary care.

We will optimise choose and book to include community service options.

We are reviewing and utilising GP’s with a specialist interest capacity and capability (GPwSI).

We are reviewing the Clinical Assessment Service to include a wider range of new outpatient pathways which will be triaged to ensure that patients are seen within the appropriate time by an appropriate professional in a local setting.

4.1.8 Transforming community services through Polysystems

In addition to the shift of care from an acute setting we are also redeveloping and co-locating community providers to ensure that each Polysystem population is able to access appropriate services and receive proactive care that enables them to self manage their own health and be appropriately sign posted to the right care at the right time from the most appropriate professional. Polysystems will provide us with a delivery network through which providers such as GPs, Pharmacists and the third sector can work together in a more efficient and targeted way focused upon keeping their local community healthy.

The following community services have been prioritised as areas of transformation within our Polysystems.

4.1.8.1 Long term conditions and case management

We will strengthen the capability and capacity of both community and primary care providers within each Polysystem to ensure we support those with long term conditions. We will have integrated, community-based services with integrated care pathways and, where appropriate, locality-based, integrated, multi-disciplinary, health and social care teams. Supporting people with LTCs to remain well and reduce the incidence of hospital admission is one of the key aims for health and social care services.

Some out-of-hospital services for people with LTCs have already been developed locally. These models will be expanded to be delivered within Polysystems to ensure local people are offered an integrated approach.

4.1.8.2 Case management

A smaller group of people with particularly wide-ranging problems need a highly personalised service. Evidence shows that high quality and personalised case
management can improve patients’ lives dramatically, reducing non-planned admissions to hospital and allowing patients to return home more quickly. The key to meeting the personal needs of these patients will be a specialist clinician, often a nurse, who works with patients and social care providers to manage the delivery of care.

Many people requiring this type of care will have a number of chronic (long-lasting) conditions, often on several different medications, who are at high risk of emergency admission to hospital. Care for these people can be managed within the Polysystem using a community matron or other professional using a proactive case management approach, to anticipate, co-ordinate and join up health and social care.

4.1.8.3 Rehabilitation and enablement

Everyone who might benefit from enablement will have timely access to enablement and rehabilitation appropriate to their needs. People will have the opportunity for enablement as the first option, before other health and social care service options are considered. Wider community services, as well as third sector and self-help organisations, play an important role in enablement and will be considered as part of future pathways.

4.1.8.4 End of life care

The primary need for end of life (EoL) care is to improve the experience of people living in Newham and facing the end of life. Given the expertise, commitment and innovation in Newham, further development of EoL care services will be delivered by teams within each Polysystem. The long-term outcomes sought are:

- People are given the support they need to die in the place of their choice
- Family members and carers are supported throughout, including psychological and bereavement support
- Local services achieve the National EoL Care Strategy Quality Markers

Our plans for developing these services are advanced. We are developing the service specification with our joint commissioners in LBN and are working actively with our provider of community services. Our advanced process of separation from the provider services organisation will increase our ability to deliver on this complex area of transformation during 2010.

4.1.9 Estates Planning through Polysystems

Each Polysystem will ensure that services are delivered in settings which are accessible, appropriate and convenient to patients. We have designed Polysystems around the hub and spoke model and will ensure that only those spokes that are of high quality are utilised in taking forward service delivery within Polysystems. Current estate that does not meet the required standards will be decommissioned and we will work closely with providers to identify alternative solutions. We will also seek to increase the utilisation of our assets which will include maximising the use of rooms and working with some of our providers to relocate office bases from some buildings so that the space can be reconfigured to provide a clinical function.

We are engaging in a programme of work to take a detailed review of our estates utilisation and provide key insight into what opportunities exist in terms of making sure we have the right numbers of buildings in the right places to equip each Polysystem adequately and highlight gaps.

Key insights from this work already:
• A majority of PCT owned buildings do not open either on weekends or evenings. This would boost capacity significantly. For example by opening one of our buildings in the South Polysystem in the evenings and weekends would yield approximately 140 additional clinical sessions per week. Core capital expenditure costs are already covered within this time and only additional facilities management costs such as utilities would be incurred.

• Within existing opening times there is potential to release significant capacity from under utilised gaps in clinics or poor use of space/scheduling.

• Most GP clinics are operating at capacity (in core hours). It is in these areas where we need to prioritise hub development to ensure they can grow with their population base.

The development of Polysystems estate plans have included:

• Modelling of activity levels required for each Polysystem, and management of service configuration across the borough

• Agreeing what services will be delivered and where

• Developing required services for delivery in the community

• Agreeing service delivery methodologies and procurement of provider, where required.

This work has begun through the modelling described elsewhere in the CSP and will form the basis of discussions with a range of partners and providers across the borough. NHS Newham is committed to working with partners, including the London Borough of Newham, to deliver healthcare from shared facilities, including delivery of other services from health facilities to improve access for patients and service users.

Knowing where we need services will give us an indication of constraints to delivery, ie if there are no premises in a particular location that may be used. It will also help identify opportunities to commission services in space which is underused, eg outpatient activity movement to local healthcare buildings.

4.1.10 IT and health intelligence in Polysystems

The success and sustainability of each Polysystem will be dependent on an IT structure that enables seamless care to be delivered between all providers and partners. NHS Newham is in the process of rolling out EMIS Web and QUTE to all its GP practices. EMIS web will link to RIO and NUHTs EPR system. This will support the future delivery of seamless care across different providers.

4.2 Prioritising our approach to improving health and well-being

We will set out in our commissioning strategy the challenges that have led to the formation of these goals and the ways in which we will start to address them. Achievement of the eight Healthcare for London pathways provides the framework in which we will start to identify the initiatives we need to implement. Further information on the priority areas below can be found in the JSNA.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Case for change</th>
<th>Related initiatives</th>
</tr>
</thead>
</table>
| Helping the people of Newham to lead healthy lifestyles | The biggest reversible impact on poor health outcomes in the borough is from high levels of smoking in some ethnic groups, low levels of physical activity and poor diet within Newham’s communities The people of Newham face significant health inequalities with high disease and | • Let’s get moving and physical activity social marketing  
• Healthy eating  
• Child obesity management  
• Newham alcohol harm reduction programme |
early deaths from conditions such as cardiovascular disease, diabetes and cancer
We have already made significant inroads into improving the health of the people of Newham. Our stop smoking initiatives have drastically reduced the number of smokers by 2171.
Around 60% of adults in Newham do no physical activity at all, compared with around 49% for London as a whole.
Children in Newham have the second highest rates of obesity in the country and rates for Year 6 children have increased, 25.6% are classified obese.
Alcohol-related hospital admissions are particularly high in Newham and have risen by 60%, and unlike some boroughs, the problem here is not related to street drinking.

| Improving access to employment, in healthcare delivery for local people | Educational attainment and access to employment are two key components of the wider determinants of health that play an important part in the health and well-being of the people of Newham.
People are likely to have worse health than the rest of the population if they experience one or more of: material disadvantage, lower educational attainment and/or insecure employment.
There needs to be a continued focus on ensuring that access to employment is a priority, by using the opportunities the 2012 Olympics and Paralympics bring to residents, alongside the continuing regeneration across Newham. | • Strategic Regeneration Framework |
|---|---|---|
| Early identification and treatment of cardiovascular disease and diabetes | Cardiovascular disease is the main cause of death in the under 75s in Newham, and is mostly preventable.
Early implementation of the NHS health checks has helped us to identify more than 18,000 people in Newham who would benefit from intervention.
Cardiovascular disease impacts disproportionately on the health of the people of Newham.
Diabetes and hypertension are long term conditions that have a significant link with more serious vascular events and conditions. | • Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and end of life care
• NHS health checks (vascular risk assessment)
• Intermediate diabetes team |
| Improving mental well-being | Almost 20% of Newham residents have a mental illness.
Research shows that there are links between mental ill health and deprivation, and a greater prevalence of poor mental health. | • Developing community mental health services
• Developing dementia services |
<p>| Health among certain ethnic groups and vulnerable groups | People can be particularly at risk of developing mental health problems if they suffer from chronic long term conditions, and after major trauma such as stroke and falls. Investment in timely and practical support such as access to counselling, befriending services and occupational therapy can help prevent mental health and well-being deteriorating, and help people to regain confidence, maximise independence and reduce social isolation. |
| Improving cancer survival rates to be better than London | For some cancers the incidence is lower in Newham than the national average; however, the five-year survival is lower; this is particularly true in relation to bowel and breast cancer. Cancers account for 25% and 36% of all deaths in women and men respectively in Newham. Late presentation is causing reduced survival from cancer, and results in unnecessary and preventable deaths. In 2007, a total of 322 people died from cancers in Newham, accounting for nearly a quarter of all deaths. NHS Newham spend £21 per weighted population head less than our ONS cluster whilst achieving worse cancer mortality. | • Improving the early diagnosis of cancer |
| Improving maternity services and reducing infant mortality | Newham has a young population with the highest birth rate in England (95.6 per 1000). Newham has high rates of low birth weight babies, which is a risk factor for infant mortality. Infant mortality has been high but has improved (6 per 1000 live births from a high of 8 per 1000 live births), although it is still higher than London. Diabetes, poor nutrition and overweight are linked and associated with poorer health outcomes for mother and baby. NHS Newham spend £90 per weighted head of population, £19 more than our ONS cluster and £33 more than the national average while achieving worse health outcomes. | • Developing maternity services |
| Early diagnosis of HIV and sexually transmitted infections | Sexually transmitted infections, particularly Chlamydia, are on the increase in Newham. Rates of HIV infection are high (7.1%) and one third of people with HIV are diagnosed late. The Chlamydia Screening Programme needs to improve the proportion of | • Delivering effective community based sexual health services |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Solutions</th>
</tr>
</thead>
</table>
| Chlamydia screens                        | Chlamydia screens undertaken in core services to screen 10,500 people aged 16-24 compared to 6,500 in 2008/09. | • Delivering effective community based sexual health services  
• Developing maternity services  
• Developing children and young people’s services in Newham |
| Reducing teenage pregnancy               | There has been a decrease in the teenage pregnancy rate in Newham, but it is still above the national and London rates. Newham has a young population and we need to continue to reduce teenage pregnancy rates, and to support teenage parents to prevent a continuing cycle of poverty and social exclusion. |                                                                     |
| Improving health outcomes of vulnerable children | Over 50% of children in Newham are living in poverty.  
There needs to be investment in implementing the local safeguarding board plan for meeting the health needs of children in care and other vulnerable children in need groups.  
There also needs to be investment in implementing the Aiming High Plan, aimed at increasing short breaks for disabled children, young people and their families.  
Urgent care services for children are not adequate. | • Let’s get moving and physical activity social marketing  
• Developing children and young people’s services in Newham  
• Healthy eating  
• Child obesity management |
| Improving access to high quality primary care and community services | Access to services is a key theme running through our plans arising from conversations with the public.  
The most recent patient survey showed Newham as one of the worst performing PCTs for access to primary care services.  
Late presentation has been identified as a crucial factor in heart disease, diabetes, cancer and STIs.  
Improving access to local authority and healthcare services underpins improving health and well-being. | • Delivering outpatient care in Polysystems  
• Let’s get moving and physical activity social marketing  
• Healthy eating  
• Delivering effective community based sexual health services  
• Improving the early diagnosis of cancer  
• Developing primary and community mental health services  
• Reducing health inequalities experienced by people with learning disabilities  
• Developing urgent and unscheduled care within Polysystems  
• Developing maternity services  
• NHS health checks  
• Olympic Polyclinic  
• Intermediate diabetes service  
• Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and end of life care |
| Achieving financial sustainability       | We know that the NHS will have to respond to the economic impacts of the financial downturn.  
The expected high level of population growth. | • Improving productivity in primary care services  
• Decommissioning services of limited clinical value |
in Newham, especially after the Olympics in 2012, means our existing model of health delivery will become unaffordable. NHS London has challenged London PCTs to implement the aggressive scenario in Healthcare for London in the context of reduced growth in healthcare funding.

4.3 Effective use of resources
We have reviewed how NHS Newham is allocating resources between different areas to maximise impact on health outcomes, quality of care and reduction of health inequalities. We are part of the London Programme Budgeting Group and are developing further our approach. At present, the main source is the Department of Health Programme Budgeting data that analyses spend by PCT on 23 programme budgeting categories. Analysis is useful in raising questions around relative spend across programmes triangulated against other data such as outcomes and activity. The table below shows our expenditure by each programme area in comparison to other PCTs.

For benchmarking purposes Newham is compared against a cluster of other PCTs. The clusters are defined by the Office of National Statistics as areas that show similarities across a range of social measures. The cluster (London Cosmopolitan) includes the following PCTs:

- Newham
- City & Hackney
- Lambeth
- Lewisham
- Southwark
- Haringey
- Brent
- Heart of Birmingham

![Spend and Outcome relative to other PCTs in England](image)
We have prioritised our analysis on those areas where we are an outlier (national and/or cluster); there are clearly poorer outcomes for the category and/or the category has a high level of resource allocation. We are continuing to analyse this information to inform our commissioning and are focusing on the following areas:

- Newham’s spending on cancer has consistently been in the lowest 4 PCTs in the country. The reasons for this are not clear. Certainly this is partly because Newham has a low incidence of cancer and possibly because of the weighting of the population creates a denominator that is too large. However the fact that both City & Hackney and Tower Hamlets PCTs are also very low spenders would indicate that it may be to do with the recorded cost of cancer at Barts & the London Trust. Whether this is because the cost of these services is cheaper or because the Trust’s costing apportionment is not robust it is not easy to speculate. There is also a sub-categorisation of spending into different types of cancer. However most expenditure is being counted as “Other Cancers and Tumours”, which implies that the costing to sub-categories is not being done by the providers.

- Newham is a high spender nationally; ranked 5th. This is perhaps to be expected given the high numbers of low-weight babies and infant mortality for the PCT. All the PCTs in the cluster are high spenders, although Newham is the highest spender. Comparison with the other PCTs is made difficult because of the pooling arrangement that exists in London for spending on neo-natal care and because the numbers of babies that require neo-natal care is very small. The 45% increase in spending in 2007-08 is partly due to an increase in Newham’s contribution to the shared risk pool and partly because Newham had a small number of early-term babies born that required large investment to improve their health.

- Newham is a high spender compared to other PCTs in the cluster; however, compared to the National position Newham ranks only 129. The ranking graph shows that expenditure in this area for the rest of the cluster is very low. When the high prevalence and mortality rates for CVD is taken into account it is perhaps surprising that the level of spending is not higher. There is no apparent correlation between the prevalence of CVD and the amount that a PCT spends. One factor that contributes to this is that the number of admissions for CVD is relatively low. Across the country there is a good correlation between mortality for CVD and admissions, however in Newham the results show low admissions. This could indicate a high level of un-met demand which could be released by the initiatives on CVD risk assessment. Once again the large amount of cost attributed to “Other Problems of Circulation” puts into question the validity of the sub-categorisation into CHD and Cerebral-Vascular.

- Newham is a very low spender on respiratory diseases; ranked 150th in the country. Newham is also a low spender in the cluster although all PCTs in the cluster are low spenders. Data from elsewhere indicates that Newham has low incidence and low admissions for Respiratory problems.

- Newham is a high spender on maternity in both the cluster and in England. This perhaps is to be expected given the high birth rate. We continue to work with our providers to prioritise improvements in maternity

4.4 Healthcare for London

Healthcare for London sets a framework to support the development of a modern health service for Newham which will improve both health and the services we commission. The principles and
policies contained within Healthcare for London are now an integral part of NHS Newham’s strategies.

We have entered into an ambitious programme to reconfigure the acute landscape. Health for NEL supports the redesign of the Healthcare for London pathways:

- Maternity and newborn
- Children and young people
- Acute care
- Planned care

We are committed to developing work at a borough level to support and augment the sector-wide work on the four pathways above, and through local implementation of the following four Healthcare for London pathways:

- Staying healthy
- Long term conditions
- End of life care
- Mental health

The table below outlines the priorities we have identified across ELCA to support achievement of our strategy. More information on the initiatives below is available in the sector ICSP.

<table>
<thead>
<tr>
<th>HfL Pathway</th>
<th>ELCA support initiative</th>
<th>Related NHS Newham initiative/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned care</td>
<td>Community tariff for services in the community</td>
<td>Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC</td>
</tr>
<tr>
<td>Planned care</td>
<td>Shift settings of care outpatient activity (not maternity)</td>
<td>Delivering outpatient care in Polysystems</td>
</tr>
<tr>
<td>Planned care</td>
<td>Decommission low clinical value procedures/Demand management</td>
<td>Decommissioning services of limited clinical value</td>
</tr>
<tr>
<td>Long term conditions</td>
<td>Reduce acute LTC activity; demand management outpatient</td>
<td>Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC</td>
</tr>
<tr>
<td>Long term conditions</td>
<td>Performance manage acute providers (LOS etc)</td>
<td>Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC</td>
</tr>
<tr>
<td>Acute care</td>
<td>Shift of acute A&amp;E activity to UCC</td>
<td>Developing urgent and unscheduled care within Polysystems</td>
</tr>
<tr>
<td>Acute care</td>
<td>Drive productivity of acute providers to upper quartile targets</td>
<td>Decommissioning services of limited clinical value</td>
</tr>
<tr>
<td>Maternity</td>
<td>Capture saving in maternity by reducing N12/NZ</td>
<td>Developing maternity services</td>
</tr>
<tr>
<td>Maternity</td>
<td>Shift care into non-acute settings</td>
<td>Developing maternity services</td>
</tr>
<tr>
<td>Mental health</td>
<td>Create a MHCU to drive productivity</td>
<td>Developing community mental health services</td>
</tr>
<tr>
<td>Mental health</td>
<td>Support borough redesign of the dementia pathway</td>
<td>Developing dementia services</td>
</tr>
<tr>
<td>Children and young people’s</td>
<td>Shift of acute A&amp;E activity to UCC</td>
<td>Developing children’s and young people’s services in Newham</td>
</tr>
<tr>
<td>Children and young people’s</td>
<td>Commission Paediatric assessment &amp; treatment model</td>
<td>Developing children’s and young people’s services in Newham</td>
</tr>
</tbody>
</table>
The eight tables below set out the best practice identified in Healthcare for London in each of the eight pathways, how we plan to respond as a sector and at borough level, and which of our needs we will start to address.
### Acute care

<table>
<thead>
<tr>
<th><strong>Best practice</strong></th>
<th><strong>Self-care, support and advice</strong></th>
<th><strong>Primary care and community services</strong></th>
<th><strong>Ambulance services</strong></th>
<th><strong>A&amp;E</strong></th>
<th><strong>Non-elective admissions</strong></th>
<th><strong>Specialist acute care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health advice, support and information easily available to all via telephone, online and other means, eg NHS Direct, local pharmacy</td>
<td>Provision of single urgent care service for each local community Service open at least 12x7 Integration of urgent care with primary care Access to diagnostic services Skill mix to deal in most efficient way with patient needs Doctor presence 12x7 Provision of community care 12x7 aligned to primary care/urgent care service in order to prevent admission to hospital Access to LTC co-ordinator Access to specialist input/advice</td>
<td>More treatment at scene with appropriately specialised practitioners, Clear pathways and protocols to allow ambulance staff to take patients to most appropriate place for care Common receiving location in all geographies, ie common (same hours, same service) urgent care centre in all Polysystems</td>
<td>Early diagnosis and timely provision of definitive treatment Clear and transparent clinical pathways Rapid access to community care, LTC co-ordinator and specialist advice Provision of UCC (integrated with primary care) on front door</td>
<td>Early management by dedicated acute team Provision of emergency surgery services on networked basis</td>
<td>Treatment as per SHA-wide agreement for acute stroke, cardiac and major trauma</td>
<td></td>
</tr>
</tbody>
</table>

| **Gaps** | Extending telehealth and telecare | Provision of community care 12x7 aligned with primary care/urgent care service in order to prevent admission to hospital Ensuring diagnostic support within each Polysystem | Urgent care front end to A&E |

| **Initiatives** | Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC | Developing urgent and unscheduled care within Polysystems | Developing urgent and unscheduled care within Polysystems |
### 4.6 Maternity

#### Best practice

<table>
<thead>
<tr>
<th>Pre-conception</th>
<th>Antenatal care</th>
<th>Birth</th>
<th>Post-natal and neonatal care</th>
</tr>
</thead>
</table>
| Implement integrated programme of women’s health, sex education and contraception through primary care, community and schools | Adopt NICE guidance for antenatal care:  
- 7–10 antenatal appointments  
- All women should be registered with a midwife by 12 weeks  
- 2 ultrasound per low risk pregnancy  
- Include all national screening programmes in routine care  
- Rigorous ongoing risk assessment  
Stratify patients by risk  
Assign midwifery groups responsibility for identifying high risk women and targeting services at them  
Move planned service from hospital, to GP practices and to distributed easy-access local community centres, to facilitate registry and productivity  
Remove GPs from pregnancy testing | Ensure choice of location for birth based on risk profile:  
- Access information, eg risk profile of different units  
- Default option: midwife led  
- Clear transfer protocols to allow rapid transfer from midwife led to obstetric where required  
Continuity of care throughout antenatal, birth and post-natal but esp. 1:1 care during birth  
- Provide high quality, safe maternity services  
- Provide formal clinical networks  
- 98hrs per week of consultant presence on labour ward rising to 168hrs in future  
- Handle complexity through specialisation  
- Provide and maintain high quality estate  
- Increase midwife productivity in order to provide 1:1 midwife care using existing resources | Provide high quality, routine post-natal care focus on people who need it, based on social risk and clinical need  
Support breastfeeding to increase initiation rates  
Provide accessible, targeted specialist post-natal care if needed  
Provide high quality neonatal care  
Pilot offering appointments in health centre instead of home (when women want it) |
| Ensuring early registration with a midwife  
Easy access local community based services | Continuity of care and 1:1 midwife care  
Choice of location of birth  
Increasing midwife productivity | Supporting breastfeeding |

#### Gaps

<table>
<thead>
<tr>
<th>Pre-conception</th>
<th>Antenatal care</th>
<th>Birth</th>
<th>Post-natal and neonatal care</th>
</tr>
</thead>
</table>
| Ensuring early registration with a midwife  
Easy access local community based services | Continuity of care and 1:1 midwife care  
Choice of location of birth  
Increasing midwife productivity | Supporting breastfeeding |

#### Initiatives

<table>
<thead>
<tr>
<th>Pre-conception</th>
<th>Antenatal care</th>
<th>Birth</th>
<th>Post-natal and neonatal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering effective community based sexual health services</td>
<td>Developing maternity services</td>
<td>Developing maternity services</td>
<td>Developing maternity services</td>
</tr>
</tbody>
</table>
### 4.7 Planned care

<table>
<thead>
<tr>
<th>Best practice</th>
<th>Self-assessment and Self-care</th>
<th>Primary and community care</th>
<th>Acute and specialist services</th>
<th>Rehabilitation and continuing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shift towards patient-supported self-care: Give patients information and support networks on their condition Promote use of equipment to help patients self-manage effectively Allow patients direct access to therapies</td>
<td>Strengthen primary care and redesign pathways to shift care closer to home Enable primary care to access a range of diagnostics directly, prior to specialist referral Provide outpatient appointments, diagnostics and treatment locally Do minor operations outside hospital (quality concerns) Protocols to prevent inappropriate referral Ensure doctors and patients use referral decision aids</td>
<td>Redesign and streamline care pathway steps: Separate ambulatory surgery from complex and emergency surgery with more surgery in elective centres Surgical procedure direct-listing Institute high quality, streamlined pre-operative assessment services Make day surgery the default, admission as the exception Institute one-stop specialist services Inform commissioning and clinical shared decision making with patient-reported outcome measures and surgical thresholds</td>
<td>Admit with planned discharge date and facilitate discharge from planned care as soon as possible Match local intermediate care and step-down beds to patient needs and ensure community ‘discharge home’ support for patients post-procedure</td>
<td></td>
</tr>
</tbody>
</table>

| Gaps | Ensuring diagnostic support within each Polysystem Outpatient appointments within Polysystem Developing enablement services in Polysystems Developing community tariffs to improve productivity | Decommissioning unnecessary procedures and procedures of limited clinical value | Reducing length of stay through planned discharge at admission One-stop rehab |

| Initiatives | Delivering outpatient care in Polysystems Improving productivity in primary care services Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC Olympic Polyclinic | Decommissioning services of limited clinical value | Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC |
### 4.8 Children and young people

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Protection and care for vulnerable children</th>
<th>Primary care</th>
<th>Community care/therapies</th>
<th>Specialist care</th>
<th>Tertiary care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Best practice</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Proactive targeted action to increase breastfeeding rates (exclusive at 6 months)</td>
<td>High quality, co-ordinated services for vulnerable children</td>
<td>High quality primary care services with staff trained to care for children</td>
<td>Multidisciplinary teams providing care for children and young people, based around primary and community care</td>
<td>Access to specialist advice via paediatric assessment units on all acute sites</td>
</tr>
<tr>
<td></td>
<td>Proactive, targeted action to address health behaviours – diet and exercise</td>
<td>Access to 12x7 urgent care, integrated with primary care services</td>
<td>Co-ordination between hospital and community paediatric services</td>
<td>Smaller number of inpatient units to concentrate expertise</td>
<td>Smaller number of inpatient units to concentrate expertise</td>
</tr>
<tr>
<td></td>
<td>Increased uptake of national immunisation programmes</td>
<td>Increased uptake of national immunisation programmes</td>
<td>Shift of outpatient services into the community</td>
<td>Fewer, designated centres for paediatric surgery</td>
<td>Fewer, designated centres for paediatric surgery</td>
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<td></td>
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<td></td>
<td>Support for care at home</td>
<td>Rapid transfer to tertiary centres where required</td>
<td>Rapid transfer to tertiary centres where required</td>
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<tr>
<td><strong>Gaps</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Targeted programmes to reduce child obesity</td>
<td>Safeguarding children through reviewing health visitors</td>
<td>Developing integrated children’s care in Polysystems</td>
<td>Developing the Children’s Trust</td>
<td>High quality dedicated tertiary centres operating at clinical scale (?)</td>
</tr>
<tr>
<td></td>
<td>Effective teenage pregnancy services</td>
<td>Developing children’s services in primary care</td>
<td>Improving children’s services in community care</td>
<td>Improving children’s services in community care</td>
<td>Clear protocols for transfer of children</td>
</tr>
<tr>
<td><strong>Initiatives</strong></td>
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<td></td>
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<tr>
<td></td>
<td>Child obesity management</td>
<td>Developing children’s and young people’s services in Newham</td>
<td>Developing children’s and young people’s services in Newham</td>
<td>Developing children’s and young people’s services in Newham</td>
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</tbody>
</table>
### 4.9 Long term conditions

<table>
<thead>
<tr>
<th>Prevention and early diagnosis</th>
<th>Integrated primary and community care</th>
<th>Inpatient and acute care</th>
<th>End of life care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Best practice</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted health behaviour interventions (see ‘staying healthy’ care pathway)</td>
<td>Integration of a multidisciplinary team comprising specialist and primary/community care professionals as well as social care</td>
<td>Minimum use of inpatient care – “every admission is a failure”</td>
<td>Ensure a seamless transition to end of life care</td>
</tr>
<tr>
<td>Identification of at risk groups</td>
<td></td>
<td>Rapid discharge back into primary/community team</td>
<td>Supporting people to make effective choices about end of life care</td>
</tr>
<tr>
<td>Establish risk registers</td>
<td>Regularly updated register of all patients</td>
<td>Immediate communication and co-ordination with out of hospital team</td>
<td></td>
</tr>
<tr>
<td>Personalised information for at risk groups</td>
<td>Implementation of best practice care pathways and protocols, for patient segments – packages of care</td>
<td>Access to shared record</td>
<td></td>
</tr>
<tr>
<td>Adoption of evidence based screening programmes (see staying healthy)</td>
<td>24x7 service to proactively care for patients with single point of contact and responsibility</td>
<td>Reduction in planned admissions for diagnosis and care management</td>
<td></td>
</tr>
<tr>
<td>Proactively looking at expected versus reported prevalence at practice/practitioner level</td>
<td>Monitoring of adherence to care pathway and performance management</td>
<td>Net savings resulting from improved management of out of hospital care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clear governance model across primary, community and specialist care</td>
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<td></td>
<td>IT system to support care across all aspects</td>
<td></td>
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<tr>
<td></td>
<td>Use of expert patient programme</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Financial incentives for patients and providers for best practice care</td>
<td></td>
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<tr>
<td></td>
<td>Multidisciplinary team approach</td>
<td></td>
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<td></td>
<td>Self-care and home monitoring of condition using e-health technologies</td>
<td></td>
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<tr>
<td></td>
<td>Expert patient programme</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Community based diagnostics</td>
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</tbody>
</table>

| **Gaps** | | | |
| Annual health checks for learning disability patients | Developing Polysystem based integrated case management teams rather than stand alone teams | Providing community based diabetes care | Implementing best practice for end of life care |
| Wide-reaching NHS health checks | | | |

| **Initiatives** | | | |
| Annual health checks for learning disability patients | Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC | Intermediate diabetes services | End of life care |
| NHS health checks | | | |
### 4.10 Staying healthy

#### Best practice

<table>
<thead>
<tr>
<th>Changing health behaviours</th>
<th>Protection and prevention</th>
<th>Reducing disease burden</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gaps</strong></td>
<td><strong>Initiatives</strong></td>
<td></td>
</tr>
<tr>
<td>Refocusing smoking cessation to target groups</td>
<td>Let’s get moving and physical activity social marketing</td>
<td>Developing Polysystem based integrated case management teams rather than stand alone teams</td>
</tr>
<tr>
<td>Targeted programmes for obesity and healthy eating</td>
<td>Healthy eating</td>
<td>Ensuring diagnostic support within each Polysystem</td>
</tr>
<tr>
<td>Newham alcohol harm reduction programme</td>
<td>Child obesity management</td>
<td>Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC</td>
</tr>
<tr>
<td>Delivering effective community based sexual health services</td>
<td></td>
<td>Delivering outpatient care in Polysystems</td>
</tr>
<tr>
<td>NHS health checks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Target programmes at specific population groups

- Interventions rooted in a clinical evidence base – access evidence base and case studies where they exist, UK and international
- Tender out services, eg smoking cessation, obesity management
- Consider use of individual incentives
- Change skill mix, eg use health coaches
- Use electronic interactive tools, eg pedometers, self-monitoring of BMI, Internet based advice

#### Target efficiency programmes to increase usage, eg, breast cancer screening at BLT improved to achieve national targets

- Outcome based payment incentives to providers
- Target efficiency programmes to increase usage
- Manage long term conditions effectively

#### Integrate a multidisciplinary team comprising specialist and primary/community care professionals as well as social care

- 100% diagnosed patients on register with agreed personal care plan
- Regularly update register of all patients
- Implement best practice care pathways and protocols, for patient segments – packages of care
- 24x7 service to proactively care for patients with single point of contact and responsibility
- Monitor adherence to care pathway and performance management
- Clear governance model across primary, community and specialist care
- IT system to support care across all aspects
- Use expert patient programme
- Financial incentives for patients and providers for best practice care
- Self-care and home monitoring of condition using e-health technologies
- Community based diagnostics

## Protection and prevention

- Redesigning community sexual health services
- Extension of the NHS health checks
- Improving cancer detection and screening

#### Reducing disease burden

- Developing Polysystem based integrated case management teams rather than stand alone teams
- Ensuring diagnostic support within each Polysystem
- Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC
- Delivering outpatient care in Polysystems
### 4.11 Mental health

<table>
<thead>
<tr>
<th>Best practice</th>
<th>Public awareness and health promotion</th>
<th>Primary care</th>
<th>Local service access</th>
<th>Severe enduring illness care planning</th>
<th>Inpatient care</th>
<th>Carer support</th>
<th>Suicide prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>Normalise mental health De-stigmatise mental health Address inequalities and social exclusion</td>
<td>Early intervention Child and adolescent mental health services Accessible primary care based mental health services Implement NICE guidance on depression and anxiety</td>
<td>Community mental health teams Ensure easy access to mental health services Availability of psychological therapies Assertive outreach Crisis resolution</td>
<td>ICPs for patients with enduring mental illness Ensuring effective care packages for people with dementia</td>
<td>Reducing long term hospitalisation Ensure access to high quality specialist services Integrated health and social care assessment 24/365 access to specialist teams</td>
<td>Providing services to carers Breaks for carers</td>
<td>Suicide prevention strategy NSF 12 points to a safer service</td>
</tr>
</tbody>
</table>

| Gaps | Developing primary care based mental health services | Developing community based mental health services Integration of community, primary and acute mental health services Developing a single point of referral Improving community mental health team productivity | Dementia care | Dementia carer support |

| Initiatives | Developing community mental health services | Developing community mental health services | Developing dementia services | Developing dementia services |
### 4.12 End of life care

<table>
<thead>
<tr>
<th>Public awareness</th>
<th>Assessment and care planning children</th>
<th>Co-ordination of care</th>
<th>Delivering high quality care</th>
<th>Last days of life</th>
<th>Care after death</th>
</tr>
</thead>
</table>
| **Best practice** | Identify patients early in all care settings  
Multidisciplinary working  
Agree individual care plans and regular review of needs and preferences using a holistic approach – advance care planning  
Assess needs of carers | NHS Newham governance structure – managed clinical network  
Defined responsibilities for aspects of care and case management  
Single point of contact 24/7  
Integration of health, social and voluntary sector services  
Timely sharing of clinical information | Leadership from specialist palliative care  
Adopt best practice care in all settings  
Availability of appropriate non-acute care settings  
Provide accessible hospices (specialist palliative care)  
Ability for rapid response to increase care packages, for discharge to preferred care setting, and for managing symptoms | Support patients to die in the setting of their choice  
Review needs and preferences for place of death  
Involve carers, assess needs and provide support to carers  
Implement the principles of Liverpool Care Pathway | Sensitive care of the deceased  
Timely delivery of death verification and certification  
Assess bereavement issues  
Signposting to comprehensive bereavement support |
| **Gaps** | Using holistic care planning and assessment | Developing an end of life care component to Polysystem based integrated case management teams | Developing an end of life care component to lead and support end of life care in Polysystem based integrated case management teams | Increasing compliance with the Liverpool care pathway | |
| **Initiatives** | End of life care  
Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC | End of life care  
Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC | End of life care  
Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and EoLC | End of life care |
4.13 Initiatives

The tables below outline the initiatives we have identified to meet our needs and to effectively implement Healthcare for London. Each table gives information on the initiative, its impacts, cost, and QIPP benefits.

<table>
<thead>
<tr>
<th>1. Let’s get moving and physical activity social marketing</th>
<th>Lead director: David Cryer</th>
<th>Programme: Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does the initiative involve?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing a targeted exercise programme for those at greatest risk</td>
<td></td>
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</tr>
<tr>
<td>• Implement a healthy living programme based on the Go London Strategy with emphasis in 2012/13 to ensure effective use of the Olympics as an enabler to increase physical activity</td>
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</tr>
<tr>
<td>• Developing local social marketing campaigns, focusing on identifying the barriers to, and opportunities for, increased physical activity among different high risk age and ethnic groups</td>
<td></td>
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</tr>
<tr>
<td>• To support the social marketing campaign we will develop a team of community physical activity facilitators to help patients engage in physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing healthy living skills in all frontline staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What QIPP benefits will we see?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Replaces existing ‘exercise on referral’ programme, which is unable to prove that it makes a long term impact on clients’ health outcomes</td>
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</tr>
<tr>
<td>• By changing the behaviours of our population we can help them to lead healthier lives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We will develop primary prevention services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the effects of the transformation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 10,000 new, and 20,000 follow-up patient attendances by the end of 2011/12 and then per annum in Polysystems</td>
<td></td>
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</tr>
<tr>
<td>• Social marketing will not shift activity in the short and medium terms but it should reduce ill health in the long term</td>
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</tr>
<tr>
<td>• 34,000 people who were previously inactive taking up some activity</td>
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<tr>
<td>• 12,000 more people active at least 3x per week</td>
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</tbody>
</table>

Base case: In 2010/11 we will invest £805k non-recurrently

Down side: In 2010/11 we will invest £805k non-recurrently

Upside: In 2010/11 we will invest £805K non-recurrently with £4.9M additional non-recurrent spend in 2011/12, £14M additional non-recurrent spend in 2012/13 and £5.9M additional non-recurrent spend in 2013/14 to support the full implementation of the Go London strategy

<table>
<thead>
<tr>
<th>2. Healthy eating</th>
<th>Lead director: David Cryer</th>
<th>Programme: Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does the initiative involve?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Establishing a healthy eating team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Providing community based prevention programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing healthy eating services within Polysystems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing a social marketing campaign</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What QIPP benefits will we see?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• By changing the behaviours of our population we can help them to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the effects of the transformation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2,400 new patients seen per annum in Polysystems</td>
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</table>
lead healthier lives
- This is a need that is currently unmet
- We will develop primary prevention services

| Base case: | In 2010/11 we will invest £800k non-recurrently |
| Down side: | In 2010/11 we will invest £800k non-recurrently |
| Upside: | In 2010/11 we will invest £800k non-recurrently |

- 240 patients achieving 10% weight loss, within 6 months of accessing service
- A further 360 patients achieving between 5% and 10% weight loss, within 6 months of accessing service

3. Delivering effective community based sexual health services

| Lead director: Carol Hill | Programme: Personalisation |

**What does the initiative involve?**
- Redesigning sexual health to be an integrated service provided in Polysystems rather than in a sexual health centre
- The HIV testing pilot will be evaluated and extended
- Implementing the London sexual health tariffs
- Developing and implementing a chlamydia and sexual health enhanced service in primary care (for both GPs and pharmacies)
- Funding for the Open Doors street sex worker team
- Funding for Open Doors for indoor sex workers
- Funding for voluntary sector providers
- Providing sexual health promotion within the borough to target those at greatest risk
- Improving services for teenage parents

| Base case: | In 2010/11 we will invest £50K recurrently |
| Down side: | In 2010/11 we will invest £50K recurrently |
| Upside: | In 2010/11 we will invest £50K recurrently |

**What QIPP benefits will we see?**
- Services closer to home
- Improvements in sexual health case finding
- Reducing unit costs by delivering a service through our Polysystems rather than in GUM
- Medium and long term reductions in activity due to prevention

| What are the effects of the transformation? |
| We will deliver existing services closer to home through Polysystems |
| We will attempt to shift appointments to in Polysystems |
| We will integrate services into the community |
| Screen an additional 3,600 people per annum rising to 4,000 by 2020 |
| Reduce percentage of people diagnosed late with HIV by 55% by 2015 |
| Increase chlamydia screening in 16–24 yrs to 25% (from 15% = c. 3,600 additional screens per annum rising to 4,000 by 2020. |

4. Improving the early diagnosis of cancer

| Lead director: Rachel Flowers | Programme: Long term conditions |

**What does the initiative involve?**
- Engaging with public, patients, community partners to deliver preventative and health improvement services across a wide range of
environments
- Developing prostate cancer clinic in community setting possibly through the polyclinic or in conjunction with West Ham Football Club
- Develop plans for providing digital mammography services in Newham and age extension of breast cancer services. Possibilities for this service are the use of symptomatic breast services at NUHT, or the Polysystem approach
- Using community development approaches to increase uptake of screening services
- Working with health trainers to improve uptake of screening, challenge beliefs, and promote understanding of early signs and symptoms
- Developing a LES for GPs to get more engaged in promoting services
- Social marketing to better understand local people’s beliefs about cancer and how it might be prevented, to target messages more effectively

<table>
<thead>
<tr>
<th>What QIPP benefits will we see?</th>
<th>What are the effects of the transformation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowers patients to use knowledge to improve understanding of signs and symptoms and have healthier lifestyles</td>
<td>We will deliver services in the community closer to home</td>
</tr>
<tr>
<td>Increases patient independence</td>
<td>Reduction in cancer presentations to acute sector over time</td>
</tr>
<tr>
<td>Reduces cancer presentations over time</td>
<td>Reduces GP and clinic presentations and follow-ups</td>
</tr>
<tr>
<td>Reduces GP and clinic presentations and follow-ups</td>
<td>An additional 1,840 women having breast screening per year</td>
</tr>
</tbody>
</table>

Base case: In 2010/11 we will invest £472k non-recurrently
Down side: In 2010/11 we will invest £472k non-recurrently
Upside: In 2010/11 we will invest £472k non-recurrently

5. Developing primary and community mental health services

<table>
<thead>
<tr>
<th>What does the initiative involve?</th>
<th>Lead director: Carol Hill</th>
<th>Programme: Personalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A ‘well-being single point of referral’ well-being care network will increase access to IAPT and support recovery and inclusion</td>
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<tr>
<td>Increased capacity through investment in 27 trainee workers funded recurrently through IAPT 2 monies which became available in 2009/10</td>
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<tr>
<td>Further developing primary care expertise to ensure early identification for treatment and support for mental health problems to meet individual needs with the right service first time</td>
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<tr>
<td>Provision of a range of services through Polysystems to maximise access, choice and personalisation without the stigma of mental health services’ traditional settings</td>
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<tr>
<td>Commissioning a single contract for an integrated approach across a number of providers</td>
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<tr>
<td>A review of capacity, productivity and model of care provided by the community mental health services in the context of Polysystem developments</td>
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<tr>
<td>The integrated service will have a single clinical lead and a dedicated clinical reference group ensuring that appropriate criteria are in place, links with other services are maintained and specific cases requiring detailed consideration are dealt with speedily</td>
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<table>
<thead>
<tr>
<th>What QIPP benefits will we see?</th>
<th>What are the effects of the transformation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic approach to referrals will be instrumental in improving access and quality</td>
<td>Increasing IAPT usage by</td>
</tr>
<tr>
<td>Removing duplication of skills and services through the development of an integrated service with clear</td>
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</tbody>
</table>
Pathways and clear criteria for users stepping up and down from one level of intervention to another matched to needs at the time
- Clear specifications for service performance as part of an integrated approach to service contract for 2010 onwards
- Reduced CMHT caseloads will improve care co-ordination, and enable more effective shared care with primary care and improved clinical outcomes
- Patient flow will increase by 20%–30%
- The expertise within CMHTs will be used to support primary care and the third sector
- By improving expertise in primary care (GPs and other health professionals) mental health problems will be identified and treated earlier, resulting in less need for long term, more expensive treatment and support later on. This will help keep people in employment and reduce social exclusion

<table>
<thead>
<tr>
<th>Pathways and Clear Criteria</th>
<th>2010–2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear specifications for service performance as part of an integrated approach to service contract for 2010 onwards</td>
<td></td>
</tr>
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<td></td>
</tr>
</tbody>
</table>

Base case: In 2010/11 we will invest £1,118K non-recurrently, in 2011/12 this will increase to £1,175K non-recurrently. This funding is part of a central allocation

Down side: In 2010/11 we will invest £1,118K non-recurrently, in 2011/12 this will increase to £1,175K non-recurrently. This funding is part of a central allocation

Upside: In 2010/11 we will invest £1,118K non-recurrently, in 2011/12 this will increase to £1,175K non-recurrently. This funding is part of a central allocation

<table>
<thead>
<tr>
<th>6. Decommissioning services of limited clinical value</th>
<th>Lead director: Robert Moore</th>
<th>Programme: Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does the initiative involve?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- We will identify areas where there is limited clinical value and decommission these services</td>
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<tr>
<td>- We will develop more robust claims management procedures</td>
<td></td>
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<tr>
<td>- We will commission outpatient care in line with best-in-class new to follow-up ratios to deliver savings of £5.4M in 2010/11</td>
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<td></td>
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<tr>
<td>- We will decommission unnecessary diagnostic activity</td>
<td></td>
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</tr>
<tr>
<td>What QIPP benefits will we see?</td>
<td>What are the effects of the transformation?</td>
<td></td>
</tr>
<tr>
<td>- More appropriate use of current resources</td>
<td>- Reduction in services of limited clinical value</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Decommissioning 78,404 follow up appointments</td>
<td></td>
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</tbody>
</table>

Base case: As this initiative is cost saving we will undertake the initiative in all three financial scenarios. The savings assumed from this are counted elsewhere. In 2010/11 we will make saving of £696K from decommissioning procedures of limited clinical value and £5.4M from reducing new to follow up ratios to best in class.
Down side: As this initiative is cost saving we will undertake the initiative in all three financial scenarios. The savings assumed from this are counted elsewhere. In 2010/11 we will make saving of £696K from decommissioning procedures of limited clinical value and £5.4M from reducing new to follow up ratios to best in class.

Upside: As this initiative is cost saving we will undertake the initiative in all three financial scenarios. The savings assumed from this are counted elsewhere. In 2010/11 we will make saving of £696K from decommissioning procedures of limited clinical value and £5.4M from reducing new to follow up ratios to best in class.

7. Developing dementia services

<table>
<thead>
<tr>
<th>Lead director: Rachel Flowers</th>
<th>Programme: Long term conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does the initiative involve?</td>
<td></td>
</tr>
<tr>
<td>- Completion of a local joint dementia commissioning strategy to ensure that resources/services are being used effectively and local processes are in line with the objectives set out in the national dementia strategy. This may involve redesigning current services in line with national recommendations</td>
<td></td>
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<tr>
<td>- Commissioning suitable liaison support for people with dementia to enable them to stay in their own homes for longer, to prevent unnecessary hospital admission, support hospital discharge (reduce lengths of stay) and prevent/delay admission to long term care</td>
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<tr>
<td>- Focusing on early identification of dementia, ensuring that appropriate information and support is available (including via the voluntary sector) in the community</td>
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<tr>
<td>- Delivering a dementia training programme for health and social care staff, and to in-borough nursing and residential care homes</td>
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<tr>
<td>- Considering collaborative commissioning approaches to meet the needs of people with early onset dementia</td>
<td></td>
</tr>
<tr>
<td>- Continuing discussions with East London Foundation Trust in relation to proposals for the redesign of older people’s mental health services across inner NEL</td>
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</table>

| What QIPP benefits will we see? |
| - Early identification will give people with dementia and their carers an opportunity to plan for the future and to decrease or delay the need for intensive support |
| - A reduction in inappropriate emergency hospital admissions and reduced lengths of stay on acute wards |
| - A reduction in long term placements |

| What are the effects of the transformation? |
| - The commissioning strategy will inform the redesign of services in line with national recommendations |

Base case: In 2010/11 we will invest £185K, in 2011/12 we will invest an additional £62K. This initiative creates recurrent cost savings of £184K, £275K, £479K in 2011/12, 2012/13, 2013/14

Down side: In 2010/11 we will invest £185K, in 2011/12 we will invest an additional £62K. This initiative creates recurrent cost savings of £184K, £275K, £479K in 2011/12, 2012/13, 2013/14

Upside: In 2010/11 we will invest £185K, in 2011/12 we will invest an additional £62K. This initiative creates recurrent cost savings of £184K, £275K, £479K in 2011/12, 2012/13, 2013/14

8. Reducing health inequalities experienced by people with learning disabilities

<table>
<thead>
<tr>
<th>Lead director: Carol Hill</th>
<th>Programme: Personalisation</th>
</tr>
</thead>
</table>

Commissioning Strategy Plan 2010 – 2015 77
What does the initiative involve?
- Appointing a strategic health facilitator to oversee it
- Rolling physical checks and individual health action plans for individuals with LDs as part of DES/LES (100 checks in year one increasing to 1,200 in year four)
- Data from annual health checks will be collated and used to plan health activities specifically targeted at identified needs. A primary healthcare plan for people with learning disabilities will be drawn up
- Commissioning programmes/interventions that empower people with LDs to take control of their own health needs, such as the ‘expert patient programme’
- Learning disability nurses and other specialist health practitioners will move away from direct support/intervention towards health facilitation
- Mainstream staff will be trained/supported to communicate with/offer interventions to people with learning disabilities

What QIPP benefits will we see?
- This will improve health and well-being outcomes for a group of patients that currently experience severe health inequalities
- This will lead to a decline in acute interventions and an increase in prevention and health promotion activities
- An initial increase in GP appointments/length of time needed for GP appointments as GPs detect previously unknown health issues
- An increase in screening/diagnostic services and then in health interventions from universal services as health checks detect previously unknown health conditions
- A long term reduction in GP appointments – GPs should be more skilled in communicating with people with LDs, thus reducing the time to diagnose and determine the correct support/intervention
- A reduction in double support (patients receiving interventions from specialist LD services and universal services on one health issue)
- A reduction in use of the community learning disability team

What are the effects of the transformation?
- Initially there will be a greater demand on universal health services across the board as previously undiagnosed conditions are identified
- There will be an increased need for screening/health promotion activities for people with learning disabilities as we move to enablement
- There will be a need for targeted health services to meet specific health needs identified by health checks
- Health conditions will be detected earlier. This will lead to a medium term reduction in acute care (as health promotion/prevention strategies succeed)
- Health action plans should outline the support individuals need and therefore enable paid carers/families to offer health promotion/maintenance/facilitation activities, this will lead to a decrease in the need for specialist LD services
- In the long term there will be a decrease in chronic health conditions such as diabetes, obesity etc. This should reduce the need for ongoing health interventions from specialist and universal services

<p>| Base case: In 2010/11 we will invest £109K recurrently, in 2011/12 this will have an additional £32K recurrently, in 2012/13 we will invest a further £62K recurrently |
| Down side: In 2010/11 we will invest £109K recurrently, in 2011/12 this will have an additional £32K recurrently, in 2012/13 we will invest a further £62K recurrently |
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<table>
<thead>
<tr>
<th>9. Developing urgent and unscheduled care within Polysystems</th>
<th>Lead director: Robert Moore</th>
<th>Programme: Productivity</th>
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</thead>
<tbody>
<tr>
<td><strong>What does the initiative involve?</strong></td>
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<tr>
<td>• Developing a 24 hour primary care led centre delivering urgent care services on the existing A&amp;E site at NUHT and operating a ‘see and treat’ model</td>
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<tr>
<td>• Incorporating a GP Practice within the UCC, open from 8am to 8pm, which will register patients on a permanent basis, or if appropriate, on a temporary basis and arrange transfer to a GP practice of the patient’s choice</td>
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<tr>
<td>• Providing 8 to 8 primary care led unscheduled access to a GP without an appointment within each of our Polysystem hubs</td>
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<tr>
<td><strong>What QIPP benefits will we see?</strong></td>
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<tr>
<td>• A more rapid and seamless service for patients</td>
<td>• The interim UCC is now treating 52% of patients attending A&amp;E services. It is expected that increased hours, improved effectiveness and increased skills of practitioners will increase that to 60%</td>
<td></td>
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<tr>
<td>• Improved patient experience</td>
<td>• The total annual attendances at the ED and UCC are 105,000. Currently 54,000 are being seen in the interim UCC – 60% would be 62,900 attendances.</td>
<td></td>
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<tr>
<td>• Shorter waiting times for patients</td>
<td>• A nil detriment is currently in place for the interim UCC, once this agreement has expired the UCC will be seeing 60% of patients attending the NUHT site</td>
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</tr>
<tr>
<td>• Fewer non-elective admissions</td>
<td>• We would like to shift 12,500–25,000 urgent care attendances to the local Polysystem hubs as part of unscheduled care by 2013 as demand grows</td>
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<tr>
<td>• More patients who genuinely need A&amp;E able to access services within the 4 hour wait target</td>
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<tr>
<td>• We expect savings to be realised through charging a lower patient tariff of £55 for every UCC attendance, a reduction of 23% compared with the existing A&amp;E tariff</td>
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<td></td>
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<tr>
<td>• Locally available urgent care</td>
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</table>

**Base case:** As this initiative is cost saving we will undertake the initiative in all three financial scenarios. The savings assumed from this are counted elsewhere.

**Down side:** As this initiative is cost saving we will undertake the initiative in all three financial scenarios. The savings assumed from this are counted elsewhere.

**Upside:** As this initiative is cost saving we will undertake the initiative in all three financial scenarios. The savings assumed from this are counted elsewhere.

<table>
<thead>
<tr>
<th>10. Developing maternity services</th>
<th>Lead director: Carol Hill</th>
<th>Programme: Personalisation</th>
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</thead>
<tbody>
<tr>
<td><strong>What does the initiative involve?</strong></td>
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<tr>
<td>• Commissioning pre-conception care for women with pre-existing health problems and lifestyle issues</td>
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<tr>
<td>• Commissioning direct access to midwives, choice of antenatal care and access to antenatal classes</td>
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<tr>
<td>• Meeting the national target to increase access by 12+6 weeks to 80% in 2009, 90% thereafter</td>
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<tr>
<td>• Promoting normal childbirth and provide choice in place of birth based on assessment of safety for mother and baby</td>
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<tr>
<td>• Commissioning a homebirth service to ensure choice of place of birth</td>
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<tr>
<td>• Commissioning Maternity Direct to reduce infant mortality, encourage direct early access and reduce unnecessary hospital admissions</td>
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<tr>
<td>• Commissioning a maternity DVD, and addressing language inequalities and the Maternity Matters choice agenda</td>
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</table>
- Mainstream care at the 4 new community maternity centres in children’s centres and schools, to increase early direct access and reduce unnecessary hospital activity
- Commission choice of post-natal care to women, especially those in most need
- Commission BABS (Birth and Breastfeeding Support) voluntary service to support vulnerable women through pregnancy and birth and enhance breastfeeding rates at 6 weeks
- Maternity Indicators and CQUIN indicators are part of the maternity SLA agreement to ensure compliance and robust monitoring

**What QIPP benefits will we see?**
- This initiative offers access to women, particularly some of the most vulnerable, in a local setting
- Specialist midwife in each team to work with specific groups, ie teenage parents
- Midwives can see women who otherwise may access services late on in pregnancy
- Drop-in service, no appointment required
- Self-referral directly to service
- Free pregnancy tests, so if positive the woman leaves with necessary health information, booking and first scan appointments
- Reduction in N12s as some women can be assessed/monitored by their local midwife
- Less staff sickness and absence
- Reducing unit costs by delivering a service through our Polysystems rather than in hospital (target price 30%–50% lower)

**What are the effects of the transformation?**
- 51,000 midwifery appointments in Polysystems
- Maternity care will be delivered in the community
- Reduction by 50% of N12 attendances by 2013
- 7 fewer infant deaths per year (20% reduction)
- 20% reduction in low birth weight babies
- 18 fewer women smoking at time of delivery

**Base case:** We will invest a further £42K recurrently in 2010/11 in addition to our existing recurrent commitment of £432K

**Down side:** We will invest a further £42K recurrently in 2010/11 in addition to our existing recurrent commitment of £432K

**Upside:** We will invest a further £42K recurrently in 2010/11 in addition to our existing recurrent commitment of £432K

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**11. End of life care**

**Lead director:** Carol Hill  
**Programme:** Personalisation

**What does the initiative involve?**
In five years’ time, people approaching the end of life will be known about and offered the support they need to plan ahead and make an informed choice about whether they wish to die at home (including in care homes). The health and social care services to support them at home will be well publicised in all communities and easily accessed through a single point of contact. Families/carers will be involved and supported up to and including bereavement. Admission to acute care will take place only where absolutely necessary, with the majority of treatment provided through the Polysystems. Discharge planning will start on admission and be reviewed and updated throughout the hospital stay to ensure rapid discharge, unless a care plan specifies the choice to die in hospital. Primary and community services will implement the Gold Standard Framework, and the Liverpool Care Pathway will be implemented across acute, primary and community services.

**What QIPP benefits will we see?**
- Significant increase in choice, location, co-ordination and access to quality of care
- LES: year 1 target = 25% of practices; year 2 target = 50% of practices; year 3 target = 75% of

**What are the effects of the transformation?**
- Increase in proportion of deaths at home: 2009: 18.1%; 2010: 20.3%;
practices; year 4 target = 100% of practices
- LCP facilitation in primary, community and acute health services
- GSF facilitation in primary care
- Out of hours access to palliative care medicines
- Whole systems redesign
- New services for beneficiaries currently underserved
- Qualitative investigation outcomes
- Consultations undertaken
- Bereavement support

2011: 21.0%
- Increase in proportion of total deaths occurring within care homes setting
- Reduction in A&E attendance
- Provision of bereavement support and increased psychological support resulting in reduction in referrals to CMHTs and in medication usage

Base case: We have an existing commitment recurrently of £455K from 2009/10, this will be used to deliver the planned End of Life Care initiative
Down side: We have an existing commitment recurrently of £455K from 2009/10, this will be used to deliver the planned End of Life Care initiative
Upside: We have an existing commitment recurrently of £455K from 2009/10, this will be used to deliver the planned End of Life Care initiative

12. Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and end of life care

Lead director: Rachel Flowers
Programme: Long term conditions

What does the initiative involve?
- Redesign of existing professional group based services to multi-professional teams
- Development of a multidisciplinary health and social care team within each of the four Polysystem to deliver effective case management for long term conditions, end of life care and effective enablement

Teams will undertake: assessment, case management, support planning, some direct elements of treatment and care, brokerage of non-direct elements of support plan, ensuring engagement with and support for informal carers, services delivered at home, within step-down units, residential and nursing homes, performance management of best practice, discharge planning from referral to reduce length of stay

We will explore the viability of:
- introducing community tariffs for activity
- including drug and alcohol teams within the service design
- extending the existing telehealth and telecare pilot
- use disease registers to enable effective communication and patient management

What QIPP benefits will we see?
- Reduces presentations to A&E
- Reduces unplanned hospital admission and readmission
- Shortens hospital lengths of stay for planned and unplanned admissions, creates bed capacity and enables decommissioning of beds
- Reduces GP and clinic presentations and follow-ups
- Reduces the level of intervention from the team, over time

What are the effects of the transformation?
Redesign of the following existing teams:
- community matrons
- district nurses
- continuing care and community nurses
- specialist nurses
- home rehabilitation service
- Cost of this care is lower than equivalent stay in hospital
- Reduces dependence on longer term care
- Empowers patients to exercise choice, to self-manage and to plan how their support needs will be met
- Patients become more independent at home
- Reduces the incidence of unsafe discharges
- Significant increase in choice, location, co-ordination and access to quality of care
- Improves patient satisfaction

- intermediate care, respite and CC beds
- OTs, SLT, physiotherapies and psychology
- day hospital
- social care
- Activity reductions are expected in GP care, acute care and A&E
- Diagnostic wastage should be reduced
- The number of people dying in hospital should be reduced
- More self care will take place in the home
- 30% reduction in non-elective activity related to long term conditions

Base case: In 2010/11 we will invest an additional £500K recurrently to support the redesign of the team. The existing budget for the teams being redesigned is £19.6M, this will be used to fund re-provision of the service.

Down side: As this initiative is linked to cost savings in long term conditions management it will be undertaken in all three financial scenarios. In 2010/11 we will invest an additional £500K recurrently to support the redesign of the team. The existing budget for the teams being redesigned is £19.6M, this will be used to fund re-provision of the service.

Upside: As this initiative is linked to cost savings in long term conditions management it will be undertaken in all three financial scenarios. In 2010/11 we will invest an additional £500K recurrently to support the redesign of the team. The existing budget for the teams being redesigned is £19.6M, this will be used to fund re-provision of the service.

### 13. Delivering outpatient care in Polysystems

<table>
<thead>
<tr>
<th>Lead director: Robert Moore</th>
<th>Programme: Productivity</th>
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</table>
**What does the initiative involve?**
- The four Polysystems will accommodate and support the delivery of the majority of first and follow-up outpatient clinics. Healthcare for London (HfL) recommends that 40%–60% of London’s outpatient appointments could be delivered within the community at a lower cost setting
- NHS Newham aims to shift over 65% of its outpatients to the Polysystems and will work with local clinicians to agree this process, in the first 2 years we will shift the top 11, by volume, outpatient specialities
- Developing four Polysystem hubs to provide outpatient care

**What QIPP benefits will we see?**
- People will be able to access care closer to home and receive at least as good care as in the acute sector
- We will reduce the unit costs overall by an average of 30%
- We should prevent unnecessary follow-up activity

**What are the effects of the transformation?**
For first outpatients: 50% new setting, 20% primary care, 30% remain in acute
For follow up 20% decommissioned

Of the remaining: 60% shifted, 20% primary care, 20% remain
- In 2011/12 we will shift 75,214 OPAs (including maternity care)
- In 2012/13 we will shift an additional 30,086 OPAs
- In 2013/14 we will shift an additional 29,183 OPAs
- In 2014/15 we will shift an additional 15,043 OPAs
Base case: As this initiative is linked to cost savings in shifting outpatient care it will be undertaken in all three financial scenarios. Additional non-recurrent transitional costs associated with this initiative are an investment of £4,467K in 2011/12 and £1,211K in 2013/14.

Down side: As this initiative is linked to cost savings in shifting outpatient care it will be undertaken in all three financial scenarios. Additional non-recurrent transitional costs associated with this initiative are an investment of £4,467K in 2011/12 and £1,211K in 2013/14.

Upside: As this initiative is linked to cost savings in shifting outpatient care it will be undertaken in all three financial scenarios. Additional non-recurrent transitional costs associated with this initiative are an investment of £4,467K in 2011/12 and £1,211K in 2013/14.

### 14. Child obesity management

- **Lead director:** David Cryer
- **Programme:** Prevention

**What does the initiative involve?**
- Running a pilot programme during 2010 in two primary schools and one nursery, with matched control schools.
- Extending programme from autumn term 2010, targeting highest risk schools.
- Offering 1:1 family weight management to families with overweight and obese children, using evidence based behavioural change techniques, setting short and longer term health behavioural change goals. Regular support and follow-up for 1 year.

**What QIPP benefits will we see?**
- Long term reductions in child obesity and related complications including diabetes and heart disease.
- This addresses a significant area of unmet need.

**What are the effects of the transformation?**
- Reduced child consultations, treatments and admissions for diseases associated with obesity.

**Base case:** In 2010/11 we will invest £170K recurrently, in 2011/12 this will increase to £230K recurrently.

**Down side:** In 2010/11 we will invest £170K recurrently, in 2011/12 this will increase to £230K recurrently.

**Upside:** In 2010/11 we will invest £170K recurrently, in 2011/12 this will increase to £230K recurrently.

### 15. Improving productivity in primary care services

- **Lead director:** Robert Moore
- **Programme:** Productivity

**What does the initiative involve?**
- We will work with our primary care providers to challenge productivity. We know that we have to see a demonstrable improvement in primary care productivity given the challenging financial environment.
- We will decommission services of limited value or productivity, for example, the Access Diversion Scheme. A review of this scheme highlighted under-usage at both provider sites. Therefore by decommissioning this scheme, to re-invest the budget in another access initiative to drive up productivity, and more importantly improve patient satisfaction in accessing GP services, as we are currently failing on these Vital Signs indicators.
- We will review the Extended Hours LES to ensure that we commission services that demonstrate value for money, specifically introducing measures to increase usage of the service and reduce the numbers of DNAs.
- We will support GP practices to develop their list sizes to a minimum of 6000 registered patients however list cleansing will become a regular exercise to ensure 'clean' patient lists. Over the next 5 years, and as per the CSP, NHS Newham plans to undertake regular list cleansing activities as our registered population of approximately 344,400 already exceeds our ONS population of 252,000, and it is anticipated our population will grow considerably over the next few years. NHS Newham plans to undertake 2 cleansing exercises in 2010/11.
- We will review all our Local Enhanced Services: Ensuring that the specification for each of the LESs aren't provided anywhere else in the...
contract (i.e. the PCT paying twice, if for example, the specification almost matches QOF indictors); Benchmarking the cost of the LESs against similar LESs offered elsewhere in London/England; and if appropriate, decommission the respective LES(s). The key principle abiding the review of all our LESs is to ensure that we are commissioning services which will provide demonstrable and measurable health outcomes, thereby reducing health inequalities. These services should be provided by suitably qualified clinicians and at times suitable to patients.

- We will review our PMS Agreements to ensure that we commission services that demonstrate added value when compared to the baseline GMS contract. We aim to achieve this by:
  - Implementing a new contract;
  - Negotiating new PMS objectives aligned to our CSP.
- By focussing on a range of core objectives, linked to our CSP, which are more challenging than the standard GMS contract, we aim to improve the management of LTC within a primary care setting and increase uptake to screening services. Therefore, improving the health of people living with LTCs and reducing the number of deaths due to cancer (specifically, cervical, breast and bowel).
- New GP services will be procured on time-limited APMS contracts in order to develop measurable KPIs within a robust management framework.
- We will support our primary care providers to develop their skills, utilising a range of approaches in order to facilitate a sound primary care infrastructure to develop and delivery services via a Polysystem.

What QIPP benefits will we see?

- Practices will improve quality through achievement of QOF and quality based KPIs.
- Ensuring that contracts reflect service provision will promote productivity through appropriate monitoring.
- Ensuring that contracts promote delivery against current needs should improve productivity, specifically in relation to growth monies & refocus on what growth monies are being used for.
- Practices will be expected to agree with the PCT a minimum number of appointments per 1000 patients
- Where quality or productivity issues are identified remedial plans will be developed
- The new service specification / contract will define new appropriate and increased productivity for the same value.
- More appropriate use of current resources

What are the effects of the transformation Service

- Transformation of the primary care landscape to larger GP practices
- Better quality care
- Rewards for the best performing

Financial

- These will be managed within the existing resource

Base case: As this initiative is linked to cost savings it will be undertaken in all three financial scenarios. There is a non-recurrent investment in each year between 2010/11 and 2012/13. Recurrent savings of £998K, £948K and £901K in 2011/12, 2012/13, 2013/14 will be realised. A three year non-recurrent investment of £150K will be made in 2010/11, 2011/12 and 2012/13

Down side: As this initiative is linked to cost savings it will be undertaken in all three financial scenarios. There is a non-recurrent investment in each year between 2010/11 and 2012/13. Recurrent savings of £998K, £948K and £901K in 2011/12, 2012/13, 2013/14 will be realised. A three year non-recurrent investment of £150K will be made in 2010/11, 2011/12 and 2012/13

Upside: As this initiative is linked to cost savings it will be undertaken in all three financial scenarios. There is a non-recurrent investment in each year between 2010/11 and 2012/13. Recurrent savings of £998K, £948K and £901K in 2011/12, 2012/13, 2013/14 will be realised. A three year
non-recurrent investment of £150K will be made in 2010/11, 2011/12 and 2012/13

What does the initiative involve?
- Creation of a multidisciplinary team that is consultant led and GP championed
- Intermediate diabetes team will facilitate and support Tier 1 and Tier 2 practices to enable provision of essential and extended care, and provision of Tier 3 care in community based settings.
- The team will support development of high quality primary care services, acting as trainers and facilitators, ensuring ongoing accreditation of primary care providers, managing complex cases that do not need to be seen in an acute setting, and providing a mechanism for outpatient care from the acute sector to community and primary care settings.

What QIPP benefits will we see?
- Increased life expectancy
- Improved quality of life
- Reduction in emergency and inpatient service use
- Reduction in long term recurring, intervention
- Reduction in cost of advanced complications
- Reduction in acute emergency admissions
- Reduction in 1st and FUP activity

What are the effects of the transformation?
- Increase to 70% for patients with diabetes in whom the last HbA1C is 7.5 or less in the previous 15 months
- 50% reduction in emergency admissions with primary care diagnosis of diabetes by 2012
- 20% reduction in amputation rates by 2012
- 50% reduction in non-elective admissions with primary diagnosis of diabetes by 2012
- 50% reduction in CVD events by 2012
- Reduction in mortality rate to 70 per 100,000 by 2015

Base case: An additional £472K recurrent funding in 2010/11 will be invested
Down side: An additional £472K recurrent funding in 2010/11 will be invested
Upside: An additional £472K recurrent funding in 2010/11 will be invested

17. NHS health checks  | Lead director: Rachel Flowers  | Programme: Long term conditions
What does the initiative involve?
- Developing the existing vascular risk assessment service to deliver health checks to target populations
- Engaging with public, patients and community partners to deliver preventative and health improvement services across a wide range of environments
- Systematically assessing the target population to manage and reduce risk of cardiovascular disease
- Using point of care testing services during the assessment and supporting the outcome with a range of interventions suited to reduce and manage individual risk. These services will include ‘motivating behaviour change’ programmes which will offer support to stop smoking, promoting physical exercise as part of the physical activity pathway, weight management and treatment for identified conditions where these have been diagnosed

What QIPP benefits will we see?

What are the effects of the
- Increased numbers of diabetics identified. These people will be identified earlier in the disease pathway and can thus be managed more effectively
- Increased numbers of people with impaired glucose tolerance who can be actively managed to improve health outcomes
- Increased numbers of people who choose to stop smoking
- Increased statin and anti-hypertensive prescribing to manage those people identified with CVD-related conditions
- Reduced numbers of stroke and heart attacks
- Using the national modelling tool with local demand and prevalence rates – activity per annum per 15,000 checks undertaken:
  - Smoking cessation referrals: 417
  - Brief exercise discussion: 8,043
  - Obesity referrals for intensive support: 2,689
  - CKD diagnosis: 448
  - Anti-hypertensive prescriptions (pts): 2029
  - Statin prescriptions (new): 1,205
  - IGT diagnosis: 533

18. Strategic Regeneration Framework

<table>
<thead>
<tr>
<th>Lead director: David Cryer</th>
<th>Programme: Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description of initiative:</strong></td>
<td>The Strategic Regeneration Framework brings together the regeneration of the physical area of the host boroughs and the socio-economic regeneration of the communities who live within it. Because these are the most deprived communities in England the SRF has as its organising principle that over a 20 year period conditions for the people who live in the host boroughs will improve to the point where they can enjoy the same social and economic conditions as Londoners as a whole. This is the principle of convergence. The SRF has been approved as a basis for the legacy regeneration of the host boroughs by the Secretary of State for Communities, the Minister for the Olympics, the Mayor of London and the Mayors and Leaders of the host boroughs. That approval extends to the agreement of the inclusion of the principle of convergence in the relevant planning and policy development of local and regional government and the relevant activities of national government and the active support of officials at all levels to assist in SRF implementation.</td>
</tr>
<tr>
<td><strong>The SRF will work by improving the co-ordination and delivery of socio-economic interventions linked to the Olympic Games legacy of physical transformation and raised aspiration. SRF will provide sub regional strategic leadership to address barriers to improvement and harness the opportunities available through the sub region’s improved connectivity, housing offer, public realm and economic growth. The Strategic Regeneration Framework needs to influence all aspects of the regeneration of the host boroughs sub region over a 20 year period. It therefore requires a flexible</strong></td>
<td></td>
</tr>
</tbody>
</table>
and iterative approach, combined with firm and determined objectives and clear outcomes for the community. It also needs a strong and continuing governance framework that can throughout the 20 years hold to account all those responsible for the delivery of SRF.

The added value of having the SRF is derived from three principal sources:

- Planning and delivery on a more strategic basis than previously
- Building links between traditionally separate programme areas, such as health and housing, where an integrated approach offers significant net gains
- Getting to grips with opportunities which hitherto have lacked a clear champion to take them forward

<table>
<thead>
<tr>
<th>What QIPP benefits will we see?</th>
<th>What are the effects of the transformation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each action plan for the SRF will be robust and fully costed</td>
<td>NHS Newham will be an effective partner in leading and driving forward the SRF</td>
</tr>
<tr>
<td>Individual and cumulative initiatives as set out in the SRF could have a transformational impact. For example, if there is a significant shift from custody to treatment in relation to drugs, there will be individual quality of life impacts, and community quality of life impacts due to reduced re-offending and drug-related violent crime</td>
<td></td>
</tr>
</tbody>
</table>

Base case: An additional recurrent investment of £36K will be invested in 2010/11

Down side: An additional recurrent investment of £36K will be invested in 2010/11

Upside: An additional recurrent investment of £36K will be invested in 2010/11

19. Developing children and young people’s services in Newham

<table>
<thead>
<tr>
<th>What does the initiative involve?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing the Children’s Trust</td>
</tr>
<tr>
<td>Ensuring integrated working with children's centres and Polysystems</td>
</tr>
<tr>
<td>Developing work targeted at vulnerable young women: young girls in care, girls on the at risk register, homeless young women, young people in trouble with the law and so on, and young women in newly arrived communities including economic migrants</td>
</tr>
<tr>
<td>Social marketing campaigns aimed at the above, given the differences and barriers to accessing resources and services</td>
</tr>
<tr>
<td>Workforce development skills in agencies working with adolescents and vulnerable communities</td>
</tr>
<tr>
<td>Development of data systems</td>
</tr>
<tr>
<td>Piloting work in hotspots, ie North and South Canning Town, Forest Gate, Stratford and East Ham</td>
</tr>
<tr>
<td>Increased paediatric services in the community to prevent admission and facilitating early discharge and deliver community outpatients along planned and development pathways</td>
</tr>
<tr>
<td>Multidisciplinary assessment, case management and delivery teams to offer a rapid response and support care at home or closer to home for children and families with complex needs and disabilities</td>
</tr>
<tr>
<td>Focusing on prevention within school nursing and allied professions, working with parents, teachers and communities</td>
</tr>
<tr>
<td>Introducing an 11am–11pm GP led primary care team to triage paediatric attendees in A&amp;E</td>
</tr>
</tbody>
</table>

Lead director: Carol Hill

Programme: Personalisation
- Introducing clinical supervision to mentor and support project team, to deal with complaints and review quality of medical records and consultations
- Introducing patient flow co-ordinator to ensure appropriate movement of patients to clinician and to support the operation of the new patient pathway
- Audit manager to produce daily audit figures

<table>
<thead>
<tr>
<th>What QIPP benefits will we see?</th>
<th>What are the effects of the transformation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Services being commissioned by the Children’s Trust will be tailored to need</td>
<td>- Paediatric GP navigation within urgent care and A&amp;E</td>
</tr>
<tr>
<td>- Vulnerable children with unmet needs will have their needs met</td>
<td>- Fewer children being admitted</td>
</tr>
<tr>
<td>- Fewer unnecessary admissions</td>
<td>- Integrated children’s services as part of Polysystems</td>
</tr>
<tr>
<td>- This service will expect to see up to 33 patients a day, reducing A&amp;E attendances</td>
<td>- New services developed for vulnerable children</td>
</tr>
<tr>
<td>- This will reduce exiting costs</td>
<td></td>
</tr>
</tbody>
</table>

Base case: This initiative is cost saving and will deliver recurrent savings of £574K from 2010/11
Down side: This initiative is cost saving and will deliver recurrent savings of £574K from 2010/11
Upside: This initiative is cost saving and will deliver recurrent savings of £574K from 2010/11

20. Newham alcohol harm reduction programme

<table>
<thead>
<tr>
<th>Lead director: David Cryer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme: Prevention</td>
</tr>
</tbody>
</table>

- What does the initiative involve?
  This programme of work seeks to reduce alcohol-related harm in Newham. The indicator, “VSC26 Rate of alcohol-related hospital admissions” is the key performance indicator of alcohol-related harm. It will implement the following services and changes:
  - Alcohol Directed Enhanced Service in primary care settings
  - Early identification and intervention
  - Workforce development
  - Specialist community based treatment
  - Specialist residential rehabilitation
  - ED and ward based alcohol interventions
  - Communication and educational messages about safer drinking

- What QIPP benefits will we see?
  - It is anticipated that the quality of alcohol interventions will be improved through providers being required to demonstrate and evidence innovation and creativity in responding to patients’/service users’ needs in a cost-effective fashion
  - Improved care pathways
  - As the numbers of problematic drinkers are diverted from the acute setting, staff will have free

- What are the effects of the transformation?
  - Increased numbers of patients being diverted from the acute setting
  - Increased numbers in specialist
| capacity to treat individuals whose primary reason for presentation to acute is not related to alcohol | treatment following identification and referral from primary care |
| increased numbers accessing community based treatment |

| **Base case** | We will invest £499K recurrently in 2010/11 with an additional; £5K recurrently in 2011/12, £20K in 2012/13 and £20K in 2013/14 |
| **Down side** | We will invest £499K recurrently in 2010/11 with an additional; £5K recurrently in 2011/12, £20K in 2012/13 and £20K in 2013/14 |
| **Upside** | We will invest £499K recurrently in 2010/11 with an additional; £5K recurrently in 2011/12, £20K in 2012/13 and £20K in 2013/14 |

<table>
<thead>
<tr>
<th><strong>21. Olympic Polyclinic</strong></th>
<th><strong>Lead director:</strong> Charles McNair</th>
<th><strong>Programme:</strong> Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What does the initiative involve?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Construction of a facility for the 2012 Olympic and Paralympic Games to provide health services for the athletes – to be handed over to NHS Newham for the delivery of services in legacy phase 2013 to ensure additional population growth can be seen in community setting to deliver financial balance</td>
<td></td>
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<tr>
<td>• Incorporation of Olympic Polyclinic to become hub for North West Polysystem by 2013 to deliver services for the projected population growth modelled using the NHS London commissioning and finance model</td>
<td></td>
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</tr>
<tr>
<td>• In addition to the project management of the building, key issues for development prior to handover include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Ensuring transformational service model put in place for provision of community based services</td>
<td></td>
<td></td>
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<tr>
<td>▪ Agreeing approach to multidisciplinary workforce training within facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Ensuring commissioning and procurement structure put in place for range of services within the building</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Ensuring benefits of shared occupancy with Community Development Trust realised</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What QIPP benefits will we see?</strong></td>
<td></td>
<td><strong>What are the effects of the transformation?</strong></td>
</tr>
<tr>
<td>• Services will be delivered in a fit for purpose building</td>
<td>• We will have a building capable of meeting the population growth expected to occur after the Olympics</td>
<td></td>
</tr>
<tr>
<td>• A range of services will be available under one roof</td>
<td>• We will have a purpose-built building to deliver health and social care within Newham</td>
<td></td>
</tr>
<tr>
<td>• Health and social care will be delivered in the same building</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All shifts are included within the outpatient activity shifts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Base case:** This initiative is cost neutral to the PCT until 2013/14 when the building becomes operational, savings from outpatient and urgent care savings are reflected in other initiatives and the building works are being funded by £16.4M capital investment through DH from 2013/14 we incur recurrent capital charges of £150K |
| **Down side:** This initiative is cost neutral to the PCT until 2013/14 when the building becomes operational, savings from outpatient and urgent care savings are reflected in other initiatives and the building works are being funded by £16.4M capital investment through DH from 2013/14 we incur recurrent capital charges of £150K |
| **Upside:** This initiative is cost neutral to the PCT until 2013/14 when the building becomes operational, savings from outpatient and urgent care savings are reflected in other initiatives and the building works are being funded by £16.4M capital investment through DH from 2013/14 we incur recurrent capital charges of £150K |
### Developing children and young peoples services in Newham
- NHS Health checks
  - Implement stringent performance management Performance manage poor providers
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Intermediate diabetes service
  - Review and redesign existing service
  - Align services and embed within Polysystems
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Decommissioning services of limited clinical value
  - Identify existing commissioned services of limited clinical value
  - Decommission services
  - Completed
- Improving productivity in primary care services
  - Complete PMS review and review DES
  - Review and redesign PSU, TPCT, ADS
  - Procure CDS and dental service
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Olympic Polyclinic
  - Commence building work
  - Complete building work
  - Revisit building for use post Olympics and Paralympics
  - Open Polyclinic
  - All planned activity delivered
  - Completed
- Agreed key areas to provide tests
  - Begin testing
  - Design referral pathways
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- NHS Health checks
  - Implement stringent performance management Performance manage poor providers
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Agree key areas to provide tests
  - Begin testing
  - Design referral pathways
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Developing dementia services
  - Proceed emergency admission avoidance service
  - Develop and embed Children's trust
  - Integrate Children's services and Polysystems
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Developing children and young peoples services in Newham
  - Develop local strategy and embed training
  - Commission liaison support and information
  - Benchmark progress
  - Introduce LES with 25% coverage
  - Redesign service
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- End of life care
  - Commission new service
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Commission liaison support and information
  - Benchmark progress
  - Introduce LES with 25% coverage
  - Redesign service
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Establish and run pilot project
  - Extend project after pilot
  - Develop family weight management services
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Child obesity management
  - Recruit team to support SNR
  - Enable team to work on SNR
  - Review and redesign alcohol DES in primary care
  - Develop workforce
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Strategic regeneration framework
  - Review and redesign alcohol DES in primary care
  - Develop workforce
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Newham alcohol reduction programme
  - Review and redesign alcohol DES in primary care
  - Develop workforce
  - Monitoring and review
  - Monitoring and review and evaluation
  - Completed
- Monitoring and review
  - All planned activity delivered
  - Completed
  - Monitoring and review
  - All planned activity delivered
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  - Monitoring and review
  - All planned activity delivered
  - Completed
  - Monitoring and review
  - All planned activity delivered
  - Completed
  - Monitoring and review
  - All planned activity delivered
  - Completed

### Our timeline for transformation (base case)

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>Commence building work</td>
</tr>
<tr>
<td>2011/12</td>
<td>Complete building work</td>
</tr>
<tr>
<td>2012/13</td>
<td>Refit building for use post Olympics and Paralympics</td>
</tr>
<tr>
<td>2013/14</td>
<td>All planned activity delivered</td>
</tr>
<tr>
<td>2014/15</td>
<td>Completed</td>
</tr>
</tbody>
</table>
Our timeline for transformation (base case)

<table>
<thead>
<tr>
<th>Activity</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing health inequalities experienced by people with learning disabilities</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Healthy eating</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Delivering effective community based sexual health services</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Improving the early diagnosis of Cancer</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Delivering primary and community mental health services</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Reducing health inequalities experienced by people with learning disabilities</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Developing urgent care within Polysystems</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Developing maternity services</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Polysystem health and social care case management teams</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
<tr>
<td>Delivering inpatient care in Polysystems</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
<td>Development of service specification and procure</td>
</tr>
</tbody>
</table>

Monitoring and review and evaluation

Complete
5 Delivery: delivering and enabling the transformation

5.1 Enabling strategies

5.1.1 Developing programmes to deliver transformation

Building on our successful introduction of our PMO and programme approach we will develop five programmes alongside our WCC/OD programme to support delivery of the targets and milestones identified. The table below describes how we will organise our programmes to deliver the initiatives:

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Long Term Conditions</th>
<th>Productivity</th>
<th>Personalisation</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Strategic Regeneration Framework</td>
<td>Improving the early diagnosis of Cancer</td>
<td>Delivering outpatient care in Polysystems</td>
<td>Developing maternity services</td>
<td>Olympic Polyclinic (as initiative)</td>
</tr>
<tr>
<td>2 Child obesity management</td>
<td>Intermediate diabetes service</td>
<td>Improving productivity in primary care services</td>
<td>Reducing health inequalities experienced by people with learning disabilities</td>
<td>IM &amp; T (as enabler)</td>
</tr>
<tr>
<td>3 Let’s get moving and physical activity social marketing</td>
<td>Developing integrated health and social care teams in 4 Polysystems for rehab/enablement, LTCs and end of life care</td>
<td>Decommissioning services of limited clinical value</td>
<td>Developing primary and community mental health services</td>
<td>Estates (as enabler)</td>
</tr>
<tr>
<td>4 Healthy Eating</td>
<td>NHS health checks</td>
<td>Developing urgent and unscheduled care</td>
<td>End of Life Care</td>
<td>Workforce (as enabler)</td>
</tr>
<tr>
<td>5 Newham alcohol harm reduction programme</td>
<td>Developing dementia services</td>
<td>Tariffs &amp; standard care packages (with the sector)</td>
<td>Developing children &amp; young people’s services in Newham</td>
<td>Performance &amp; Quality (as enabler)</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>Delivering effective community based sexual health services</td>
<td>Modeling (as enabler)</td>
</tr>
</tbody>
</table>
Each programme will have a lead director and a programme leader. We will use the talent management approach outlined on our OD plan to identify programme and work stream leaders.

5.1.2 Workforce

5.1.2.1 Developing our workforce

As we develop as a World Class Commissioning organisation, we must plan carefully for how we will ensure that we have the competencies and leadership to drive through our transformation agenda in a challenging financial climate. To do this we have three areas that we will concentrate upon:

- Ensuring the organisation has the leadership capacity and capability to deliver the transformational changes NHS Newham wishes to make
- To further develop NHS Newham as an employer of choice
- Ensure NHS Newham develops a matrix working approach

We have already put in place a number of processes and supporting pieces of work to enable our workforce; this has included:

- In order to improve the competency base of the organisation to deliver its goals NHS Newham held assessment and development sessions for a number of its senior staff
- We have refreshed our approach to performance review, objective setting and learning and development in support of the CSP, World Class Commissioning competency and programme management approach.

In order to develop competency from its baseline status, NHS Newham has taken opportunity to use competency and skills development programmes for staff in the following areas:

- Commercial skills development (through Commissioning Support for London)
- Workforce transformation (NHS London)
- Effective writing (Commissioning Support for London)
- Coaching skills for quality improvement (Improvement Foundation)
- King’s Fund leadership development programme

Our organisation development plan outlines the steps we will take to support our workforce to become World Class Commissioners.

5.1.2.2 Supporting our providers to develop their workforce

Our ability to deliver this transformation is dependent upon a provider landscape capable of transforming at a rapid pace of change. We will need to work closely with our existing providers to develop comprehensive workforce development plans that will enable them to flex their existing resources. Alongside this we need to identify and work with new providers, especially in our well developed third sector to create a supply chain that uses local people and new skills to deliver new models of care.

5.1.3 Estates

NHS Newham faces a number of challenges in respect of primary and community services estate.

The LIFT programme has made a massive improvement in the quality of our own estate and the primary care environment in recent years. However, there are a number of premises that remain on the primary care portfolio that do not meet the minimum standards required of the primary care costs directions and fall well short of modern acceptable standards.
We have a responsibility to ensure that the services are commissioned from fit for purpose buildings. As part of the Transforming Community Services and GP reclassification project, provider buildings are being assessed to help commissioners with the decision whether to provide services from those buildings or decommission services from poor premises. Our own buildings are included in this. This will be used as an important lever in improving the quality of primary care.

The six facet survey that was conducted in 2004 is being refreshed and expanded. It will now include utilisation, environment and sustainability, and infection control.

Previous surveys gave us indications to the sort of problems facing our primary care and community services estate. These include:

- Compliance with DDA requirements
- Backlog maintenance
- Poor functionality and estate that is not fit for purpose.

Early findings from this refreshed survey of our owned or leased clinical space shows a poor use of clinical space. During core hours (Monday to Friday, 9am to 5pm), the average use of clinical rooms during October was 30%.

There have been some big improvements in access to primary care in recent months with practices opening for longer during core hours, and some into evening and weekends. There has been little evidence to demonstrate this across the primary care spectrum and with our other community based services, and the above is based upon core hour use.

The recent GP survey results suggested that patients would like to see practices open more in evenings and on Saturdays. Providing wider opening hours access would enable us to gain 20% more room availability, but the usage figures would not warrant extending these hours across all buildings. It does demonstrate that clinics would need to be reconfigured to ensure better usage within a smaller number of our premises.

Our estates plan is not about building new buildings. The value locked up in existing healthcare estate is considerable, and better use of that estate is seen as key to the delivery of Polysystems and efficiencies targeted towards patient care.
5.1.3.1 Assessing the estate

In addition to our refresh of the six facet survey our LIFT Co partner is undertaking as assessments of other public sector properties, ie Newham University Hospital Trust and the London Borough of Newham.

5.1.3.2 Commissioner investment asset management strategy (CIAMS)

NHS Newham will collate the information from these surveys using the CIAMS toolkit, developed by the Department of Health. The toolkit allows for basic information to be captured so that commissioners can identify opportunities, constraints, or gaps. The toolkit will capture information relating to:

- Functionality
- Statutory compliance
- Utilisation
- Patient safety and infection control
- Condition
- Investment costs
- Sustainability
- Patient opinion

The aim of the toolkit is to provide a high level snapshot of where services are being provided, whether the property is appropriate for that use, whether the premises have space to accommodate other services, and whether investment is required to bring the premises up to standard.

5.1.3.3 GP reclassification

NHS Newham is working with a property management specialist, the London LMC, and the National Patient Safety Advisory Service to deliver a classification model that will provide up to date information about general practice estate.

To ensure equity, our buildings have been included in this work. This is partly to ensure that there is a measurement of poor building condition, but also to reflect where investment has raised the bar on estate provision, eg the Centre and Vicarage Lane. The reclassification exercise will measure the same categories as the CIAMS work in order to ensure consistency, but it will be in a more mature form. The surveys are being conducted throughout November and December. The model will be available in January/February 2010.

5.1.3.4 Utilisation

Utilisation and appropriate use of space is a major issue for both commissioning and provider services. With more outpatient activity dispersed from a centralised to a localised model the use of estate across the healthcare sector will be high on the agenda over the next couple of years.

NHS Newham has a responsibility to ensure that it is getting value for money from the use of space and that services are located in the places that our patients need them, and that required investment in facility condition has resulted in more effective use of space.

The assessment of utilisation has been prioritised to ensure that it focuses more on services and premises where there is most influence:

1. NHS Newham's estate
2. GP premises
3. Dental premises
4. Other provider premises.

The results of the utilisation study will inform discussions with a range of providers including General Practice and the Provider Arm of NHS Newham. These discussions will focus on:
- Describing gaps in the effective use of existing space;
- Exploiting opportunities to increase utilisation through rationalisation of service provision, and increased provision in community facilities;
- Identifying enhancements to existing facilities which would result in increased utilisation;
- Opportunities for disposal of facilities.

These discussions will be tied into commissioning negotiations including setting targets for utilisation and productivity improvements, whilst recognising the financial impact of access requirements on providers in the management of distribution of services. NHS Newham acknowledges the requirement for it to behave as a “good” landlord, where the PCT own facilities from which services are provided. This process will also aid us in our discussions with those providers who are in poor facilities and who require support to identify alternative solutions for the provision of services to patients.

5.1.3.5 *Ways of working*

NHS Newham will develop new methods of working through innovation to enable effective use of space and cost-effective delivery of services. A good example of this is the digitisation of paper records. This provides space savings and allows for more efficient filing systems with faster and safer referrals of information between health professionals.

NHS Newham will be more innovative in the way it accommodates its services. The cost of providing medical space is high in comparison with other building types, but we traditionally house administration, management, and domiciliary and school nursing services within healthcare buildings. This will form another critical element in our discussions with providers, helping both parties see improvements in cost-effectiveness and productivity.

5.1.3.6 *Investment in estates*

NHS Newham has opportunities to invest in premises through capital allocation, primary care investment funds and through revenue streams. Improving our knowledge of the estate, particularly with regard to usage, and planning our development of services will result in savings via:
- reduction in capital charges via disposal of property;
- reduced rent reimbursement on space not being used for care delivery;
- reduced facilities management costs on unused space;
- reduced maintenance through improved quality of buildings.

Investment in future will be targeted at:
- ensuring compliance with statutory and health and safety requirements;
- enablement works to improve utilisation;
- environment and environmental improvements, eg achieving sustainability targets;
- enablers to productive use of space, eg ICT.

The process will include the inclusion of targets for investment, eg achieving 80% usage of clinical space, achieving categories 1 and 2 in quality standards for accommodation.
5.1.3.7 Capturing the outputs

The outputs of all this work will be captured in the three components of the TCS estates strategy:

- A decommissioning plan – to map out exactly when premises will be decommissioned so that investment can be redirected into alternative premises. This is particularly relevant to our own property, but is also relevant to other providers’ premises, where we should not commission services or provide rent reimbursement because of poor premises. It will clearly spell out which premises are not economically viable for improvement. It will give clear signals to commissioners and providers alike about securing alternative accommodation before decommissioning.
- A premises development plan – a clear plan will be developed describing the improvement of the existing estate where deemed appropriate. The development plan will prioritise investment as outlined above. The primary care improvement programme budget will continue to support GPs in the improvement of their estate.
- Strategic services development plan – this is being developed with our LIFT Co partners and will identify gaps in future building provision. It will outline potential new build capital investment programme.

The implementation of the three plans will be managed to deliver the future capacity and commissioning requirements, and to deliver efficient use of the healthcare sector estate.

5.2 CSP and Communications

Community ownership of health sits at the heart of the way we approach the commissioning of world class services. So it goes without saying that communications and engagement have a key role to play in the delivery of our Commissioning Strategic Plan (CSP).

Our communications and engagement plan focuses on a set of objectives that will support the achievement of our shared vision and priority outcomes as expressed in the CSP, and the World Class Commissioning core competencies. Some of these also support the delivery of our organisational development plan.

Our communications plan is evidence based – the objectives reflect findings of national and local surveys, and qualitative engagement work, and data that are drawn from our Joint Strategic Needs Assessment.

It shows how we will take a sector-wide approach to communicating and engaging around issues that we have in common with neighbouring organisations, such as the Olympics and the Health for NEL consultation.

The objectives set out in the plan focus on:

- Health improvement: social marketing around priority issues identified in the CSP, and healthier living support in diverse community settings
- Enabling all sections of the community to engage with services, and putting patient experience at the heart of service development
- Strategic engagement with and involvement of partners, stakeholders and clinicians
- Enabling staff to fulfil their roles in the context of World Class Commissioning and to act as advocates
- Promoting and sustaining the NHS brand and values
- Reputation management
For each objective we have outlined the actions we are taking, and set out where we are aiming to be a year from now. Detailed action plans will be produced for the work programmes identified for each objective.

The Newham Health Debate is a key component of our communication and engagement plan. We have developed a vision where:

- Local people are enabled to improve their own health, through advice, support and activities that are offered within their communities
- People have choices about how they access services
- Support for health improvement and traditional health services are delivered in a way that focuses on individual need, not provider convenience
- The focus on individual need extends to the way all local services are provided
- All but the most specialised, intensive health services are delivered in modern convenient community facilities
- Local people are able to influence and engage with every step of service planning and development.

5.3 Our plans for market development

The future provider landscape within Newham will:

- promote patient choice;
- actively innovate based on patient feedback and satisfaction, in order to maintain high quality services and proactively demonstrate a desire to continually improve;
- provide value for money and affordable services which are free at the point of access for all patients;
- provide sustainability across all healthcare services;
- provide a high performance autonomous provider network;
- adopt a fair, level playing field which is accessible to a wide range of providers from all sectors;
- allow free competition where possible and appropriate (within limitations where key services cannot be permitted to fail);
- encompass providers from a range of sectors including the voluntary and independent sectors;
- display the identifiers of the free market (for example ‘natural’ movements in entries and exits);
- limit price variation between providers for the same service.

NHS London (Using Markets in System Management, 2009) has outlined a seven step approach to market management:
Over the last 12 months Newham has developed a detailed analysis and understanding of its provider landscape. This has been underpinned by a detailed sector-wide market analysis and segmentation model, which was tested against its community services. The Health for NEL programme has also been established and is designed to configure the landscape of acute providers, with quality, efficiency and patient choice as the key drivers for change. This has provided the local detail necessary to focus upon developing models for care closer to home, which are reflected within the procurement strategy.

There is also a sector-wide ‘strengthening commissioning’ programme which has a focus on primary care; each work stream has produced an action plan which will inform future market stimulation exercises, ie diabetes, access.

Newham has developed a Procurement strategy and procurement toolkit, which supports the assessment, stimulation and understanding of the market both locally and sector-wide.

Although the sector market analysis exercise is an essential part of understanding the wider provider landscape, Newham has also market tested a number of local services. The market segments have been reviewed and tested for the following reasons:

- A particular market segment was previously identified through the CSP process and it was necessary to build a sustainable system with more choice and accessibility to local services, e.g. developing new diabetes pathways and services through practice based commissioning (PBC).
- Commissioner intervention was necessary to deliver service improvement against local or national standards, ie vascular screening, retinal screening and community dental services.
- Market was stimulated as a result of likely future gaps as a result of population growth and need, making the system operate effectively.
- Commissioners have worked closely with providers and developed an in-depth understanding of the market segments and the future models required across four Polysystems.

The following table outlines the services we have market tested and the types of market interventions undertaken. The impact of all the market segmentation exercises has led to a greater understanding of available markets and commissioners have gained considerably more experience at understanding and assessing services and the markets they belong to.
### 5.3.1 Planned market stimulation activities

<table>
<thead>
<tr>
<th>Area of Activity</th>
<th>Description &amp; market stimulation exercise</th>
<th>Identification of procurement route</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Closer to Home</td>
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<tr>
<td>Planned Care</td>
<td>65% shift of current acute Outpatient activity (New &amp; Follow-up) shift into a Polysystem setting. 20 service areas identified based upon Health for NEL pathways.</td>
<td>Each Polysystem will select top four outpatient services to develop a business plan (reflecting the PCT CSP and Operating plan).</td>
</tr>
<tr>
<td>Urgent &amp; Unscheduled Care</td>
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<tr>
<td>Urgent Care Centre</td>
<td>Urgent care centre (below), Unscheduled care to be delivered from Polysystem hubs</td>
<td>Procurement plan to be identified for each Polysystem hub</td>
</tr>
<tr>
<td>Transforming Community Services</td>
<td>A 24 hour Primary Care Led Centre delivering Urgent Care Services on the existing A&amp;E site at NUHT. The centre will provide a GP practice and a single entry navigation system to both the Urgent Care Centre and Accident and Emergency Department. Procurement route to be identified, compete dialogue</td>
<td>April 2010 Service specification completed Procurement plan details timetable and identification of preferred route for procurement</td>
</tr>
<tr>
<td>Long term Conditions</td>
<td>Improve market knowledge and identify current market segments to review Pathway reviews and development-integrated model care of in line TCS, Putting People first and Polysystem agendas.</td>
<td>Workstreams set up to identify new service specifications and appropriate procurement routes. New contracts will be outcome focused and specify packages of care rather than service lines.</td>
</tr>
<tr>
<td>Rehabilitation &amp; Intermediate Care</td>
<td>Work with current market segments to identify establish new service specifications</td>
<td>New contracts will determine procurement route</td>
</tr>
<tr>
<td>Developing children and young people’s services</td>
<td>Develop children’s trust model across Polysystems</td>
<td>Procure emergency admission avoidance service. Procurement route to be agreed</td>
</tr>
<tr>
<td>Developing Dementia Services</td>
<td>Identify current market segments to develop local strategy for delivering integrated models of care</td>
<td>Procurement route to be identified</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>Working with current market segments to provide 4 maternity centres (across Polysystems)</td>
<td>Open procurement route</td>
</tr>
<tr>
<td>Mental Health Service</td>
<td>Working with mental health market segments Market management exercise with user involvement and delivery service to encourage service user involvement and delivery service</td>
<td>Tender</td>
</tr>
<tr>
<td>Sexual Health Services</td>
<td>Market segments identified to design consistent primary care led</td>
<td>Local enhanced service to be procured to align with</td>
</tr>
<tr>
<td>End of life care</td>
<td>Pathway redesign for of end of life care delivered across Polysystems</td>
<td>Working group to assess procurement route where necessary</td>
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</table>

**Primary care**

<table>
<thead>
<tr>
<th>Olympic Polyclinic</th>
<th>PolyClinic services to be modelled in line with Transforming community services and delivery of services outside of Hospital</th>
<th>Business case approved by HfL Service planning in line with Polysystem modelling and delivery of Services Outside of Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Dental Services</td>
<td>Market analysis and stimulation exercise undertaken to understand variety of community dental services currently provided and types of provider within the market. New service specification and market analysis conducted</td>
<td>New service April 2010 Restricted procurement route PQQ stage – Dec 2010</td>
</tr>
<tr>
<td>Dental Access</td>
<td>Additional Dental contract using the new Personal dental Services plus agreement</td>
<td>Polysystem area to be identified. Restricted procurement route.</td>
</tr>
<tr>
<td>GP Practice</td>
<td>GMS Practice list within North East Polysystem identified for procurement process</td>
<td>Restricted Procurement route</td>
</tr>
<tr>
<td>Dental Access Programme</td>
<td>Procurement of dental services</td>
<td>Pending</td>
</tr>
</tbody>
</table>

More details of the planned procurements can be found in the procurement strategy

**5.4 Delivery risks**

The key risks are:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Likelihood</th>
<th>Mitigation</th>
<th>Financial risk</th>
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</thead>
<tbody>
<tr>
<td>The model assumes significant growth in population during the planning period. If the population of Newham grows at an even faster rate, this will place even further burden (and cost to the PCT) of commissioned services.</td>
<td>25%</td>
<td>We have modeled GLA low and high growth to identify the scale of the problem and the impact will increase growth by 1.5</td>
<td>A 1.5% additional increase during the planning period will generate a further cost pressure, which will be activity driven, of £5m.</td>
</tr>
<tr>
<td>The plan requires the delivery of significant savings to be generated from service transformation. Our internal model is based on the NHS London Polysystem model. It is in line with NHS London’s methodology, but remains untested until the year 2014.</td>
<td>25%</td>
<td>Services are redesigned and in many cases opened up to competitive tendering processes to ensure the providers we work with want to support</td>
<td>A 10% shortfall on the transformation savings target will generate a financial shortfall of £4.2m.</td>
</tr>
<tr>
<td>Transformation Agenda is Underway</td>
<td>25%</td>
<td>To Develop Robust Transformation Plans in 2010/11 Based on Decommissioning (SACU) and Transformation (Polysystems Development)</td>
<td>A 50% Shortfall on 2010/11 Transformation Savings Equates to £2.8m. The Risk is to Investments in Initiatives.</td>
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<tr>
<td>Under all funding scenarios significant transformation savings are required in 2010/11 to deliver the required target surplus based on 1% of turnover. The risk of failure to reach this target, potentially jeopardises investment in the initiatives described in this document in 2010/11</td>
<td>25%</td>
<td>Detailed Review and Challenge Both Internally and with Our Providers Will Be Carried Out During the Next Few Weeks Ahead of Publication of the Annual Operating Plan.</td>
<td>The Additional Savings Required Under the Downside Scenario in 2011/12 and 2012/13 (Over Base Case) is £16.3m. 20% Deferment Equates to £3.3m.</td>
</tr>
<tr>
<td>The Pace of Change of the Transformation Agenda, Particularly under the Aggressive Scenario, Necessary to Match Savings Requirements under the Downside Model, is Ambitious and Requires More Detailed Scrutiny.</td>
<td>25%</td>
<td>Further Work, in Consultation with the Sector Acute Commissioning Unit and Our Acute Providers is Necessary to Ensure that These Assumptions are Realistic. Additionally We Have Introduced More Rigorous Claims Management, Which Will Need to be Reflected in Next Year’s SLA Plans</td>
<td>A 1% Shortfall Equates to £3m in 2010/11.</td>
</tr>
<tr>
<td>Following Detailed Negotiations with NUHT, Our Main Acute Provider, The PCT Will Be Seeking to Rebase the SLA in 2010/11, Based on the Detailed Work Carried Out Regarding Claims Management. There is Also an Assumption That Acute Activity Will Grow Next Year at 2.25%, Rather than the GLA Low Growth Projected Increase of 4.22%.</td>
<td>25%</td>
<td>Detailed Discussion with Our Providers Will Be Carried Out as Part of the Operating Plan Process. We Will Work with Providers to Support Their Transformation.</td>
<td>The Risk Is Estimated at £2.8m.</td>
</tr>
<tr>
<td>The Plan for 2010/11 Has Been Developed in Advance of SLA Negotiations with All Our Providers. Our Intentions May Not Match Those of Our Providers</td>
<td>15%</td>
<td>To Mitigate, Early Savings Have Been Identified and the Phasing of the Initiatives Will Support the Financial Savings Required</td>
<td>A 1% Increase in Inflation Would Cost the PCT Circa £5m.</td>
</tr>
<tr>
<td>Inflation May Be Different from the Assumptions Used in Our Financial Model. This Will Depend on the State of the Economy and Given Current Circumstances, That is Difficult to Predict.</td>
<td>25%</td>
<td>We Have Recruited Managers and Clinical Directors for Each of Our Polysystems to Support Primary Care to Increase Activity and Productivity</td>
<td>The Risk Has Been Quantified Earlier.</td>
</tr>
<tr>
<td>The Plan Is Predicated on Primary Care Delivering on Managing Greater Activity Away from Acute Settings. Should the Primary Care Providers Fail to Deliver This, It Will Increase the Pressure on the Acute Sector and Thereby on Costs.</td>
<td>50%</td>
<td>Underpinning the Transformation Plan Is a Need to Develop the Workforce in</td>
<td>Transformation Investment (Pump Priming) Has Been Built Into the</td>
</tr>
<tr>
<td>The Plan Requires, Alongside Primary Care, Community Health Services Managing a Significant Increase in Workload, Partly</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue</td>
<td>Probability</td>
<td>Description</td>
<td>Risk Mitigation</td>
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<tr>
<td>to be met from internal efficiencies and partly through growth.</td>
<td></td>
<td>both primary care and in community health services. Our OD plan identifies how we will work with providers to support this transformation. The acceleration of the transformation plan may require investment in 2010/11, of up to £1.5m.</td>
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</tr>
<tr>
<td>Our Polysystems and clinical commissioning may not develop at the pace we require. This will mean that we are unable to shift care closer to home at a lower cost</td>
<td>25%</td>
<td>To deliver care closer to home at a lower cost we have aligned PBC to Polysystems and have identified the phasing that is necessary to support the transformation. We have recruited managers and clinical directors for each of our Polysystems.</td>
<td>The risk has been quantified earlier</td>
</tr>
<tr>
<td>If our long term conditions management teams do not enhance health and social care case management we will not prevent hospital activity and increase costs</td>
<td>75%</td>
<td>The supporting initiative is within the first wave of service redesign. A redesign team will be used to support the transformation. The value of the LTC saving is £7.3m. A 20% shortfall equates to £1.5m.</td>
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</tr>
<tr>
<td>Introducing a community tariff to drive productivity may increase costs if we have not established the required activity and put in place the contractual levers to prevent excessive cost</td>
<td>50%</td>
<td>The baseline will be established, activity levels will be agreed. Demand management measures will be put on place contractually. The savings included to date are limited. A further 10% aligned with sector thinking would generate a further £5.7m over the planning period.</td>
<td></td>
</tr>
<tr>
<td>There may not be a workforce in place to support the new ways of working</td>
<td>50%</td>
<td>We will work with the voluntary sector to provide some of the workforce and work with our ELCA and LBN partners to identify effective OD solutions to this problem.</td>
<td>The OD plan may require further investment of £1.5m to deliver the required savings (non recurrently).</td>
</tr>
</tbody>
</table>
6 Declaration of Board approval

The Board has been involved in the strategic planning process that has led to the production of this plan, endorses the decision making process and approves this Strategic Commissioning Plan for Newham.