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1. Introduction

1.1. Foreword

A healthy future for all Redbridge residents

When we developed our initial five year plan last year, we didn’t come up with it on our own. We listened to and acted on what we had heard from a wide range of stakeholders. We hold firm to the vision that we all signed up to at that time. Improving the health of all residents, while closing the gap between those who experience the best and worst health outcomes drives everything we do.

This strategy sets out our plans for the next five years. Much has changed since last year, including the way community and hospital services are commissioned. All PCTs are now in year two on their road to becoming ‘world class’ commissioners. One of the first steps we needed to take was to transfer the adult community services we directly provided. Across London six sector chief executives were appointed and Heather is now one of these. The aim was to create acute commissioning units (ACU) for each, to strengthen commissioning from the hospital sector and deliver improved services for patients. The outer north east London (ONEL) ACU is hosted within our organisation and is making great strides in delivering improvements.

We have achieved a lot in the last 12 months. When we talked about polyclinics and polysystems¹ in our plan last year, they were still a relatively new idea to many people. Now that we have Loxford polyclinic open, residents have been able to see the benefits of the wider range of services available closer to home.

We said we would achieve 100% polysystem coverage in the borough and have done just that. Every person in Redbridge is now a member of a polysystem, and what’s more they can play an important role in determining the future services within it. We are planning four more polyclinics, which will sit as the ‘hub’ within their polysystems. The next one will be developed at King George hospital later this year and there will be another one opening each year after that.

Building on the success of the Loxford polyclinic community panel, we set up four more community panels for each polysystem. The Loxford panel played a critical role in providing the community voice throughout the development of the polyclinic. They were involved in tender panels for services such as a healthy community café and pharmacy, through to advising us on the right signage and publicity for the polyclinic. We hope that more people will join us and have a say in the development of services within their area.

Change will not be effective without clinicians in the driving seat. That’s why this year we recruited inspiring clinical leaders to head each polysystem. These GPs guide a strong collective of local health professionals who will lead the commissioning of health services within each polysystem, fully supported by us.

¹A polysystem is a network of integrated health services in a locality with a polyclinic at the hub, and GP surgery ‘spokes’. In Redbridge each serves approximately 50,000 people.
But there is more to do. Rather than a ‘light touch’ redrafting of our strategy we have taken the opportunity to reframe our approach. We explain the clear case for changing the way that services are provided and have summarised our plans for achieving this.

Several years ago a consultation for Londoners, based on then health minister Lord Darzi’s proposals, showed a real appetite for change amongst Londoners. Here in Redbridge we rose to the challenge. All London PCTs have been given a clear message from the authority that oversees PCTs (NHS London) that we all need to step up the pace of change.

A wholesale review of hospital services for the wider north east London area started in 2009. We believe that Redbridge residents deserve the best care, and hospital services currently fall short of their expectations. The details are summarised in this plan, but you can find out more by visiting the Health for north east London programme website.

Partnerships are strong in Redbridge and crucial if we are to achieve our vision. Strategic partners in Redbridge also have an overriding vision for a borough that by 2018 will be a safe and clean place, where people are proud to live, work and invest and a place that is caring, vibrant and healthy.

We know that people’s health is determined by a range of factors including their housing, education and local environment. Our strategic partners have an important role to play in supporting the sustainable community strategy ambition to ‘improve people’s health, care and wellbeing’. We equally accept that we have a wider part to play. Helping to develop the local economy, creating a greener and more sustainable borough and making the most of the opportunities the 2012 Olympic and Paralympic Games are also shared ambitions that we are working towards.

A recent assessment of public services in Redbridge – called a comprehensive area assessment – provided useful feedback about where partners collectively need to focus attention. We were also pleased to see Redbridge Council’s website receive a prestigious ‘green flag’ for innovation in communicating with residents. We are increasingly raising the profile of health services and encouraging debate about future developments on the site.

We are committed to working with our partners to achieve the best health outcomes for local people. This five year plan sets out how we intend to do this, and we hope you will join us to make our vision a reality.

Heather O’Meara,  
Chief Executive,  
NHS Redbridge  
and ONEL Sector

Edwin Doyle,  
Chair, NHS Redbridge

2Health for NEL http://www.healthfornel.nhs.uk/  
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2. Vision

2.1. Introduction

We have a clear vision to improve the health and wellbeing of the people of Redbridge while at the same time reducing health inequalities.

For us, improving the health of everyone in our borough is important. But we are also clear that the gap between people’s life expectancy in the most deprived and affluent parts of the community must be reduced. We didn’t develop this aspiration on our own. It was refined following discussions with the public, patients, clinicians and local partners such as Redbridge Council.

Last year we developed our ambitious strategy, which set out the roadmap for achieving this vision. We are now in year two. This chapter summarises how we came to agree and develop an innovative ‘Rich Picture’ vision. We also describe the goals and priorities that we need to focus on to realise it. Finally, we outline our organisation’s values which underpin everything we do.

“Creating the Rich Picture together has not only made me better understand how everything links together, but has brought us together as a cluster team with a common purpose and direction”

Debbie Cook, Nurse Practitioner, Rydal Practice Woodford
2.2. Picturing our vision

We wanted to develop something distinctive that could be owned, understood and remembered by our stakeholders. Our then senior committee of clinical representatives, the Professional Executive Committee (PEC), led the process to develop our Rich Picture. The picture visually describes the plans for the future of Redbridge health services and it appears overleaf. It has proved invaluable in explaining our vision at staff workshops, partner and community events over the past year.

The Rich Picture shows, in concentric circles, the levels of care that Redbridge residents will receive. It clearly demonstrates a patient-centred focus on health and wellbeing, with the majority of services available closer to home. Residents are encouraged to stay healthy through eating well, exercising and accessing information and support online or through ‘telecare’ provision. Services are primarily delivered through a polysystem of local GPs, pharmacies, social services and the voluntary sector. As the strategic delivery unit, the polysystem will enable us to make significant and tailored health improvements for the communities within them. The diagram demonstrates the clear pathways that enable people to get the support they need, rather than navigating the maze that some describe at the moment.

Where necessary, there is also a fast track procedure for patients to receive acute care, perhaps for a stroke or heart attack, in a specialist hospital environment. Some services now available in hospital will also be brought into the community. X rays, ultrasound scans, rehabilitation after a stroke or minor operations all feature at the local polyclinic, which sits at the heart of the polysystem.

The emphasis of the Rich Picture is to develop local, accessible community services. But there is also an emphasis on getting people to the right place, seeing the right professionals and at the right time to get the best quality care. Central to all of this is flexibility and quality for patients, with services that fit around their busy lives and expectations.

4Telecare - may include health advice phone systems and websites, equipment to enable blood pressure or glucose monitoring, medication reminder systems, falls’ sensors.

“Having conversations about the Rich Picture has made me realise that the vision is possible and if the PCT and clinicians work together we can deliver it.” Shaheen Bhatia, Pharmacist, Ilford.
Redbridge Health and well-being
Progress in making the Rich Picture a reality

Our current annual health report shows the progress we have made in delivering our rich picture vision and reducing health inequalities. We now have the polysystems in place and this should enable us to achieve change in health outcomes at a greater pace than ever before.

In section five on pages 78 and 80 we demonstrate our achievements over the past year in making our Rich Picture spring to life and off the page.

2.3. Our goals

The PEC also led the process to develop our goals with a range of stakeholders, and these were refreshed last year. By 2015 we will:

- Have no ward in Redbridge with male or female life expectancy at birth below the London average life expectancy for men and women
- Be commissioning services that meet the highest evidenced based standards of clinical quality and demonstrate continuous improvement in the quality of care across all settings, including primary and community care
- Have improved service user and carer experience of local health services so that satisfaction ratings increase year on year
- Have made sound financial investments which are evidence based and agreed with clearly defined and measurable outcomes

2.4. Our values

Our Board refreshed these in 2006, making them more focused on commissioning and aligned with our future aims. These values drive our vision and goals. We will:

- Inform, involve, consult and empower the community and stakeholders in an honest and open way, so that they can increasingly contribute to our plans and shape decision making
- Secure high quality services that deliver the best possible health outcomes within available resources
- Treat people with dignity and respect, recognising diversity and treating people equally
- Work with organisations that share our values, encouraging innovation and creativity to continually improve outcomes for patients and the community
- Equip our staff to do their job, providing a robust framework within which staff can maximise their effectiveness, be recognised and rewarded for success and learn through experience

Annual Public Health Report 2009
2.5. Health outcomes

All PCTs must choose the priorities that they intend to focus on as part of the World Class Commissioning\(^6\) (WCC) process. In addition to the two predetermined national priorities which focus on life expectancy and tackling health inequalities, we must select up to eight extra priorities. After looking closely at the evidence and discussing with colleagues last year we chose the ones listed below. We believe these will make the biggest difference to our local communities’ health and wellbeing:

- Increasing the rate of measles, mumps and rubella (MMR) immunisations for children - both first and second doses
- Improving the survival rate from cancer
- Minimising stroke deaths within 30 days of someone having a stroke
- Reducing death from cardiovascular disease\(^7\) (CVD)
- Controlling levels of blood sugar for people with diabetes (this enables people with diabetes to stay healthier)
- Increasing the number of deaths that occur at home rather than hospital – so giving people more choice about where they die.
- Halting the increase in reception class childhood obesity
- Halting the increase in year six childhood obesity

We checked these again this year with our senior clinicians through the Clinical Commissioning Board, reviewed performance against our peers and agreed to keep the same set. Given the new indicator on health inequalities we decided that we no longer needed our specific local indicator on the same issue. In later chapters we explain the reasons why these are so important, how we have performed and our targets for improvement over the next five years.

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\(^6\)World Class Commissioning is a Department of Health programme. It sets out expectations for how PCTs can become commissioners of world class health services. PCTs are measured on their progress every year. More information available here: [http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm)

\(^7\)Cardiovascular disease involves the heart, veins and arteries
3. **Context**

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3. Context

3.1. Introduction to the case for change

This chapter sets the scene for our approach and outlines the issues that have informed our strategy. We discuss what’s influencing and driving our plans locally. This covers:

- The north east London, regional and national policy context
- The needs of our community and the health issues they face
- The changing financial background

This evidence will demonstrate the compelling case for change in the way health services are provided locally. We focus particularly on the role of polysystems and clinical leadership, outlining the current context for both in Redbridge. We close with a summary of what this means for us as the commissioner for all NHS services in the borough.
3.2. National and regional policy framework

3.2.1. Vision for the NHS
Over the past few years, Lord Darzi, eminent surgeon and former Health Minister has led a number of reviews outlining how the NHS in England needs to develop. High quality care for all: NHS Next Stage Review, published in July 2008 outlined the need for the NHS to be clinically led and focus on:

- Preventing ill health and improving poor health
- Fairness, choice and ensuring services are accessible to all
- Effectiveness and providing world class services for people when they are unwell
- Safety and inspiring confidence in those it serves
- Putting quality at the heart of everything it does
- Providing patient-centred care
- Being locally accountable

High quality care for all builds upon the recommendations in the 2007 report Healthcare for London: a Framework for Action, which set out the vision for health provision in London. It was developed following wide consultation and gives a clear direction and expectations for London’s health service. The key principles are:

- Services focussed on individual needs and choices
- Localise where possible, centralise where necessary
- Truly integrated care and partnership working, maximising the contribution of the entire workforce
- Prevention is better than cure
- A focus on health inequalities and diversity

3.2.2. Consulting the Capital
The proposals in the document were put to Londoners during an extensive consultation in late 2007 and early 2008. Thousands of Londoners gave their views, including several hundred Redbridge residents and a number of local community groups. In line with other Londoners, Redbridge residents were supportive of the proposals. In summary, local residents said:

- They would like to see GP surgeries open for appointments in the evening and at weekends (90% saying this would be very or fairly useful)
- There should be greater investment to support people with long term conditions (e.g. diabetes) in the community (70% agreed)
- Out of the twelve services listed, they would like to see the following six prioritised in any polyclinic development in the order they are listed:
  - GP services
  - tests such as blood tests, scans, x ray
  - outpatient appointments such as care before and following birth
  - minor procedures such as injections in joints or some operations
  - proactive management of long term conditions
  - urgent care provision
  - pharmacy
- Nearly two thirds strongly or tended to agree that all GP practices should be part of a polyclinic or networked to one (through a polysystem)

We have taken on board these findings and you will hear later in this plan about how we have made these aspirations a reality for Redbridge residents through polysystem development.

3.2.3. Care settings and pathways
Healthcare for London and subsequent working groups looked at the following themes and developed recommendations for improved care pathways for each.

People receive healthcare in different settings, sometimes this might be in their own homes, and at other times a trip to hospital is needed. We know from Consulting the Capital and other feedback from patients that while they are prepared to travel for specialist healthcare, they would like most services delivered closer to home. A Framework for Action outlined the recommended range of healthcare settings.

Both the pathways and settings are illustrated in the diagram on the following page.
Our strategy focuses on what we are doing to deliver care within people’s homes and through their local polysystem. Aspects of all the care pathways will potentially be delivered through the polysystem and polyclinic. The sector strategy focuses on hospital settings and the acute element of the pathways listed above. A clear picture for how people receive their care from prevention and birth through to the end of their life is articulated in both strategies. You will hear more about these and how we intend to implement the pathway recommendations in section four.

3.2.4. Healthcare for London in our sector
We have considered health provision at a north east London level\[^{10}\]. People sometimes go outside the borough they live in for healthcare. With more choice for patients about where they can have hospital treatment, they sometimes go even further afield.

The population in north east London is rising rapidly and the number of people with long term conditions such as diabetes and heart disease is also set to increase. Patients here are high users of Accident and Emergency (A&E) services, often when they could be better treated by their GP or nearer to home. We also know that access to and the quality of primary care that many people experience does not always meet their expectations. Health outcomes for patients are not as good as they could be and the cost of services in the sector is unsustainable given the financial climate and rising demands.

These are just some of the reasons why a full scale review of hospital services in north east London started earlier this year. Residents in this part of London have expressed a desire to see the services outlined in Darzi’s vision, and is the job of health leaders in the sector to make this a reality.

\[^{10}\]Covers the boroughs of Redbridge, Barking and Dagenham, Havering, Waltham Forest, Hackney, Tower Hamlets, City and Hackney and Newham
3.2.5. Health for north east London

The Health for north east London (Health for NEL) programme is both the inner and outer north east London sector’s response to Darzi’s vision.

The programme is run on behalf of north east London’s primary care trusts and acute hospital trusts. The aims are to:

- Help save lives, significantly improve the health of thousands of patients, and result in a healthier population
- Ensure the NHS delivers the best possible care, taking advantage of new medical developments and improving the way it delivers care to patients
- Do more to prevent illness in the first place, rather than just treating it, and enable people to live healthily – and be treated – in their own communities
- Bring some services closer to people’s homes and centralise others to provide better specialist care

The proposals are clinically driven. The programme is led by two clinical directors and informed by six clinical groups with health professionals from across north east London. The plans to improve hospital services have been closely aligned with the drive to provide more quality care in the community.

Alongside proposals for changes to acute services are programmes in each PCT. In Redbridge, as in the other PCTs, we plan to provide more care outside of hospital, based on polysystem networks of health professionals in community settings linked to a polyclinic hub offering a wide range of services.

The programme, while clinically led, is jointly overseen by our Chief Executive and ONEL lead, Heather O’Meara, and the lead for inner north east London (INEL), Alwen Williams. There has already been extensive engagement on the Health for NEL programme. Local GPs, PCT staff, council colleagues and councillors, MPs, patient representatives and the Local Involvement Network (LINK)\(^1\) are just some of those who have given feedback to date. The consultation started formally on 30 November 2009 and runs for 14 weeks.\(^2\)

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\(^1\)LINks are made up of both individuals and community groups who work together to help people influence, or change the way that health services and social care are delivered in their borough.

\(^2\)For more information visit [http://www.healthfornel.nhs.uk/](http://www.healthfornel.nhs.uk/)
3.2.6. What does Health for NEL mean for Redbridge?

One of the biggest challenges is to achieve the shift of care from a hospital to community setting – where people have told us they would prefer to receive the majority of their care. The programme also focuses on a new vision for King George Hospital, which is based in our borough within the Seven Kings polysystem. This proposal builds on our original plan to develop a polyclinic on the hospital site and enhance the unscheduled care centre services there.

We will work with partners to keep people healthy in the community so that wherever possible they stay well and out of hospital. This strategy outlines our plans for delivering care closer to home, providing people with a far greater choice of services on their doorstep.

We do not underestimate the degree of engagement required. While many people are unhappy with current provision, people can find change difficult and it is our job to ensure that the arguments for doing things differently are explained well.
3.3. Our local population demographics and health needs

3.3.1. Introduction
Our backgrounds have an impact on our health. Our gender, ethnicity, age, income, family history of disease or living conditions all play a part in how healthy we are. It’s our job to keep up to date with changes in the local population and understand what that means for the services we commission. In 2009 we fully established our polysystems. So to inform the delivery plans being developed by our clinical directors and polysystem development boards, we conducted a thorough needs assessment and profile for each area.

3.3.2. A healthy population?
At first glance of the statistics, Redbridge residents look healthier than most, with general health above the London and national average. On closer inspection however, the picture is more complex, with high and increasing numbers of people with serious health conditions. There is also a marked difference between the health outcomes of residents living in the poorest and those in the wealthier parts of the borough. This section looks at the data and pulls together a picture of the most pressing needs we must address.

3.3.3. Demographic trends
We have a population of 255,000, and by 2017 this is expected to increase by 6%. Within this rise, the most significant increases will be of children and young people and over 64 year olds. A larger older population will want to see a focus on enabling them to maintain independence and stay in their own homes. We will also need to focus our attention on addressing the needs for children given the trends.

Redbridge already has an ethnically diverse population. This includes large Asian and Black African communities and in recent years increasing numbers of migrants from Eastern Europe. This trend towards a more mixed population is set to continue and services will need to adjust so that they are culturally appropriate. By this year 50% of young people will be from a Black and minority ethnic (BME) background.

We have significantly higher numbers of statutory homeless people in Redbridge, but relatively small numbers of rough sleepers. These groups experience considerably worse health than the general population, and can struggle to access services.

We also have more children living in poverty than the England average, and the majority of these appear to be from BME backgrounds (using the measure of percentage of children receiving free school meals). In addition the new Roma and Eastern European communities tend to have young families.

3.3.4. Health status
Life expectancy for men and women is better in Redbridge than the national average. Death rates from smoking and the estimated level of adult binge drinking fall below the national average.
We have high and increasing numbers of people with long term conditions such as Coronary Heart Disease (CHD), Chronic Obstructive Pulmonary Disease (COPD) and diabetes. These rises are in part due to an ageing population and our growing South Asian community, who are more prone to diabetes. Rates of asthma and Congestive Heart Failure also feature in the top five most prevalent conditions.

The level of physical activity among children and adults is lower than the national average. We also have higher numbers of obese children than other parts of England, particularly those from poorer households.

Teenage pregnancy rates are below London and the national average, but are moving against the trend generally and rising in Redbridge.

Men living in the most deprived parts of the borough die earlier on average than those in more affluent areas. The difference is on average 6.5 years, while for women it is 2.8 years. We want to change this and tackling health inequality features in our overriding vision.

New cases of tuberculosis (TB) are rising, particularly within the Asian community and the reasons for this are varied. Health, housing and levels of deprivation all have an impact and require a multi-agency response to tackle the issue.

We are pleased to see that overall life expectancy is improving and death rates from all causes combined have decreased for men and women in Redbridge. People are also now less likely to die early from cancer, heart disease and stroke. However, we still think there is room for improvement and want to further reduce premature deaths from these diseases.

3.3.5. Joint Strategic Needs Assessment

Last autumn, in partnership with Redbridge Council and informed by the community and voluntary sector, we looked at the current and future health and social care needs of all our communities.

We produced a ‘Joint Strategic Needs Assessment’ (JSNA). We used this to help develop the priorities and targets that we, along with all public bodies such as the Council, Police, fire service and voluntary sector organisations should focus on through the Local Area Agreement (LAA)\(^{13}\).

Above all, the JSNA demonstrated a need for a coordinated prevention and early intervention programme for public and voluntary agencies across Redbridge. In addition we identified a need for further in-depth needs assessments for vulnerable groups who tended to experience the worst health outcomes; development of knowledge management with the Council and better ward based information. It also highlighted a number of priorities which we needed to focus on, including to:

- Improve life expectancy, especially in deprived wards
- Improve outcome based commissioning
- Ensure respect and dignity for all service users
- Commission more prevention and early intervention services
- Involve statutory, voluntary, private organisations and local communities more
- Personalise systems of care

\(^{13}\)A Local Area Agreement is a three-year funding arrangement between central Government and a local area, as represented by a Local Strategic Partnership (LSP) of public and voluntary groups. The LSP will set out a plan of priorities for its area, in return for greater flexibility of funding streams.
• Engage more with our communities including diverse and hard to reach groups
• Increase immunisation rates
• Reduce risk of low birth weight babies and peri-natal mortality
• Increase rates of physical activity and healthy nutrition
• Improve drug misuse services
• Commission more effective screening services
• Improve end of life care services

The further in depth needs assessments proposed for the more vulnerable members of the community included among others: disabled children, rough sleepers and people with learning disabilities and complex needs.

3.3.6. An area focus
Now that we have five polysystems up and running, we need to understand the populations within each to make the right commissioning decisions. A detailed polysystem needs analysis was carried out earlier this year, building on the findings of the JSNA. These findings demonstrate the variations between the polysystems and also pick up some differences between wards within polysystems. Pages 28 and 29 highlight the issues for each.
Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. The main symptom of COPD is an inability to breathe in and out properly.

Diabetes mellitus is a condition in which the pancreas no longer produces enough insulin or cells stop responding to the insulin that is produced, so that glucose in the blood cannot be absorbed into the cells of the body. Symptoms include frequent urination, lethargy, excessive thirst, and hunger.

Fairlop Polysystem
- Relatively older population
- Mainly White British population (although in two wards up to 30% of the population are BME)
- Some wards experience significant deprivation
- High emergency admission rates
- Highest prevalence of COPD and CHD (coronary heart disease)
- High proportion of smokers and binge drinkers
- Above average levels of adult obesity
- Two of the wards are identified as teenage pregnancy hotspots (Hainault and Fairlop)

Wanstead Polysystem
- Relatively older population
- Less ethnically diverse and mainly White British
- Area of relative affluence
- High life expectancy
- High prevalence of chronic obstructive pulmonary disease (COPD)\(^\text{14}\)
- Lowest user of unscheduled care services
- Lowest emergency admissions rates
- Snaresbrook ward has a high TB notification rate
- High proportion of smokers and binge drinkers

Cranbrook Polysystem
- Relatively young population
- Close to 60% of population BME – Asian 44%, Black 10%
- Area of marked deprivation
- Highest prevalence of diabetes mellitus\(^\text{15}\) and high prevalence CHD
- High user of unscheduled care services
- High TB notification rates
- High levels of childhood and adult obesity
- Valentines ward is a teenage pregnancy hotspot

\(^{14}\)Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. The main symptom of COPD is an inability to breathe in and out properly.

\(^{15}\)Diabetes mellitus is a condition in which the pancreas no longer produces enough insulin or cells stop responding to the insulin that is produced, so that glucose in the blood cannot be absorbed into the cells of the body. Symptoms include frequent urination, lethargy, excessive thirst, and hunger.
Context

Loxford Polysystem

- Youngest population profile
- Expected to see most population growth
- Over 60% BME population - Asian (45%), Black (13%) and other BME groups (4%)
- Area of marked deprivation
- Highest prevalence of coronary heart failure (CHF) and high prevalence of diabetes mellitus and CHD
- High emergency admission rates
- Highest user of unscheduled care services
- Highest TB notification rates
- High levels of childhood obesity
- Loxford ward is a teenage pregnancy hotspot

For more information about polysystem health needs please refer to our latest annual public health report.

Seven Kings Polysystem

- Relatively young population profile
- Over 44% BME population - Asian (30%), Black (10%), other BME groups (4%)
- Area of significant deprivation
- High prevalence of diabetes mellitus and CHD
- Highest emergency admission rates
- Highest user of unscheduled care services in Redbridge
- High TB notification rates within all wards in this polysystem
- High levels of childhood and adult obesity
- High levels of smoking
- Includes ward with highest teenage pregnancy rate

For more information about polysystem health needs please refer to our latest annual public health report.
Understanding long term conditions and the impact on hospital care by polysystem

This chart illustrates the depth of detail that our new health analytics tool can provide. It helps to demonstrate the variation in need and service utilisation by polysystem and provides us with the opportunity to track improvement over time. We talk more about how we intend to make best use of this kind of data later in the document.

### All Redbridge

<table>
<thead>
<tr>
<th>Long Term Condition</th>
<th>No. of Patients</th>
<th>In patient (IP) Admissions Per 1000</th>
<th>A&amp;E Visits Per 1000</th>
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</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>18,562</td>
<td>58</td>
<td>784</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>1,413</td>
<td>798</td>
<td>1,739</td>
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<tr>
<td>Congestive Heart Failure</td>
<td>916</td>
<td>393</td>
<td>1,638</td>
</tr>
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<td>Cancer</td>
<td>3,001</td>
<td>475</td>
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### Cranbrook

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NB Please note that these tables only contain patient data input over the past two years, so do not give the total figures for all conditions on these pages.

### Kings

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### Loxford

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### Wanstead

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3.4. Insights from patients, public, clinicians and local partners

3.4.1. A listening and responsive organisation

Engagement is central to our approach. The first version of this strategy was developed last year through listening to a range of stakeholders, including workshops with over 40 senior internal and external strategic partners. In addition, we saw over 5000 members of the public at roadshows last year. We also held ‘polyplan’ events with clinicians to develop our polysystems model and have looked closely at all survey results from patients.

A recent London Ipsos MORI report showed that residents in Redbridge are more likely to feel that they can influence what their local PCT does than residents in other PCT areas. We’re proud to be an organisation with a reputation for listening and taking on board people’s concerns. We want to continually test whether we are on the right track. These are just some of the highlights from the past year.
3.4.2. What we did and what we heard

**Activities**

- Held workshops to outline and discuss a new way of working – in line with our ‘Aspire’ organisational development programme.
- Invited a local authority colleague to run a session on the sustainable community strategy and our workforce’s role in delivering it.
- Developed a series of peer-led ‘knowledge bites’ aimed at equipping staff with the skills and knowledge to do their job.
- Promoted the annual staff survey and took part in the Healthcare 100 survey which aims to identify top employers.
- Surveyed our staff to inform a workforce health and wellbeing programme.
- Involved the Loxford community panel in the development of our first polyclinic.
- Representatives sat on tender panels for polyclinic services, advised on signage and way-finding and took part in community art projects.
- Established four more community panels, aligned to each of the polysystems.
- Set up provider scrutiny sessions for our patient experience panel – enabling them to question performance of the four main service providers.
- Saw over 2000 people during the health and wellbeing roadshows in March, which also sought views on the pan-London stroke and trauma consultation.
- Consulted BME residents to find out about low take-up rates of screening programmes.
- Looked at the results from patient surveys conducted over the past year and developed action plans where we were concerned about rates of satisfaction.

**Feedback**

- That they liked working for us – our overall scores were above average for the national survey, and we were rated as a top 100 healthcare employer based on the results of a separate survey.
- Through the Aspire workshops staff told us that the healthcare system was too complex, with unclear access points and patchy standards. They wanted to play a role in improving navigation and services for local people.
- Staff expressed a wish to work across directorates in a programme management way – using and developing their skills.
- They wanted to see more activities to help promote their wellbeing – both mental and physical.
- The Loxford community panel told us that it was time for them to chair their own meetings and take a broader role in the polysystem, rather than just the polyclinic. They also offered to help us set up the new panels.
- Our patient experience panel told us that they weren’t sure their feedback was having the right impact and wanted to review their terms of reference.
- Participants in the screening workshops told us that we needed to make more use of BME media and faith networks.
- Ipsos MORI surveys: local GPs were strong on opening hours and weaker on telephone access, so we organised a session for reception staff. We have developed a robust action plan to address underperformance in terms of patient experience given that this is a priority goal for us.
**Context**

Parents / carers

Involved parents of disabled children in workshops looking at a new model for services.

Established a Carers’ Advisory Group for a Department of Health national pilot scheme for carers’ Health and Wellbeing Checks.

**Activities**

Parents of disabled children told us that Kenwood House, where services for disabled children are based, is not fit for purpose.

That we should support carers to remain healthy, so they in turn can better support those they are caring for.

**Feedback**

Clinicians

We have engaged with hospital, primary and community staff on care pathway development, redesign and service reviews.

Consulted GPs about moving fully from practice based clusters to the five polysystems and leading commissioning through the polysystems.

We now have a business as usual approach to clinical engagement and it is at the core of what we do. There are five monthly polysystem development boards, chaired by the clinical directors. All practices have a seat at the table.

We established the Clinical Commissioning Board, which now leads on borough based clinical commissioning. Each polysystem GP clinical director is a member of the Board.

**Activities**

GPs agreed to establish the polysystems fully, and for these to be the vehicle through which local commissioning decisions be made.

As a result of the Health for NEL programme we established a number of working and advisory groups on developing ‘out of hospital’ solutions. These have strong primary and secondary care clinical representation.

The Clinical Commissioning Board committed to changing the way personal medical service (PMS) practice funding is allocated — so now all polysystem patients will benefit from GP led services such as dermatology and end of life care rather than just some practice patients. Negotiations on how this will be delivered will begin shortly.

**Feedback**

Politicians

Took part in Health Scrutiny working groups, such as the Life Expectancy group, with our director of public health as joint lead.

Held quarterly and one to one meetings with Chair, Chief Executive and local MPs.

We aligned our polysystems to the Council’s ward councillor led area committees to ensure regular reporting to councillors and the communities in those areas.

We have established a number of joint board sub-committees with Council cabinet member and PCT non executive director membership – for example the Health and Social Care Advisory Committee (HSCAC).

**Activities**

We heard that they agreed that services needed to change and for more services to be brought closer to home; but among the issues they raised had concerns about the timing of the Health4NEL consultation given upcoming local and national elections.

Local MPs and many councillors have also been supportive of the drive for greater clinical leadership and want to be more involved in the direction of health services locally. We do recognise that there is more to do to fully engage all councillors in our polysystem vision.

The local Health Scrutiny Committee, local MP and several councillors have received tours of the new polyclinic and been impressed with the services on offer there.

**Feedback**
Summary of the impact of engagement

Engagement is only worthwhile for parties if issues raised are properly considered and where appropriate taken on board. We don’t enter into the process lightly and below are just some of the changes we have made.

Staff
Following last year’s survey, we developed an action plan to secure improvement for the areas where we believed we could improve staff experience. We also developed the range of health and wellbeing activities provided for staff — for example through increasing the exercise classes provided at work locations.

Patients / public
A representative from the Loxford community panel was present at each event aimed at recruiting residents for the four new polysystem panels. They shared their positive experience and helped us gain many members for each panel.
A subgroup of the patient experience panel revised the terms of reference and a report from their meeting will be fed directly to the Clinical Commissioning Board. The outcome of their feedback will be presented to following meetings.

Parents / carers
We secured Department of Health funding for a new project to support the health and wellbeing of carers. This programme will see 600 carers supported.
Under Heath for NEL we proposed that children’s health services should be co-located at the King George Hospital site and move from Kenwood House.
The outcome of the consultation is yet to be determined, but we are committed to a co-location approach.

Clinicians
We have developed opportunities for better joint working between clinicians in secondary and primary care — through the CHD care pathway pilot outlined on page 68.
We are holding an externally facilitated session with the Clinical Commissioning Board to ensure their input and fully work up detailed project plans for initiatives.

Politicians
We have been active, responsive and willing partners in the scrutiny process for Health for NEL and related local impact.
We are attending local area forums to outline initial plans for polysystems and discuss the Health for NEL consultation.
3.5. Service provision

3.5.1. Provider landscape

Redbridge residents receive their care from a wide range of providers. The strategic plan for the sector summarises acute provision and we focus on primary and community healthcare providers here. The general theme running through this section is a realisation that while we have some excellent provision; we are not necessarily making the best use of the skills, experience and potential of all our providers – particularly those in primary care.

We serve a population of 263,000 registered patients and commission general services for primary care through GPs, dentists, opticians and pharmacists. We commission a wide range of community services ranging from primary care nursing, podiatry services and smoking cessation to specialist support services for mental health, nutrition and dietetics, speech and language therapy and specialist palliative care.

Approximately 80% of health contacts with the Redbridge population take place in primary care delivered by independent contractors under contract with us. We do this through:

- 49 General Practices
- 42 Dental Practices
- 53 Pharmacies
- 41 Opticians

There is variation in the capacity and facilities available through GP practices. On average each GP practice has a list size of approximately 2,500 registered patients per GP; however approximately one third of GP practices operate as single handed practices with registered list sizes ranging from 1,350 to more than 4,000. Many of the primary care contractors operate out of facilities that were not designed for the delivery of 21st century health care. This impacts on capacity and the ability to deliver the challenging agenda for integrated community services.

Analysis of the primary care market suggests that pressure is placed upon primary care services through patients attending appointments when they do not require GP attention. This diverts capacity from focusing on supporting those who have long term conditions or who could be prevented from requiring hospital care. Our challenge is to empower patients to self manage their care by ensuring access to information, advice and services through the polysystem. We have also strengthened access to primary care in recent years, ensuring that we provide excellent extended hours’ provision.

This year we supported the merger of two practices to deliver services through the Loxford Polyclinic. The practice is integrated into the heart of the polyclinic to deliver integrated and seamless care from walk in appointments at the pharmacy to GP consultation and specialist services for diagnosis and treatment of long term or specialist conditions. Patients are triaged to appropriate services at each level of care. This model of care will be available at all polyclinics.

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16The number of patients registered against the number of people living in an area can vary and we are no exception.
17Triage is a process for sorting where people with immediate medical needs should be seen – for example the ambulance service will decide whether someone needs to go to a local or specialist hospital.
We have diverted pressure from GP practices by introducing a minor ailment scheme for pharmacies. A number of pharmacies have been accredited to offer advice and treatment for patients with minor ailments such as coughs, colds, minor injuries (e.g. sprains) and allergies. Pharmacies are also heavily involved and integral to the delivery of many enhanced services such as chlamydia screening, administration of emergency hormonal contraception, needle exchange and methadone provision. Greater emphasis is required to ensure pharmacies are engaged in service delivery for screening and wellbeing programmes and deliver services through a modern rather than traditional model.

We commission four community specialist services for GPs with special interests in diabetes, dermatology, minor surgery and lower back pain. This service is being reviewed to identify the opportunities for increasingly integrated services.

Dental provision in Redbridge remains above the national average with relatively good coverage for NHS dentistry. 61% of all residents have seen an NHS dentist in the last 24 months, compared to 50% in London as a whole. We remain committed to increasing access to dental services for all residents. Our focus is on improving oral health by targeting hard to reach groups in areas of deprivation or low service provision. We have just begun a tiny teeth access campaign to address oral health in the very young.

Community services
This year we, in line with all PCTs, became a commissioning focussed organisation and our ‘adult provider services’ arm was transferred to Outer North East London Community Services. We contract with them for the provision of 12 community services including: primary care nursing, podiatry, speech and language therapy, nutrition and dietetics, palliative care nursing, long term conditions support, smoking cessation and others. Across these services more than 160,000 patient contacts are provided each year at clinics throughout the borough and through domiciliary services.

We intend to continue prioritising care closer to home and delivery of services in community settings by community or primary care staff. We will focus on building capacity across community and primary care services to continue to work in partnership through polysystems to deliver care and education services to patients with long term conditions. Please see case study on page 66. To develop services further we will improve our commissioning approach through specifying the outcomes and service required rather than specifying the model of delivery.

Development of integrated polysystem services will require pump priming investment to invest in new technologies to promote flexible care services in partnership with patient self care.

Mental health
Services for people with mental health issues are provided through a range of statutory sector and voluntary sector service providers. Specialist services are commissioned for forensic mental health, eating disorders and a range of other national specialisms are provided through London wide commissioning arrangements. Mainstream mental health services are provided locally through the North East London NHS Foundation Trust,
which provides a spectrum of inpatient and community services. We plan to build and strengthen the range of voluntary sector provision which currently includes a commissioned employment service to help people into work, support services for dementia and provision of psychological therapies.

The vision for mental health services has been outlined in the Joint Mental Health Commissioning Strategy 2008-13 which we developed in partnership with the local authority. This year we became the lead commissioner for borough mental health services. The strategy puts the individual at the heart of care; with their understanding of how best to treat their illness and what would best meet their needs at the heart of service planning and the delivery. The key strategic drive is towards self-directed care and personalisation and innovative models of delivery. This includes social firms and services provided by the voluntary sector, this presents exciting opportunities for significant improvement in services.

Our key challenges will be to achieve the aspirations for improved dementia care and support further responding to the needs of children, young people and antenatal mental health care in the community and improving access to psychological therapies.

Health and wellbeing services
A range of services are commissioned from providers to support our health and wellbeing agenda. These services include those provided through the voluntary and community sector to provide information and advice on sexual health for minority and at risk communities, exercise on referral for those at risk of, or recovering from long term conditions, fit for fun schemes to involve community groups as well as obesity prevention and counselling schemes. We value the input of the voluntary and community sector (VCS), which is why we have over 20 groups operating from Loxford polyclinic, offering Asian bhangra dance sessions, HIV support, through to advice for mental health services users on housing and employment.

Screening programmes are also provided for breast and bowel screening, diabetic retinopathy and chlamydia.

Children’s Services
In addition to the services provided by GPs and hospitals, community children’s health services are provided through the Children’s Trust, which is hosted by the local authority. Redbridge has been a forerunner for effective partnership working in this area.

Here, the Children’s Trust brings together staff from health, education and social care services. By working together, staff can have a better understanding of each other’s roles and can share information and resources to support the work that they are doing with families. The end goal is for better integrated and more outcome focussed services for children, young people and their families.

The teams are based in three Children’s Resource Centres (CRCs) in the West, North and South of the borough and in addition to working closely together they also work with local schools and youth services.
Learning Disabilities Partnership
The Learning Disability Partnership was created through a special agreement in 2003 together with Redbridge and Waltham Forest Councils and PCTs. It is led through Redbridge Council and contains two borough based integrated health and social care teams. It also provides accommodation and day services.

The partnership is committed to working with a wide range of partners including, voluntary organisations, housing providers and private sector service providers.

Independent sector
The independent sector provides a range of services in Redbridge, ranging from out of hospital services to supporting people with stroke, through to the independent treatment sector centre based at King George Hospital. The treatment centre has excellent satisfaction ratings and patients can receive a range of procedures such as hip and knee replacements there – often with short waiting times. The real challenge for this service is to ensure that GPs refer patients (uptake rates are currently lower than we would wish) and that patients are aware of the service and choose to be referred.

3.5.2. Activity commissioned
This chart summarises the projected spend for this financial year.

2009-10 Expenditure breakdown £millions

- Other PCT spend, £22.48m
- GPs, £32.28m
- Prescribing, £35.51m
- Dentistry, £13.20m
- Other community, £27.67m
- Mental health, £36.58m
- Learning disability, £6.68m
- Continuing care – £11.20m
- Secondary or tertiary acute care, £191.82m
- Specialised commissioning, £13.74m

Commissioning Strategic Plan 2010 – 2015
3.5.3. Clinical quality

We have a commitment to providing services that meet the highest clinical and safety standards. Is is one of our four goals, so is a priority for us. Our robust contract monitoring process ensures that concerns are picked up as a matter of urgency.

We undertake monitoring of the clinical performance of independent contractors. For GPs in Redbridge, the Quality and Outcome Framework (QOF) is a key driver to improve clinical standards. Practices achieved on average 95% of points available in 2008/9.

In addition to this the health analytics data will help us monitor key clinical metrics by disease and identify priorities for improvement. As we proactively drive forward closing gaps in care this will improve quality and productivity outcomes.

Dental contracts are monitored by undertaking end of year reviews which focus on recall attendances18 as well as National Institute for Clinical Excellence (NICE) guidance. All practices were visited recently to assess levels of infection control and action plans are in place to address areas of concern.

In ophthalmology the optometrists complete an online toolkit to review clinical practice and assess how well they are meeting aspiration standards. Finally pharmacists are monitored through self assessment workbooks and a number of pharmacists received a formal contract review last year.

Our main provider of mental health services, North East London NHS Foundation Trust received an excellent rating for quality of services as part of the national annual health check process. Our new community services provider ONEL community services will this year be assessed under the same ‘Standards for Better Health’ process.

As outlined earlier in this section, there are concerns about the quality of local hospital services. The Health for NEL programme is focussed on addressing these issues and ensuring that clinical quality improves across the board.

3.6. Current performance

3.6.1. How are we doing?

This year we slipped to ‘fair’ under the annual health check rating for quality of commissioning. This was disappointing given strong performance across a number of indicators such as chlamydia screening, breastfeeding and number of drug users in treatment. Our Board receive updates at each meeting on how we are performing against all our national and local targets. We have not listed all of these below, but have highlighted areas of particularly strong performance and those where we need to focus efforts.

This year we are achieving strongly on the 13 and 26 inpatient and outpatient waiting targets, the 18 week referral target, the number of drug users in treatment and dental

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18People used to be called back to see their dentist every six months regardless of their oral health. To ensure better access for other patients and eliminate unnecessary visits, dentists are monitored on this. The recommended timescale is around 18 months.
access. While we have strong data on breastfeeding, we are concerned about meeting the target for the percentage of new mothers breastfeeding and have a plan in place to tackle this. Our infant feeding specialist is working closely with midwives at Barking, Havering and Redbridge University Hospitals NHS Trust.

Access to sexual health support through genito-urinary medicine (GUM) clinics is on track, but we have a lot to do to reach the increased target for chlamydia screens. We are building on our success and tactics that achieved such a high rate last year, with a tailored campaign for young people around Christmas, New Year and Valentine’s Day. The four hour target to be seen at A&E and delays in transfers of care continue to prove challenging, but the acute commissioning unit is taking decisive action. A sector wide strategic action plan covers all actions being taken at all stages of the pathway from primary care to discharge from hospital. In addition a new emergency care network has been established and is taking forward schemes that will help avoid admission, such as rapid response and a new single point of access for urgent care.

3.7. Financial position

3.7.1. Past performance
In agreeing future financial plans it is useful to review past performance.

The PCT has now been in existence for almost seven years and in that time we have seen our responsibilities increase and associated budget grow by 84% from £213m in 2003/04 to £391m in 2009/10.

The fastest growth has been in spend on our three local acute providers. These three contracts now account for almost 40% of PCT total expenditure. The management of acute spend in addition to productivity improvements in community/primary care, will be key to delivering affordable services in future years.

Whilst enjoying significant increases in funding, Redbridge remains the only PCT in London below its weighted capitation19 funding target, receiving £100m less than some other London PCTs on a weighted capitation basis.

Despite a relatively challenging financial position we managed to accrue reserves of over £20m up to March 2008. We used these in each of the last two years; 2008/9 (£4m) and 2009/10 (£10m). The strategic plan assumes that we will not rely on significant use of reserves in 2010/11 and as a result this will be a call on the first 2.5% of our growth allocations, with less than 3% being available to spend next year. As a result, 2010/11 will be our most challenging year yet from a financial perspective. The national financial environment suggests challenges will remain for at least the next five years.

Our reputation for good financial management is important to us. This has been recognised at a national level and saw us being one of only two health organisations in the country to obtain an excellent score for financial accounting in 2006/07. The

19The weighted capitation formula determines PCTs’ target shares of available budget to enable them to commission similar levels of healthcare for populations with similar healthcare needs.
following year we achieved an ‘excellent’ overall score under the ‘Auditors Local
Evaluation’ process. This saw us ranked in the top 5% of NHS organisations, and last
year we were ranked in the top 5 performing PCTs in the country under the new ‘Use of
Resources Assessment’. We are therefore, well placed to manage in what will
undoubtedly be one of the most challenging financial periods for a generation.

We have a ‘turnaround’ savings programme in place which focuses on maximising
efficiencies and savings for the remainder of 2009/10. The plans rely on maximising the
benefits of the community/primary care investment already made, including the new
3,700m² polyclinic opened in Loxford in 2009, and the development of our five
polysystems. These are central to delivering our savings plan and will support a more
sustainable financial future. By improving quality and bringing services closer to home
through the polysystem we can deliver improved health outcomes and reduced costs
for care.

Our Board play an active role in not only proposing priorities for spend, but through
intensive scrutiny of the proposals developed by senior managers. The budget setting
process typically involves a number of away day sessions with the Board early in the year.
The proposals are then refined following their input and finalised through Spring month
sessions and agreed at the Board meeting.

3.7.2 Allocative and technical efficiency gains
One of the core functions of a commissioner is resource allocation to different
population groups based on an analysis of need.

We aim to maximise the value and benefits for the population from the resources we
invest on their behalf. This can be done in two ways:

- allocative efficiency &
- technical efficiency

We can maximise value directly by allocating the resources we control among the
patient and population groups in our borough to best effect. The resources can be
invested with specific health objectives, as follows:

- to reduce health inequalities and improve equity
- to promote and improve the health of the population
- to improve the value and quality of healthcare

Allocative efficiency occurs when it is possible to redistribute resources and services to
meet the needs of any one patient without reducing the welfare of other patients.

We have undertaken significant work on allocative efficiency over the past two years.
We plan to restructure our spending plans to better meet the health demands of the
local population using programme budgeting data such as that contained in chart on
the following page.
The chart above shows that in 2007/08 we were a relatively low investor in maternity services; this led to a significant investment programme of many millions in our two local acute providers. This has moved our ranking from 146/150 to an estimated 45/150.
The chart below confirms that our decision to invest in maternity services, together with significant investment in diabetic services (endocrine), was the right decision as health outcomes are relatively low. The graph also demonstrates that generally we have been successful at allocative efficiency. We are generally a low spender as a consequence of our relatively low funding allocation. Despite this lack of investment we are generally a higher than average performer. The task over the next five years is to move all programme spending areas ‘above the line’ and more programme areas into the top left-hand quadrant.

**Outcomes and expenditure relative to other PCTs in England**

![Chart showing health outcomes and expenditure relative to other PCTs in England]

- No outcome indicators readily available
- Outcome indicators available

**Programme area abbreviations**

- Infectious diseases: Inf
- Cancers and Tumours: Canc
- Respiratory system: Resp
- Endocrine, nutritional and metabolic: End
- Genito Urinary system: GU
- Learning disabilities: LD
- Adverse effects and poisoning: Pois
- Hearing: Hear
- Circulation: Circ
- Mental health: MH
- Dental: Dent
- GI system: Gastro
- Musculo skeletal: Musc
- Trauma and injuries: Trauma
- Disorders of blood: Blood
- Maternity: Mat
- Neurological: Neuro
- Healthy individuals: Hlth
- Social care needs: Soc
Over the past two years we have developed our information systems. In addition to benchmarking with other organisations, we are now in a position where we can measure spend on conditions at GP and polysystem level and be ‘risk stratifying’ the population. Risk stratification is a way of looking at evidence and information to understand what the likely health needs may be so that we can plan ahead. This information is now being used to target initiatives at the services and groups that require it, thus further improving allocative efficiency gains. It helps us to intervene at the earliest level and keep people well in the community.

We can also maximise value indirectly by using our contracting power. We can help providers of health services improve the quality and safety of the healthcare they provide while minimising costs. This is sometimes referred to as technical efficiency.

We have shown through our past performance our effectiveness in delivering technical efficiencies. We delivered one of the highest surpluses in London despite being the lowest funded PCT on both a capitation and weighted capitation basis.

The delivery of future financial plans will depend upon continuing delivery of both the technical and allocative efficiency gains through the ‘Health for North East London’ programme.

### 3.7.3 Financial planning assumptions 2010/11 to 2014/15

The financial planning assumptions underpinning this strategy are consistent with NHS London guidance as outlined below.

#### Planning assumptions - key figures

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Inflation</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Normal inflation</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
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<tr>
<td>NHS inflation</td>
<td>2.2%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
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<tr>
<td>Total inflation</td>
<td>4.7%</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td><strong>PCT Allocation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT uplift (nominal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base case Allocation</td>
<td>2.50%</td>
<td>3.25%</td>
<td>2.50%</td>
<td>2.50%</td>
</tr>
<tr>
<td>Upside growth (percent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Downside Allocation</td>
<td>0.00%</td>
<td>0.75%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>PCT real growth (nominal growth less normal inflation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base case Allocation</td>
<td>0.00%</td>
<td>0.75%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Upside growth (percent)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Downside Allocation</td>
<td>-2.50%</td>
<td>0.75%</td>
<td>-2.50%</td>
<td>0.75%</td>
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<tr>
<td><strong>Tariff Assumptions</strong></td>
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<td></td>
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<tr>
<td>Net tariff uplift</td>
<td>1.7%</td>
<td>0.0%</td>
<td>-0.5%</td>
<td>-0.5%</td>
</tr>
<tr>
<td><strong>Contracting Assumptions</strong></td>
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</tr>
<tr>
<td>Proportion on top of total contract value that should be paid on delivery of agreed CQUINs*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.5%</td>
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</tr>
</tbody>
</table>

*This is a non-recurrent amount paid each year to reward the achievement of agreed quality and innovation targets
Indications are that the downside funding scenario is most likely and therefore plans are focused upon meeting our statutory financial requirements under this scenario. This of course results in significant surpluses being generated under the base case (see table overleaf). Should this be the outcome of Government spending reviews, there will need to be a review of how the significant surplus projected for 2012 onwards is used to further improve the health and wellbeing of the local population.

The summary shows that even under the base case scenario, we will operate at a deficit in 2010/11 if we do not radically change the way we deliver health services.

Given that increased investment in the NHS is unlikely in the coming years, the current system will soon become unaffordable if we do not change and improve quality. Clinically driven quality change, which focuses on keeping people well and seeing the right people at the right time, enables sustainability. We have been given a clear direction on the shifts of activity needed, not only to provide improved services closer to communities, but to improve value for money.

We have already started to achieve some of these shifts in Redbridge and residents like the changes. We have mentioned the GP led Urgent Care Centre at King George Hospital which already sees 40% of current A&E patients within a quick timescale. It could see many more. In chapter 4 we explain more about our plans to meet these ambitious targets.

In the base case it is assumed that our initiatives will contribute between £5m and £6m per annum savings/efficiency gains. These initiatives are more fully explained in Chapter 4. Under the worst case scenario a further £3m to £4m will need to be identified from 2011 onwards. Planning has already begun on developing these initiatives and these are outlined in the second table.
Base case – figures in £000s

<table>
<thead>
<tr>
<th></th>
<th>FY2009/10</th>
<th>FY2010/11</th>
<th>FY 2011/12</th>
<th>FY 2012/13</th>
<th>FY 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus B/FWD</td>
<td>7,500</td>
<td>5,498</td>
<td>9,557</td>
<td>21,196</td>
<td></td>
</tr>
<tr>
<td>In year surplus / deficit</td>
<td>(7,879)</td>
<td>(1,843)</td>
<td>6,581</td>
<td>14,178</td>
<td></td>
</tr>
<tr>
<td>HFL pathway initiatives in year new savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and wellbeing</td>
<td>37</td>
<td>49</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition management; LTC</td>
<td>433</td>
<td>628</td>
<td>1,014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition management; planned care</td>
<td>3,890</td>
<td>3,847</td>
<td>2,927</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition management; EOL</td>
<td>14</td>
<td>14</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition management; MH/Drugs and alcohol</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unscheduled care - Acute care</td>
<td>62</td>
<td>64</td>
<td>71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hospital - Planned care</td>
<td>1,434</td>
<td>1,293</td>
<td>985</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base case - surplus C/FWD</td>
<td>7,500</td>
<td>5,498</td>
<td>9,557</td>
<td>21,196</td>
<td></td>
</tr>
</tbody>
</table>

Increase to initiatives in downside / worst case scenario

<table>
<thead>
<tr>
<th>Downside - Surplus</th>
<th>FY2009/10</th>
<th>FY2010/11</th>
<th>FY 2011/12</th>
<th>FY 2012/13</th>
<th>FY 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes the following ‘additional’ initiatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral management – ensure best practice and consistency across PCT.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement best practice model of planned surgical care (eg reconfiguration)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathway redesign (Top 5 - ophthalmology, ENT, gynaecological, T&amp;O, rheumatology). Working with ONEL CAG to identify best practice identification of high risk patients using Health Analytic to prevent emergency admissions through targeted primary care intervention. Acute contract and performance management via ACU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7,500</td>
<td>6,498</td>
<td>5,680</td>
<td>7,108</td>
<td>5,174</td>
</tr>
<tr>
<td></td>
<td>599</td>
<td>1,371</td>
<td>1,599</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,185</td>
<td>1,016</td>
<td>1,185</td>
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<tr>
<td></td>
<td>44</td>
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<tr>
<td></td>
<td>593</td>
<td>508</td>
<td>593</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>790</td>
<td>677</td>
<td>790</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3,211</td>
<td>3,609</td>
<td>4,211</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Stepping up the pace of change
The evidence is clear and we need to take the initiative now to deliver improvements. Redbridge residents deserve the best healthcare and as local leader of the NHS, we intend to work with our partners to achieve this. The next section illustrates how.
### 4. Strategy

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<th>Section</th>
<th>Page</th>
</tr>
</thead>
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<td>4.2. Overview of our goals and initiatives</td>
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<td>4.3. Goals</td>
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<td>4.4. Choosing our world class commissioning outcomes</td>
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<tr>
<td>4.5. Meeting the aspirations within Healthcare for London</td>
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<td>4.6. Collaborating within our sector</td>
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<tr>
<td>4.7. Activity and financial analysis</td>
<td>74</td>
</tr>
</tbody>
</table>
4. Strategy

4.1. Introduction

This chapter sets out how we intend to deliver our ambitious vision given the challenges identified in the previous pages. We look at how we are responding to the recommendations within Healthcare for London – through the pathways and the settings of care. We will then describe in detail the initiatives that will enable us to bring our Rich Picture vision to life. We also talk about the new way of working that we developed last year. This will ensure that we have a ‘joined-up’ approach to delivering rapid and sustained change using programme management. Finally, we explain how we have arrived at the financial and activity assumptions that appear in sections 4.5 and 4.6.

A holistic approach to world class commissioning

We wanted to do something beyond establishing initiatives based solely on particular conditions or diseases. Through developing the initial strategy last year, we took the opportunity to change the way we work. Following deliberations with staff and other stakeholders, we established a new way of focussing on our priorities and organising our initiatives.

We also wanted to get the most from our workforce; giving staff an opportunity to use and develop their skills beyond what was required for their ‘day-job’.

As a result we established six strategic change programmes to be delivered over five years that together address all areas of pathway redesign and commissioning, and within each all of the key initiatives sit. The first four are delivery programmes and the final two are our enabling programmes. We describe the enabling programmes in more detail in the delivery chapter:

- Wellness and empowerment
- Condition management
- Unscheduled care
- In hospital care
- Partnership and borough working
- Polysystems

Each has the benefit of a dedicated programme manager, who oversees delivery of all initiatives within their programme.
4.2. Overview of our goals and initiatives

Our goals are cross cutting and apply to all programmes and initiatives. So, for example we expect patient experience to improve across the board – from screening services to end of life options. The same applies for clinical quality and investment in services. We measure performance on these for all our initiatives. Our overriding goal of reducing health inequalities is central to all that we do and we will achieve it through delivering the associated initiatives.

4.3. Goals

This section highlights what we are doing to achieve our goals.

- **Goal 1** – No ward in Redbridge will have male or female life expectancy at birth below the London average life expectancy for men and women

  Loxford has life expectancy below the London average for both men and women – this is one of the reasons we started our polyclinic development here, where the need is greatest. Based on the latest available information, women in Seven Kings have a lower life expectancy than the London average. Again, Seven Kings is a priority for polyclinic and polysystem development and will see the next one open on the King George Hospital site in 2010.

- **Goal 2** – Commissioned services will meet the highest standards of clinical quality and demonstrate continuous improvement in the quality of care across all settings

  Clinicians are increasingly taking the lead for commissioning clinical services, and through their leadership in care pathway redesign will ensure there is clinical excellence at every stage. The new clinical assurance committee will scrutinise commissioning decisions and provide assurance to the PCT Board on clinical quality. As outlined in the context section, we have systems in place to ensure that all providers meet the highest standards.

- **Goal 3** – We expect 90% of service users and members of the public to give good or excellent satisfaction ratings with local NHS services

  We know that this is an ambitious goal, but have strong action plans in place to improve performance. Our approach is supportive – for example we held a recent workshop for GP reception staff on customer care and plan to do more. However we also expect action from providers, so recently wrote to all GP practices about their practice survey
results. We congratulated the best performing GP practices, but asked those who had patient feedback scores in the bottom quartile to develop an action plan for us to review and monitor.

- **Goal 4** – we will make sound financial, evidence based investments, with clearly defined and measurable outcomes. The PCT will ensure value for money.

Our track record here is strong, and our ‘good’ rating for use of resources is testament to this. Because of the changing financial situation we have had to look even more carefully at how we invest our resources. We have used the health analytics tool to identify how best to target interventions to deliver the best health outcomes. We further explored this in detail through the recent care pathway redesign process for CHD and have also used it to develop the initiatives explained in the strategy section of this document.

Our turnaround savings plan has seen colleagues across the PCT focus their thinking on a number of initiatives that not only deliver savings, but should improve outcomes. These include schemes that support best practice in primary care ensuring patients do not receive unnecessary medical interventions and medication, but do get the care they need.

We have looked at best practice near and far, and brought in the support of experts to support our primary care clinicians to exercise scrutiny on the cost of treatments they refer patients to in acute settings.
4.4. Choosing our world class commissioning outcomes

Last year we went through a rigorous process to select the ten key outcomes for us to focus on. We looked at all the available data about our population and closely at our performance against these to date. Despite strong performance on all of these over the past year, we are clear that the outcomes are still the right ones. This view was endorsed by our Clinical Commissioning Board at their first meeting in November 2009.

The agreed priorities and reasons for choosing these are listed below. To see how we plan to improve our performance on these over the next five years, please see the delivery section.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health inequalities Life expectancy</td>
<td>All PCTs are monitored on these mandatory indicators. They are key to our overall vision of improving health for all, while also tackling health inequality.</td>
</tr>
<tr>
<td>The proportion of children who complete MMR immunisation (first and second dose) by their 5th birthday.</td>
<td>Not only is this an NHS London public health priority, but is an area where there is scope for improvement. We need children in Redbridge to have the best start in life, and ensuring that they are properly immunised is one of the first steps that needs to be taken.</td>
</tr>
<tr>
<td>Prevalence of obesity in reception children and Year 6 children. This covers two indicators and is also a LAA target.</td>
<td>We have more obese children in these age groups than the average for London and nationally. We want children to get into good habits at a young age and not be susceptible to the poor health outcomes associated with being obese.</td>
</tr>
<tr>
<td>Cancer mortality rate.</td>
<td>This disease is one of the top three causes of death in Redbridge, and much can be done to prevent it. There is a significant link in terms of health inequalities - for example residents in more deprived areas and from some of our BME communities have a lower uptake of cancer screening programmes.</td>
</tr>
<tr>
<td>Stroke deaths within 30 days. This is also a LAA target.</td>
<td>This was identified as a concern within the JSNA and is also an HfL and HforNEL priority. We will see an increase in people over 64, so stroke will continue to be an issue.</td>
</tr>
<tr>
<td>CVD Mortality.</td>
<td>This is the second main cause of death in Redbridge and more could be done to prevent it. It also is an issue particularly for the older population and key to reducing health inequalities.</td>
</tr>
<tr>
<td>Diabetes controlled blood sugar.</td>
<td>We have seen a 5% increase in patients diagnosed with diabetes since 07/08 – and this is likely to increase further. We have a higher rate than the London average. Diabetes affects every system in the body, so can have a profound wider impact on people’s health.</td>
</tr>
<tr>
<td>Deaths that occur at home. This is also a LAA target.</td>
<td>We will see an increase in our older population. Our rates for people dying at home are below the London and national average. It is not only an HfL priority, but has been identified as a local one through our LAA.</td>
</tr>
</tbody>
</table>
4.5. Meeting the aspirations through our initiatives

As mentioned in chapter three, there are eight themes that Healthcare for London focuses on and work has been done to develop care pathways for each. This section looks at each of these and outlines what we are doing to meet the recommendations, considering quality, innovation, productivity and prevention throughout. We begin with highlighting key gaps and priorities for each, outline our ambition and describe the improvements we intend to make. Appendix 1 provides more detail on the initiative projects, outlining the main milestones for each.

There is some overlap, so a number of the projects listed under ‘staying healthy’ could fit under ‘long term conditions’ for example. We do not list all of the initiatives that we are focussing on for each of the pathways here. We do however summarise the main ones in the ‘plans for home and polysystem section’ and highlight those that feature in our three year financial plan. We cover these because of the impact that they will have in enabling us to deliver Healthcare for London and Health for north east London.

4.5.1. Staying healthy

Gaps and priorities
Keeping people well is crucial to achieving our aspirations for a healthy population and sustainable health economy. Our JSNA showed us that we need a clear focus on wellbeing, prevention and early detection of disease.

Reducing rates of diabetes, childhood obesity and increasing physical activity rates amongst adults are just some of the priorities. The table on page 91 shows by just how much we plan to improve current performance for these, with adult participation in sport mentioned below. The good news is that we have willing and committed partners – the local authority and voluntary and community sector play a critical role in providing services that help people stay healthy.

Our ambition:
By 2015 we will have achieved the following world class commissioning outcomes and:

- reduced the gap in life expectancy between those in our poorest and wealthiest communities from 6.5 to 5.5 years for men and from 2.8 to 2.3 years for women
- seen male and female average life expectancy rise from 77.8 to 78.9 years and 81.9 to 82.8 respectively

And by 2011, working with our local partners through the local area agreement we will have seen:

- a 2% increase in adult participation in sport and active recreation to 22.2%
- a rise in the number of people reporting their health and wellbeing as good – from 75% to 79% (a recent Ipsos MORI survey shows that the rate has already increased to 78% in the past year)
Our plans for the home and polysystem

We will encourage people to start their healthy lifestyle in the place they live through adopting better diets, exercising regularly and avoiding habits such as smoking and excessive alcohol consumption.

For the first time we now have valuable information and data provided by our health risk stratification tool that will enable us to identify and more effectively target potentially high risk patients and keep them well. It will be used through all polysystems by June 2010.

We have already invested in increased communications and marketing resources, but will continue to effectively target our communities through a tailored approach. We will invest in proven methods and make use of products like Mosaic that enable us to segment the population and run campaigns that appeal to the different groups within.

We have adopted a more bespoke approach to engaging some BME communities to increase rates of cancer screening take-up – based on feedback from focus groups. Similarly a fun and youth oriented campaign to encourage young people to be screened for chlamydia and new branding for sexual health services should have real impact.

We have and will continue to run the popular series of health and wellbeing roadshows across the borough, with more planned for Spring 2010 in a greater range of locations. These form part of the wider Health for NEL consultation but will include a range of community and public health colleagues on hand to provide information, advice and checks.

Polysystems provide us with a delivery network through which providers such as GPs, dentists, the voluntary and community sector (VCS) can work together in a more efficient and targeted way to keep people healthy. We intend to move to a more outcome focussed model for commissioning services, and performance will be monitored through the polysystem delivery boards. We will explore an incentive scheme to ensure that all professionals use every opportunity to promote healthy lifestyles when they interact with patients.

We have developed a health and wellbeing area in Loxford polyclinic – where people can access online information and pick up leaflets about living healthy lifestyles. We intend to incorporate this into model within the wider polysystem and roll out across the borough this year. Each polysystem will develop a health and wellbeing strategy in 2010.

In partnership with Redbridge Council we secured Department of Health time-limited funding for health and wellbeing checks for carers. This pilot scheme will enable 600 carers most at risk of hospital admission to receive initial assessments, with further checks at 12 and 26 weeks. This programme should help both the carer and ‘cared for’ maintain their health.

We plan to focus on the prevention of long term conditions through polysystems – for example we will shortly be piloting the national vascular checks programme in Loxford, where we believe it will have the greatest impact.
We have plans in place to prepare for the extension of the breast and bowel screening programmes – aimed at early detection. By 2010 breast screening will be extended to women between the ages of 47-73 years. From April 2010 onwards people between the ages of 70-75 will also be invited for bowel screening.

We will continue to tackle obesity by building on the success of joint programmes like MEND (mind, nutrition, exercise, do-it!) which is run through the local authority. 45 families have been through the programme and seen significant improvements in their BMI and general health.

Breastfed children have an excellent start in life and we need to encourage more mothers to do this. We have an infant feeding specialist in post, but plan to focus on peer support and training other staff in the benefits. A bespoke campaign to encourage breastfeeding started early in 2010.

Retaining our staff and keeping them well is important if we are to deliver our challenging programme of work. We will further build on our employee health and wellbeing programme, part of our wider approach to developing employee benefits.

**Rapid change initiative:**

<table>
<thead>
<tr>
<th>Initiative projects</th>
<th>Type of initiative</th>
<th>Three year financial impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness and empowerment – Staying healthy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Value for money and productivity review of all health and wellbeing services – looking at contracts, grant agreements, current expenditure, performance, estimated future demand. The initial focus is on sexual health and obesity services.</strong></td>
<td>These projects will support a shift in the setting of care in that improved services will be commissioned that better help people stay well and avoid the need for acute care.</td>
<td>£123,000</td>
</tr>
<tr>
<td><strong>Expansion of the expert patient programme – enabling people to get more support in the community and through their peers.</strong></td>
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</table>

**4.5.2. Maternity and newborn care**

**Gaps and priorities**

The number of births in Redbridge is set to increase by 26.2% up to 2016/17. Our JSNA showed a need to reduce the number of low weight babies and peri-natal mortality. Standards of maternity care need to improve across the north east London sector, including Redbridge. Healthcare for London (HfL) advocates a midwife led approach for all births, and the proposals for consolidating maternity services at Queens Hospital should allow for more midwife support in the community.
The sector plan goes a long way to addressing the improvements required, but there is more that we can do closer to home.

**Our ambition:**
By 2011, working with our local partners through the local area agreement (LAA) we will have seen:

- a year on year decrease in the number of teenage pregnancies

**We will also measure success through:** the percentage increase in the numbers of home births, percentage of mothers smoking at delivery, percentage of people given advice on contraception, percentage of low weight babies and breastfeeding rates.

**Our plans for the home and polysystem**
We want to enable more expectant mothers to have an informed choice about where they can give birth. The 2% rate of home births in Redbridge is currently low. More mothers with uncomplicated pregnancies should be able to choose this option.

We also plan to increase the level of pre and postnatal care that will be provided to women in their own home – helping to ‘de-medicalise’ birth in line with the HfL model of care.

Midwife led care will increase, with improved ratios to better support pregnant women get the care they want and need.

There will be a greater focus on pre-conception support within the polysystem – through nutrition, stop smoking advice, exercise and other services at the polyclinic and within the polysystem. Such support is already available at Loxford and we want to roll this out to all areas as we develop our polyclinics.

Using our health analytics tool and other intelligence, we will ensure that we target expectant mothers who are most at risk of complicated births. They will be given tailored advice and support right from planning their pregnancy through to the birth and beyond.

Care does not stop once the baby is born, and we will ensure mothers are supported to give their children the best start through breastfeeding help, immunisation encouragement and general health advice.

We mentioned teenage pregnancy in the previous section, and we will continue our work through schools, outreach and other settings. We will encourage young people to understand the potential consequences of their behaviour, providing them with advice on contraception and sexually transmitted infections.

We will also explore how to better involve the voluntary sector through maternity volunteers. There is an untapped resource of women that could provide lay support.
4.5.3. Children and young people

Gaps and priorities
Improving health outcomes for young people is something that we need to work with our partners on – particularly the local authority and Children’s Trust. The HfL future model of care outlines an approach whereby children and young people can move seamlessly through the care settings. The JSNA demonstrated a need to reduce the incidence of childhood obesity, partly through increasing physical activity amongst children. The rates of immunisations for measles, mumps and rubella (MMR) were also identified as needing to increase.

Our ambition:
By 2015 we will have seen improvements for the following WCC outcomes:

- childhood immunisations for MMR rise from 75% to 93%
- the prevalence of obesity in reception children drop from 12.8% to 11% and for year six children move from 22.1% to 21.5%

And by 2011, working with our local partners through the local area agreement we will have seen:

- a 16% increase in the number of children and young people participating in sporting opportunities – bringing the total to 88%

Our plans for the home and polysystem
We know that children from poorer backgrounds tend to experience worse health than other children. We need to concentrate our efforts to ensure that this does not translate into the adult health inequality that we are working so hard to address.

We plan to work closely with the local authority and provide more support for children and young people with long term conditions (such as diabetes and cystic fibrosis) and complex needs closer to home.

In addition we will also work to identify ‘at risk’ children and families to ensure that children remain safe. Children will be supported to make the transition between childhood and adulthood, with health action as well as care plans in place.

We know that obesity can have an impact on the development of long term conditions and has the ability to compound health issues further. We want young people to adopt healthy eating and exercise habits from an early age. We are also working with the local authority on a nationally commended spin off from the Change4Life programme. We’ve developed Active4Life which focuses on fun exercise for young people. This is just one of many schemes we run in partnership with the Council and voluntary sector.

The proximity of the 2012 Games provides a unique opportunity to help inspire children and young people, and is something we are tapping into with our colleagues at the Council. We took part in a major local launch event last year, with more planned in locations across the borough up to 2012.
We are focussing on encouraging parents to prevent their children getting ill – from getting them immunised, through to maintaining good oral health. Our tiny teeth targeted campaign is just one example of the social marketing tactics that we will continue to employ. We will implement the Healthy Child programme, which is a high quality early intervention, clinical and prevention public health programme, which begins in pregnancy and extends through childhood into the end of the teenage years.

Parents have told us that they would welcome fully integrated and seamless services co-located in an appropriate facility. We agree that services should be more convenient and focussed on the needs of parents and their children. We plan to improve our care of children by developing and relocating services on the King George Hospital site such as child neuro-developmental assessments, child protection services and specialist therapy services for children with disabilities (from Kenwood Child Development Centre); and Child and Adolescent Mental Health Services (from Loxford Hall). These proposals depend on the outcome of the Health for NEL consultation, but should it be approved, the services would move from 2012.

Parents are also high users of A&E services for their children – most of which do not need to be admitted. They would be better seen in an urgent care centre or attend a minor ailments service, perhaps in a pharmacy, which would also be more convenient and closer to home. We will be developing these services as we further develop polysystems and polyclinics (see chapter 5).

We are developing a new service model for disabled children that will see a wider range of professionals working across the borough and within polysystems – for example teachers trained to deliver speech and language services – so that children can participate in mainstream provision as far as possible. This will be fully described in our revised Children and Young People’s Plan (CYPP) which is being reviewed during 2010.

How will we measure success?
We will monitor obesity prevalence, measles, mumps and rubella and other immunisation rates, teenage pregnancy rates, dentistry access, waiting times for speech and language therapy and hospital admission rates.
4.5.4. Acute care

Gaps and priorities
This pathway is mainly picked up in the sector plan, but there is a role here for primary and community care. The JSNA clearly showed a need to improve acute services, with a particular focus on the quality of stroke care and recovery from both stroke and cancer.

Our ambition:
By 2015 we will have seen improvements for the following WCC outcomes:

- A reduction in the number of people who die from a stroke within 30 days
- A reduction in the numbers of people dying prematurely (before they are 75) from cardiovascular disease (from 78.5 to 70 per 100,000) and cancer (from 99.3 to 94.85 per 100,000)

Our plans through the home and polysystem
We plan to improve information and advice to people about how to access services appropriately. We have just launched the ‘Choose Well’ campaign locally, which informs residents about what services are available and when to use them.

We have implemented the unscheduled care centre (UCC) model of care at King George Hospital (KGH). The service is open 24/7 and is primary care led – so people are seen by GPs. We plan to increase the current level of 40% to 75% patients seen who would otherwise inappropriately use A&E. This would involve increasing the now basic diagnostic provision to include x ray, ultrasound and blood tests so that there is an increased range and capacity.

Improved assessment to decide what to do with patients conveyed by ambulance is another priority and one that the London Ambulance Service is looking at as part of its transformation programme. Too often people are not taken to the best and most convenient location because of lack of awareness of local services.

We have and are further developing multi disciplinary assessment teams, which include Council social care colleagues. The focus is on managing the transition from hospital back to a community setting, through smooth discharge. We also want to prevent readmission, so rehabilitation and re-ablement are a priority.

We are planning, with our ONEL colleagues to develop a single point of access for urgent care. The overall purpose of this would be to improve access and care pathways for patients with unscheduled and non emergency care needs. This should help people get to the right place and see the right person at the right time by using a single telephone number and will result in better care and outcomes.

We have just conducted a review of urgent and out of hours’ services and over the next year plan to implement the recommendations. This will see a reduction in overlap between services and increasing provision closer to home in the polysystem. We are also exploring opportunities to commission services collectively through ONEL – e.g. telephone support. Each polyclinic will have urgent care provision.
We can also do considerable work through the home and polysystem to avoid people needing acute admission and treatment. For example avoidance of and minimising death from stroke and cancer are both priorities for us. This can be achieved in a number of ways – from encouraging healthy diets, exercise, vascular and cancer screening through to rehabilitation – such as the gym in Loxford polyclinic for stroke survivors.

**Rapid change initiative:**

<table>
<thead>
<tr>
<th>Initiative projects</th>
<th>Type of initiative</th>
<th>Three year financial impact</th>
</tr>
</thead>
</table>
| Implement an unscheduled care pathway including:  
  - Shift from A&E to unscheduled care centre (UCC), polyclinic and walk in centre (WIC):  
  - Single point of access  
  Direct access to polyclinic appointments for unscheduled care needs. | Providing more capacity in the community to treat people with unscheduled care needs will lead to a shift in activity from the acute sector. This change should realise the financial benefits in the right hand column. | £88,000 |
| Management of minor ailments in community setting | | £22,000 |
| Rapid response service | | £22,000 |
| Improve navigation through the pathway, including the London Ambulance Service (LAS) through the LAS Transformation programme. | | £66,000 |

**4.5.5. Mental health**

**Gaps and priorities**

The JSNA highlighted a need to improve the health and wellbeing of vulnerable people – this includes a focus on physical activity for people with mental health needs.

The HfL project on mental health has focussed on dementia given that it accounts for the biggest proportion of expenditure. We also describe here how we plan to deliver other services closer to home.

**Our ambition:**

By 2011, with our partners through the LAA we intend to increase the numbers of people with mental health needs in employment (the baseline is currently being set for this). We also plan to increase the percentage of vulnerable people achieving independent living from 27.6% to 48%.
Our plans for the home and polysystem
We plan to deliver more services to people at home – through supporting carers and increasing assessment services.

We have enhanced the care pathway for people with dementia in line with the national dementia strategy. We plan to increase interventions at home and the number of people treated at home for dementia.

We have a project underway to improve the care pathway for people with medically unexplained symptoms – this should result in less acute admissions. Too many people in distress go to A&E or mental health crisis centres when there are better options.

We plan to address people’s physical and mental health needs together holistically within polysystems. There is also scope for those with moderate mental health problems to access some support online at the Loxford polyclinic health and wellbeing area for example. We plan to increase this provision.

We are working to raise awareness and deal with the stigma associated with mental ill health. Through our funded BME mental health worker (based in Redbridge Council for Voluntary Services) we organised a successful and oversubscribed free mental health film festival for the Asian community last year. We are looking to do something similar with the Black community – recognising the higher rates of mental ill health experienced by some communities.

We have and will continue to train BME faith and community leaders on mental health issues to help alleviate stigma and discrimination, and support development of local partnerships.

The Richmond Fellowship provides housing, employment and other advice from Loxford polyclinic to people with mental health needs. Their work helps to tackle the knock-on effects that mental ill health can bring.

We are improving access to psychological therapies (IAPT) locally and were recently successful in a bid for an IAPT employment support coordinator. This postholder will support people with severe and enduring mental health problems find work.

Through the Redbridge Places of Change partnership, on which we are an active partner, £2million of capital funding from the Government was secured last year. The partnership also focuses on raising awareness of mental health issues and the role of GPs in managing mental health conditions in the community.
Rapid change initiative:

<table>
<thead>
<tr>
<th>Initiative projects</th>
<th>Type of initiative</th>
<th>Three year financial impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move to more primary care focussed services.</td>
<td>These initiatives will enable a shift in setting from acute to primary care.</td>
<td>£22,000</td>
</tr>
<tr>
<td>Reduce A&amp;E attendances from alcohol and drug abuse.</td>
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</table>

4.5.6. Planned care

Gaps and priorities
Through working with our clinical directors, the Clinical Commissioning Board and local GPs we could improve the quality of referrals made for planned care. We need to ensure that referrals are appropriate and that patients have real choice in where they receive their treatment.

Our ambition:
By 2015 we will have seen improvements for the following WCC outcomes for CVD, stoke and cancer (as highlighted in the previous acute care section).

We will also measure success by: monitoring the percentage of patients seen within 18 weeks, waits for diagnostic tests over 6 weeks, GP referrals into secondary care, outpatient attendance rates, first appointment to follow up ratio and readmission rates.

Our plans through the home and polysystem
Through our referral management project we are working with GPs to ensure that referrals are appropriate and that there is speedy access to diagnostic tests – many of which will be available within the polyclinic at the heart of the polysystem.

King George Hospital in our borough is proposed to be a model of excellence for elective surgery.

We will ensure that the type of services already available at Loxford, such as minor operations will be an option for other residents through their local polyclinics.

We will also promote amongst GPs and increase utilisation and activity at the independent treatment centre. Patients can have some operations here (e.g. hip or knee replacements), are generally seen quickly and the services highly rated by patients.

The level of support to enable people to deal with simple conditions simply and efficiently will be increased – for example by phone, internet or through speaking to a pharmacist.
We are currently reviewing GP with Special Interest (GPwSI) services to look at how we improve access to specialist input in the community and make the most of this local experience.

Residents can already access hospital type services at Loxford polyclinic – we will increase the amount of outpatient appointments available in the community.

We are working through the acute commissioning unit to ensure that procedures of limited clinical effectiveness such as operations to remove tonsils and grommets are only carried out as indicated by national guidance and evidence based practice. It does not benefit the patient or us as commissioner for people to receive procedures that do not have proven efficacy.

Last year we commissioned a rapid access service for people who had experienced a mini stroke or trans ischaemic attack. This service, run through Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) sees patients quickly and offers improved waiting times for diagnostics such as blood tests.

We are undertaking an audit in primary care to assess the need for diagnostics available to GPs for early diagnosis of cancer. This initiative will improve early diagnosis and survival rates and reduce cancer mortality.
Rapid change initiative:

<table>
<thead>
<tr>
<th>Initiative projects</th>
<th>Type of initiative</th>
<th>Three year financial impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute contract and performance management through the Acute Commissioning Unit.</td>
<td>Better management of our hospital providers should result in decommissioning of provision that is no longer needed. There is activity carried out that patients do not need to have.</td>
<td>£3,712,000</td>
</tr>
</tbody>
</table>

**In hospital – Planned Care**

- **Condition Management - Planned Care**
  - We are working with the ONEL Clinical Advisory Group (CAG) to identify best practice to inform care pathway redesign. The top five areas for planned care will be the focus: ophthalmology, ear, nose and throat (ENT), gynaecological, T&O and rheumatology.
  - New pathways will enable a shift in activity out of the hospital sector. Some of the planned care procedures are already available at Loxford polyclinic.
  - Implement best practice model of planned surgical care - e.g. reconfiguration of King George Hospital (KGH)
  - Improve admission and discharge planning and process
  - Increase productivity in primary and community care
  - Referral management – ensure best practice and consistency across PCT
  - Pathway redesign (top 5 as above)
  - Implement best practice model of planned surgical care (e.g. reconfiguration of KGH)
  - The other projects to the left will also have an impact on shifting activity and realising the benefits identified to the right.
  - Some referrals to hospital are inappropriate. We don’t want people to receive treatment that they don’t need. The referral management scheme will impact on decommissioning of unnecessary procedures. The same applies for pathway redesign and best practice implementation.

- **£3,712,000**
- **£12,000**
- **£633,000**
- **£44,000**
- **£492,000**
- **£6,590,000**
- **£125,000**
- **£1,918,000**
4.5.7. Long term conditions

Gaps and priorities

As we have outlined in chapter three, we have seen and will continue to see a rise in the number of people with long term conditions.

Diabetes in particular is a concern for us, which is why we have chosen it as one of our top health outcome priorities. Not only do we want to improve patient care for people with long term conditions; we also want to reduce prevalence by encouraging people to adopt healthy lifestyles (see also the staying healthy section).

Locally, we have also chosen to focus on care for people who have suffered a stroke, have coronary heart disease, cancer, diabetes or suffer from addiction to drugs. Through the north east London sector we are also focussing on COPD and asthma.

We are committed to supporting people at all stages of their illness. Over the next five years we will deliver a new comprehensive approach to condition management that focuses on care management and self-management. With this new approach we aim to prevent and reduce the number of times a patient has to spend time in hospital, improve their experience of services and improve their overall health outcomes.
Currently our local health resources predominately support 5% of the population, with 80% of GP appointments being taken up by this group. It includes those who are classified as having either a high risk or a high need of healthcare services, and those with very complex conditions and a history of frequent admissions to hospital.

**Our ambition:**

Our ambitions for achievement through our world class commissioning outcomes and the LAA are many of those listed under the other pathways. By 2015 we will have achieved our world class commissioning targets for stroke, cancer and CVD. In addition we will have seen people with diabetes better control their blood glucose levels. And by 2011, working with our local partners through the local area agreement we will have seen:

- an increase in independence for older people by increasing rehabilitation / intermediate care from 78% to 86% and increasing self directed support for social care clients from 2.3% to 30%

**Our plans through the home and polysystem**

We will look towards providing care that is closer to home, and that enhances a self-care approach. Our focus will be on achieving a successful prevention risk analysis that can be used to identify those most at risk of long-term illnesses. This will enable financial resources and services to be targeted where needed most, and tailored to suit individual needs. We discuss the ground breaking tool we have developed to enable this in chapter 5.

Provision for long term care in a home environment will be made. We will support patients and carers to manage care at home through telecare services.

Working through the polysystems we intend to ensure improvements in early diagnosis, so that we can begin to treat people quickly.

We also intend that all patients with long term conditions have a health and social care plan and are proactively managed through the polysystem – linking social care, primary care and community support such as district nurses. Specialist multi-disciplinary teams, also including consultant level support will also be available within the polyclinic hub. The polysystem delivery boards will receive regular information on those patients most at risk of hospital admission. Leads will take responsibility for ensuring that the provision identified in their care and health plans is delivered appropriately and pick up any gaps in clinical care.

In future services such as the rehabilitation gym for stroke survivors in Loxford will be rolled out to further polyclinics.

We plan to deliver tiers 1-3 of the diabetes care pathway through our polysystems. This involves care by GPs in both hub and spoke and patient education programmes delivered at the polyclinic or spoke practices if more appropriate. In addition there will support for women with diabetes to help plan their pregnancies.
Innovation will also be central to our approach. We have applied for a regional grant to deliver a pilot coaching project in our most deprived area. The ‘do it’ project will support behaviour change and encourage people to adopt healthier lifestyles – through diet, exercise, smoking and responsible alcohol consumption.

**Rapid change initiative:**

<table>
<thead>
<tr>
<th>Initiative projects</th>
<th>Type of initiative</th>
<th>Three year financial impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronal Heart Disease (CHD) pathway redesign</td>
<td>These initiatives will enable a <em>shift</em> in activity from the acute to a primary or community care setting.</td>
<td>£44,000</td>
</tr>
<tr>
<td>Better management of LTC patients in primary and community care including:</td>
<td></td>
<td>£1,072,000</td>
</tr>
<tr>
<td>- personalised care plans</td>
<td></td>
<td></td>
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<tr>
<td>- tele-health</td>
<td></td>
<td></td>
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<tr>
<td>Improve self care including medicines compliance.</td>
<td></td>
<td>£49,000</td>
</tr>
<tr>
<td>Identification of high risk patients using our Health Analytics tool to prevent emergency admissions through targeted primary care intervention.</td>
<td>Using this powerful tool will support <em>decommissioning</em></td>
<td>£959,000</td>
</tr>
</tbody>
</table>

**CASE STUDY**

**Coronary Heart Disease (CHD) pathway redesign**

Pathway redesign is fundamental to improving health outcomes, particularly for those with long term conditions. This example highlights the start of a comprehensive, multi-agency approach that we intend to use as a model for other care pathway redesign.

We established links with Kaiser Permanente, a leading health management organisation from the USA, with a wealth of experience in shaping patient centred healthcare. In early December, we jointly led an intensive and clinically led four day workshop to agree an integrated care pathway for CHD patients most at risk of hospital admissions. The aim was to develop a pathway which would improve clinical outcomes, patient experience and financial outcomes.

We brought together all local stakeholders, from local authority social services leads to polysystem clinical directors and acute consultants. They reviewed current arrangements through taking on board patient and practitioner feedback and examining current performance. Colleagues looked at the cultural and behavioural change needed and the incentives required to drive change. Together they created a cost and clinically effective care model which several attendees have already started implementing.
We know that patients are most vulnerable when they are discharged. We have taken forward the work from the Kaiser Permanente session within Wanstead polysystem. Within the polysystem a new way of following up on patients discharged from Whipps Cross Hospital (WHX) is being piloted.

Data from the electronic discharge system at WHX is sent to Wanstead GP practices within 24 hours of the patient’s discharge. This is then followed up by the practice making early contact with the patient to offer reassurance and to arrange for an appointment within 10 days. At this appointment a CHD discharge checklist is followed. This provides an opportunity for the patient and GP to establish an agreement about the support needed and how it will be provided. The discharge summary is underpinned by a 15 day clinical advice service to primary care staff about any person discharged with CHD.

A pilot community cardiology service is being established to test a new model of service provision in 2010. The model is supported by a Consultant Cardiologist and provided by a GP with a special interest and specialist nurse.

4.5.8. End of life

Gaps and priorities
Our JSNA identified a need to improve care and to strive for dignity and respect for all service users as they reach the end of their lives.

We have a lower figure than the London and England average for people dying at home, nursing care home or care home. Our figure for people who die in a hospice environment is better than the average. The trend is going in the right direction.

Our ambition
By 2015 we will have given people nearing the end of their lives greater choice over where they die. We will see the current figure of 16% of people able to die in their own homes rather than hospital, rise to at least 22%.

Our plans through the home and polysystem
Evidence shows that most people would like to die at home, and it is our job to support people to do this. We are aware that we need to significantly improve what happens in Redbridge, which is why this is one of our 10 WCC priority outcomes.

An ONEL collaborative commissioning initiative is being overseen by a pan borough steering group. One of the goals is to implement the best practice Gold Standards Framework and the Liverpool Care Pathway.

We plan to increase links between palliative care and community teams to ensure more care can be delivered in home.

We will raise public awareness and ensure that patients can make informed decisions through discussion of the issue at appropriate times. All long term condition patients should have an agreed care plan that covers this issue. Carers will be involved and supported throughout this process and following the death of the person they care for. We see carers’ role as crucial in supporting people to be able to die at home.
There will be a focus on ensuring that people nearing the end of their lives are identified wherever possible. The sector clinical working group recommended continued investment in education and monitoring the impact of training.

We plan to further develop end of life palliative care and are investing in the ONEL collaborative commissioning five year project which started last year. The project is underpinned by the five common principles from HfL outlining what excellence looks like.

Our recent comprehensive area assessment recognises this is an improving area for us. The Dementia End of Life care partnership project has been running since May 2008. It supports people at home in the end stages of dementia, as well as their families and carers. The project does and will continue to enable extra care tenants with dementia to die at home as opposed to hospital or being transferred to hospice nursing homes.

Rapid change initiative:

<table>
<thead>
<tr>
<th>Initiative projects</th>
<th>Type of initiative</th>
<th>Three year financial impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Condition Management – End of Life (EoL)</strong></td>
<td>This initiative, by enabling more people to choose where to die will result in a shift of people from hospital to home or another setting to die.</td>
<td>£44,000</td>
</tr>
</tbody>
</table>
4.6. Collaborating within our sector

We have been and will continue to work with our fellow PCTs in outer north east London. This section presents some of the projects we plan to collaborate on within each of the HfL care pathways.

**Staying healthy**
- The Sector Public Health Network (PHN) will prioritise value for money and productivity in developing a consistent set of priorities
- The PHN will develop CQUIN indicators/level of incentive for prevention and behavioural interventions
- Collectively we will strengthen public health input across the sector

**Maternity**
- We will define the offer for women in ONEL and will push for choice of birth location
- We will resolve boundary issues to support choice and best provision

**Children**
- In NHS Redbridge we will lead on HfL priorities for the sector
- We will develop a consistent urgent care model across the sector (urgent care provided by primary care clinicians, supported by a multi-disciplinary team)

**Acute care**
- We will develop an integrated/combined unscheduled care centre (UCC) specification with clear key performance indicators. NHS Havering will draft the service level specification for UCCs located with an A&E. NHS B&D will draft the same for UCC without an A&E. We will then work towards agreement for common specifications to share and these will go through the clinical advisory group (CAG) to enable clinical assurance
- A single rapid response team will be considered as part of each urgent care centre and will co-ordinate care regardless of borough of origin
- Together we will introduce a pilot for a specialist advice line and ‘hot’ clinics which we will evaluate through a retrospective audit

**Mental health**
- PCTs will look at the impact of dementia on acute admissions
- We will review acute liaison and interface with A&E to define best practice, identify metrics and incentives to minimise A&E admissions
- PCTs will agree a common approach to inpatient admission across the sector
- We will further develop contractual and performance management arrangements (better use of metrics including quality)
At sector level we will refresh the needs assessments across the PCTs
We will strengthen therapeutic inputs on wards to improve patient experience, speed recovery and reduce length of stays

Planned care
The ONEL clinical advisory group is defining new models of providing care outside of hospital. They are initially focusing on urology, ophthalmology, ear, nose and throat (ENT), trauma, orthopaedics and gynaecology
A market management and supplier event for our sector is planned for later in 2010
Primary and community services across all four PCTs will work to an agreed list of common models of care, pathways and outcomes (with common terminology that is easily understood by patients and providers)
The focus for all will be: referral management, increasing the use of the ISTC, primary and community access to diagnostic tests, improved discharge from hospital and rehabilitation services

Long term conditions
The focus will be on care and condition management through the polysystem
A sub group of CAG for unplanned care and long term conditions will prioritise and focus on the top five long term conditions. Within our sector these are asthma, diabetes, CHD, CVD and COPD
A sub group of the CAG will agree the integration between the primary and secondary care designed care pathway – and oversee the procurement of an outcome based pathway
The strategic commissioning group will oversee the implementation of the health analytics risk stratification tool. It was developed with our PCT and is currently being used in Redbridge, but will be rolled out across the wider sector
Sector PCTs will review 24/7 out of hours’ services to see if there is an opportunity to collaborate on new models of provision
PCTs will also review the sector’s interface with the London Ambulance Service to ensure the best outcomes for patients
We will share best practice. NHS Waltham Forest will share the learning from their polysystem shared patient record pilot across the wider sector. NHS Barking and Dagenham and NHS Havering will share their learning from the personalised budgets and integrated care pilots
End of life

- The CAG will lead the assessment of our current position
- All PCTs will implement the Liverpool care pathway and will collaborate to commission expert advice and respite care
- PCTs will explore an integrated provider model with Marie Curie or other integrated provider to develop a 24/7 specialist input
- We will develop performance metrics and use best practice identified by Commissioning Support for London (CSL) and NHS London
4.7. Activity and financial analysis

We have further developed the initiatives to ensure that they are in line with the expectations for Health for NEL and Healthcare for London. These have been covered in the pathway sections just before this one, but are summarised here.

These initiatives were initially discussed with the Clinical Commissioning Board at their December meeting and will be further developed within the polysystem delivery plans to be finalised in February 2010. The full details on activity and financial analysis are covered in the finance template that sits alongside this strategy. The text below accompanied the template and outlines how the figures were arrived at.

The template has been completed in line with NHS London planning assumptions, and the Health for NEL Business Case. The data included within the initiatives is driven by the McKinsey’s modelling including detailed analysis at healthcare resource group (HRG) level of the activity to be decommissioned and shifted. We have used a newly commissioned risk stratification tool "Health Analytics" to model the activity within each initiative, to allow a robust delivery solution. Actual data from Loxford Polyclinic was used to increase the accuracy of plans.

The model assumes that all activity shifted from secondary care to be re-provided within primary/community care will be delivered within a polysystem setting. The base case scenario includes an aggressive plan for delivery across 2010/11 - 2012/13, this timescale has been agreed across the sector.

<table>
<thead>
<tr>
<th>HFL pathway and initiative</th>
<th>Decommissioning initiative projects</th>
<th>Three year impact £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition Management – Planned Care</td>
<td>Referral management – ensure best practice and consistency across PCT</td>
<td>£6,590</td>
</tr>
<tr>
<td></td>
<td>Pathway redesign (Top 5 - ophthalmology, ENT, gynaecological, T&amp;O, rheumatology)</td>
<td>£125</td>
</tr>
<tr>
<td></td>
<td>Implement best practice model of planned surgical care (e.g. reconfiguration of KGH)</td>
<td>£1,918</td>
</tr>
<tr>
<td>Condition Management – LTC</td>
<td>Identification of high risk patients using Health Analyzer to prevent emergency admissions through targeted primary care intervention</td>
<td>£959</td>
</tr>
<tr>
<td>In Hospital – Planned Care</td>
<td>Acute contract and performance management via ACU</td>
<td>£3,712</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£13,304</td>
</tr>
</tbody>
</table>
| Health and Wellbeing – Staying Healthy | Vfm and productivity Review of Health and Wellbeing services  
Expand Expert Patient Programme (EPP) | £123 |
| Condition Management – Planned Care | Pathway redesign (Top 5 - ophthalmology, ENT, gynaecological, T&O, rheumatology). Working with ONEL CAG to identify best practice  
Implement best practice model of planned surgical care (e.g. reconfiguration of KGH)  
Improve admission and discharge planning and process  
Increase productivity in primary and community care | £812  
£633  
£44  
£492 |
| Condition Management – LTC | Pathway redesign (diabetes, CHD, stroke rehab, COPD, asthma) building on Kaiser Permanente CHD pathway redesign workshop  
Better management of LTC patients in primary and community care including:  
- personalised care plans  
- tele-health  
Improve self care including medicines compliance | £44  
£1,072  
£49 |
| Condition Management – EOL | Implement EOL pathway including patients having choice of place for EOL | £44 |
| Condition Management – Mental Health/Drugs and alcohol | Move to more primary focussed services  
Reduce A&E attendances from alcohol and drug abuse | £22 |
| Unscheduled Care – Acute Care | Implement Unscheduled Care Pathway inc  
- Shift from A&E to UCC, polyclinic and WIC:  
- Single point of access  
- Direct access to polysystem appointments  
Management of minor ailments in community setting  
Rapid response service  
Improve navigation through pathway including LAS through LAS Transformation Programme | £88  
£22  
£22  
£466 |
| Total | | £3,533 |
5. Delivery

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<th>Title</th>
<th>Page</th>
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<td>5.2</td>
<td>Delivery schedule for initiatives</td>
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<td>5.3</td>
<td>Past delivery performance</td>
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<td>5.8</td>
<td>Provider requirements and plurality of provision</td>
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</tr>
</tbody>
</table>
5. Delivery

5.1. Introduction

This section looks at how we plan to deliver the initiatives outlined in the previous section. For us polysystems and partnerships are the core enablers that will help us achieve our objectives. We also highlight the benefits of our new innovative health analytics tool and outline how it will help us better target resources to achieve improved health outcomes.

5.2. Delivery schedule for initiatives

The initiatives have been developed with colleagues across the PCT and indicative timescales have been agreed. Given that most of the initiatives rely on significant shifts in activity from acute to community and primary care we want to ensure that all local clinicians and partners fully support the pace and phasing of the proposed changes. Our Clinical Commissioning Board will be central to and lead this process. There are a number of targeted sessions planned with them in the first months of 2010.

5.3. Past delivery performance

This year we opened London’s first purpose built polyclinic in Loxford, one of the borough’s most deprived wards. This signalled our commitment to starting our polyclinic and polysystem programme where the need was greatest. The polyclinic is proving to be a real success and popular with patients. You will hear later in this chapter more about what’s been achieved. We will show how it is playing a role in providing tailored services in a more convenient way to Redbridge residents.

Clinicians must be in the driving seat of change. Our vision for 100% polysystem coverage has been achieved. And what’s more, we have inspiring clinical leaders, all of whom are local GPs to lead the process. Clinical directors were appointed in October to spearhead change in one of five polysystems. Working with fellow GPs, PCT staff, partner organisations and informed by a local community panel of residents, progress will be accelerated through the polysystems.
5.4. Polysystems and delivery

Polysystems are the ‘engine’ and delivery network which drives change within a geographical locality to meet the wider health and healthcare needs for a registered population. Polysystems will ensure that local services are as clinically and cost effective as possible, identifying how and where investment should happen.

We have led the way with polysystem development, and as mentioned previously already have our five polysystems fully up and running. Having the polysystem clinical directors will accelerate progress further and provide the delivery network for the initiatives outlined in Chapter 4.
5.4.1 Polysystem delivery progress to date

During the last year we have accelerated implementation of our polysystems. We have reviewed our arrangements for practice based commissioning and given each of the five polysystem boards responsibility for commissioning and managing the associated budget.

In October we appointed our five polysystem clinical directors to lead the review and implementation of revised pathways and services within each local community.

We also reviewed our management infrastructure and realigned commissioning teams to support and enable polysystem delivery, appointing five polysystem chief officers to drive this forward.

The clinical director, chief officers and PCT directors now meet monthly with community and secondary care colleagues at our newly established Clinical Commissioning Board. Please see the governance structure on the next page which demonstrates how the polysystem boards feed into the CCB and Trust Board.

The Board considers data for each polysystem and GP practice profile by disease area and/or risk to monitor the delivery of productivity and quality improvements across the borough and within each polysystem. They also review service utilisation and financial performance of GP and acute providers for individual improvement areas such as outpatients, diagnostics and medicines management.

This approach is already delivering measurable benefits which we intend to extend and scale further across all clinical areas in 2010/11 and beyond.

The Kaiser Permanente workshop and subsequent progress outlined in the case study on page 68 will also contribute to future efficiencies and improved health outcomes for patients.

A recent patient survey of over 800 Loxford polyclinic patients showed high levels of satisfaction with the services and new model of health provision. There are also some lessons for us that we are using to inform the development of future polyclinics. For more information on what has been achieved at Loxford please read the case study on page 82.

More recently we have extended our engagement within each polysystem. The membership of our polysystem commissioning boards now includes representation from all our local providers including acute hospital specialists, community nursing, social care and will be extended further.

Building on the success of the Loxford community panel we have also established four further polysystem community panels this year. The panels are proactively involved in designing, procuring and monitoring local service delivery, providing a community voice and advice to the clinical commissioning process.
5.4.2 Delivering efficiencies and productivity gains through polysystems

- This year we have reached agreement with our clinical commissioners to use primary care personal medical service (PMS) growth funding for the benefit of the polysystem population rather than just the registered PMS practice patients. This will enable all registered Redbridge residents to benefit from improvement schemes.
- Our polysystems practices will be encouraged to establish federated working practices, where they will work more closely together as one business. This should not only reduce overheads and unnecessary bureaucracy, but increase clinical time focused on managing high risk patients. This is already happening and we expect the pace of change to accelerate as GPs demonstrate the benefits of working in this way.
- We have demonstrated that our Dermatology GP with Special Interest Service has substantially reduced outpatient attendances at less than 75% of the ‘payment by results’ (PbR) tariff cost.
- We have demonstrated a 40% increase in the utilisation of the Independent Treatment Sector Treatment Centre (ISTC) based at King George Hospital, through concerted engagement of GPs through polysystem boards.
- Procurement and the tendering at Loxford polyclinic provided high quality for lowest cost and through the Alternative Provider Medical Services (APMS) contract in place there payment is paid on delivery of agreed outcomes. All new primary and community services will be APMS2 to ensure high quality and productivity.
- Review of the pharmacy local incentive scheme (LES) arrangements and move to outcome rather than income based contracts next year will also drive efficiency and improvements for patients.
- Medicines management and referral reduction initiatives have driven productivity improvements in both areas.

5.4.3 Governance of polysystems

This diagram summarises the organisation and governance arrangements.
CASE STUDY

Loxford Polyclinic

Loxford Polyclinic opened to patients in mid June 2009 and is the first purpose-built polyclinic in London. It sits at the heart of the Loxford polysystem. Clinicians were central to the development of the 30+ services offered within the clinic. These include: GPs, an in-house pharmacy, children’s health services, a healthy living café and specialised rehabilitation gym for people recovering from illness such as a stroke.

The polyclinic can now handle up to 300 outpatient type appointments a week giving local hospitals more capacity to focus on specialist care.

Over 1000 new patients have registered with a GP there, which helps with our plans to encourage more people to see GPs and be registered.

Over 1500 patients have accessed a consultation through the minor ailments service provided by the pharmacy and nearly 1000 have used the walk-in service. This helps to free up GPs and stop people attending A&E.

Over 20 community groups at the polyclinic offer a number of wellbeing services through activities such as bhangra dancing and employment advice for people with mental health problems.
5.4.5 Future polysystem delivery

We focus here on the role of the following to deliver change:

- People
- Clinical and business processes
- Information and technology
- Estate

People
Polysystems are a collaborative and partnership approach that involves everyone involved in delivering health and wellbeing support to the local community. The ambition is to bring together primary and secondary care clinicians in order to transform services. Polysystems will be held to account for their performance. The key is the people and their ability to work together to deliver this.

We now have strong clinical leadership for each polysystem, but also have a significant role in supporting them and their colleagues to develop capacity to in future take the lead for local clinical commissioning. We restructured our organisation last year and have five PCT polysystem chief officers working closely with the GP clinical directors.

We are developing polysystem organisational development plans for each polysystem. To support clinician cultural and behaviour change we have developed incentive schemes – the first of which is aimed at reducing the amount of inappropriate referrals to secondary care. The scheme not only benefits the polysystem in that they are able to recoup savings to make new commissioning decisions, but also helps the PCT in these more challenging times by sharing the financial benefits. Moving forward we will work with clinicians to agree how they can begin to effectively manage their whole polysystem budget.

To deliver our ambitious agenda we need a polysystem and wider workforce that is productive, motivated, adaptable and healthy. We also need a wider primary and community care workforce with the skills to deliver our vision through a new way of working. This ranges from developing programme management skills through to the greater focus on care provided in the community.

We developed a workforce strategy to support implementation of our strategic plan last year. The strategy was informed by the Redbridge nursing and local provider workforce strategies in addition to national and regional guidance.

The strategy focused on the workforce implications of prevention, care and support services being provided in a fully integrated fashion through polysystems. Major gaps, issues and risks are being identified to enable detailed workforce planning.

We know that we intend to significantly increase capacity for management of long term conditions – we are looking at new options for health coaches/trainers to support this.

The polysystem model and active involvement of representatives from all practitioner groups will help to break down the sometimes rigid boundaries that can exist between
those working in acute, primary and social care settings. The CHD care pathway pilot is just one example of how things are starting to change in this respect.

The availability of a suitably skilled clinical workforce will be vital to the success of our overall strategy. Nurses have an important role in this, and through our detailed Adult Nursing Commissioning Strategy for Community and Primary Care Services we explain our plans.

We still provide the training for community services staff, and recently held a ‘Six Steps Planning event’ to enable us to better understand the workforce needed to support this approach. Understanding access at various levels and interventions along a care pathway according to clinical need helps us to identify what staff are needed to ensure a quality service to the patient. Further events are planned for 2010 and beyond.

Good communications and engagement with the wider community are essential. We need to prevent people becoming ill and increasing strain on health services. We are focussing on targeted social marketing campaigns and providing information to ensure that people use services appropriately and understand how to access them. We have recently rolled out the ‘Choose Well’ campaign to advise the public on when to use a pharmacy, GP, polyclinic, A&E etc.

The community need to be at the heart of polysystems and have a say in how they are developed. Four further polysystem community panels to accompany the well established Loxford panel have recently been established. Each now has a non executive Board member who will ensure that their voice is heard at the highest level.

**Clinical and business processes**

We plan to redesign care pathways and actively manage people in the community. For example, as mentioned under the long term conditions section on chapter 4; we see polysystem boards taking collective responsibility respectively for people with long term conditions most at risk of hospital admission. This ‘panel management’ approach, as advocated by Kaiser Permanente and other leading health organisations will not only help keep people well, but enable best clinical practice and quality.

We have established the polysystem development boards, where all GP practices have a seat. We plan to widen membership on these over the next year. The Clinical Commissioning Board is also now in place, and has the leadership to drive clinical commissioning in Redbridge. The Clinical Commissioning Board accounts to the PCT Board and blends the best of Practice Based Commissioning with executive management commissioning. The Board will oversee polysystem delivery, develop a borough wide commissioning plan, develop care models and pathways and provide the clinical interface with the acute commissioning unit.

Each polysystem is developing a polysystem delivery plan that will set out how each respectively plans to deliver change. These will be completed in early in 2010 and will outline how the initiatives in chapter four will be delivered.

We are also focussing on developing the market for services (covered later in this chapter). The borough and polysystems require providers who can respond to the changing needs of our community and the aspirations in this plan – particularly within an accelerated timescale and through increased productivity.
Information and technology
We are developing a common ICT system within polysystems to enable integrated working between hub and spokes. This will shortly be piloted in Loxford.

We need to understand patients’ experience of services in polysystems. We are piloting a more convenient and effective way of collecting and analysing patient feedback through new online touch screen pads at Loxford.

Polysystem colleagues will need detailed information to ensure those most at risk of ill health and hospital admissions are well managed in the community.

Risk stratification and tailored information by polysystem will ensure decisions are evidence based. The Health Analytics programme will support this – read the case study here:

CASE STUDY
Health Analytics
To realise our aim of supporting people with long term conditions to remain in the community and keep as healthy as possible we needed to come up with an innovative solution.

In 2008 we piloted a software application aimed at enabling GPs and commissioners to identify potential emergency hospital admissions 12 months before they occur. Results from research carried out by the Kings Fund demonstrated potential savings and improved patient care from the programme. So in January 2009 we scanned the market for the right product and worked with a company called Health Analytics to develop a new tool.

The system is managed in line with data protection and confidentiality requirements and helps to understand patient support needs. It brings together ‘real time’ data extracted from GP held patient electronic records and mixes it with hospital data. The information is then ‘stratified’ to identify the likelihood of each patient requiring hospitalisation, identifying those who are most at risk. Once identified they can be closely managed by their GP and other professionals within the polysystem to ensure they are not admitted to hospital unless absolutely necessary. We are now rolling this out to all GP practices.

This allows us to demonstrate areas of high cost/risk at a borough, polysystem, practice and even an individual patient level. In this way productivity and quality improvement opportunities and priorities can be easily identified, interventions implemented and changes tracked.

With this capability we will market test outcome based pathway commissioning in one area in 10/11 incentivising acute and community providers to collaborate to deliver integrated care across secondary and primary care.
Polysystems have started to and will be increasingly delivering against indicators on health outcomes. To do this, development boards will require performance data bespoke to their polysystem. They will be held accountable for performance, but we expect there to be supportive arrangements within the polysystem to enable best practice to be shared. ‘Balanced scorecards’ outlining performance on referrals, prescribing trends, screening performance, long term condition management and patient survey results will be presented on a monthly basis.

**Estate**

We plan to develop four further polyclinics and a wider range of services in the community. Our ‘firm foundations’ estates strategy sets out our plans for implementation and investment. Given the financial challenge we need to make best use of our existing estate.

Firm foundations outlines how we will have between 2-3 ‘spokes’ and one ‘hub’ for each polysystem by 2013. To achieve this we expect GPs to collaborate and merge practices of 1-2 every year for the next five years. This is being clinically led and planned by our five polysystem commissioning boards.

The diagram below illustrates our timeline for both polyclinic and polysystem development, for which we are on track.

![Diagram of polyclinic and polysystem development timeline]

The standard services will include:

- a pharmacy
- outpatient services
- diagnostics e.g. blood testing services
- primary care – including GP practices
- urgent care
- minor ailments
- voluntary health and wellbeing services
- co-location of community and social care
## Integrating care within polysystems

<table>
<thead>
<tr>
<th>Setting</th>
<th>People</th>
<th>Services</th>
<th>Informatics &amp; Technology</th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polyclinic</td>
<td>● GPs&lt;br&gt;● GPwSI&lt;br&gt;● Practice nurse&lt;br&gt;● Pharmacist&lt;br&gt;● Hospital Consultant&lt;br&gt;● Social worker&lt;br&gt;● Specialist multi -- professional teams&lt;br&gt;● Dentist&lt;br&gt;● Podiatrist&lt;br&gt;● Therapist</td>
<td>● Planned primary care&lt;br&gt;● Urgent care&lt;br&gt;● Diagnostics e.g. X-ray, ultrasound&lt;br&gt;● Outpatients e.g. Cardiology, ENT&lt;br&gt;● Minor ailments service&lt;br&gt;● Rehabilitation, e.g. cardiac and stroke&lt;br&gt;● Voluntary services, e.g. Healthy living classes&lt;br&gt;● GPwSI services, e.g. Minor operations, Dermatology&lt;br&gt;● Therapy services e.g. audiology testing&lt;br&gt;● Blood testing&lt;br&gt;● Community information&lt;br&gt;● Patient education programmes</td>
<td>● Serves 50 – 70000 Polysystem patients&lt;br&gt;● Polysystem Patient Risk Profiling and modelling using Health Analytics&lt;br&gt;● Polysystem Call centre and booking&lt;br&gt;● Rapid access to diagnostics&lt;br&gt;● Integrated hub IT systems</td>
<td>● Strategic location&lt;br&gt;● 2000-3000 sqm&lt;br&gt;● 80% clinical space&lt;br&gt;● Community Facility&lt;br&gt;● Field staff centre&lt;br&gt;● Education centre&lt;br&gt;● DDA compliant&lt;br&gt;● Space efficiency&lt;br&gt;● Good public transport accessibility</td>
</tr>
<tr>
<td>Spoke GPs and Pharmacists</td>
<td>● GPs&lt;br&gt;● Practice nurse&lt;br&gt;● Pharmacists&lt;br&gt;● Healthcare assistants (HCAs)&lt;br&gt;● GPwSI</td>
<td>● Planned primary care&lt;br&gt;● Screening and immunisation programmes&lt;br&gt;● Long term conditions Management support&lt;br&gt;● Counselling&lt;br&gt;● Blood Testing&lt;br&gt;● Minor ailments service</td>
<td>● Serves 10 -15000 Practice patients&lt;br&gt;● Practice patient risk Profiling using health analytics&lt;br&gt;● High risk patient panel management&lt;br&gt;● Spoke IT system connected to hub</td>
<td>● 300 – 600 sq m&lt;br&gt;● Consulting rooms&lt;br&gt;● Within walking distance of home</td>
</tr>
<tr>
<td>Home</td>
<td>● The informed patient&lt;br&gt;● Carer&lt;br&gt;● Care manager&lt;br&gt;● District nurse&lt;br&gt;● Health visitor&lt;br&gt;● Midwife&lt;br&gt;● Voluntary Services&lt;br&gt;● Social care&lt;br&gt;● Specialist nurse&lt;br&gt;● Coach&lt;br&gt;● Care navigator</td>
<td>● Long term condition management&lt;br&gt;● Expert patient programme&lt;br&gt;● Telephonic coaching&lt;br&gt;● Polysystem specific websites e.g. Loxford&lt;br&gt;● Proactive community network and support&lt;br&gt;● Out of hours&lt;br&gt;● Targeted polysystem Social marketing e.g. Active for Life&lt;br&gt;● Home births&lt;br&gt;● Palliative care</td>
<td>● Personalised patient risk analysis and care plans using health analytics&lt;br&gt;● Internet care record access&lt;br&gt;● Telecare&lt;br&gt;● Telehealth&lt;br&gt;● Patient engagement e.g. polysystem Community panels&lt;br&gt;● Patient experience surveys</td>
<td>● Home&lt;br&gt;● Access to consulting rooms&lt;br&gt;● Libraries&lt;br&gt;● Public spaces</td>
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Developing and integrating community services within polysystems

Our vision is that polysystems will be clinically led with local GPs, community services and hospital specialists working together in teams in a collaborative way to deliver improved outcomes for local residents. Care will increasingly become more aligned and integrated across traditional settings, providing improved patient experience, better quality and greater productivity. This is not just about moving hospital activity into the community, the alignment of care must be fundamentally different.

We will deliver these improvements by encouraging local community and primary care providers to work in teams through more effective service models and contracts. We now know who our high risk communities are having developed our health analytics solution over the last year. We intend to develop care models for distinct and vulnerable population groups such as frail elderly and children, and for disease groups such as diabetes and CHD. We will commission in a way which focuses on keeping these high risk populations healthy and out of hospital for as long as possible. We fully expect our community nurses, therapists, GPs and hospitals specialists to want to work together to bid for and be successful in delivering these new care models.

As a first step, we are currently reviewing the way we commission our community services so that we can have as much flexibility as possible to implement these improvements. We will be trialling the introduction of outcome based integrated care models in the next year. When successful, we will extend this approach across all out of hospital services within the next three years.

5.5. Partnership role in enabling delivery

Partnership arrangements are strong in Redbridge. Through the local strategic partnership we work together to meet the aspirations in the sustainable community strategy through its delivery vehicle – the local area agreement (LAA). The senior leads for the main organisations sit on the public service board, with wider representation on the strategic partnership assembly and six cluster groups, which cover priority areas.

We have highlighted the targets for which we are responsible for and aligned these to our initiatives in Chapter 4.

The recent Comprehensive Area Assessment identified our successes as a strategic partnership in delivering the LAA. One of which was the borough’s reputation for effective and meaningful community engagement. All partners are signed up to a collective approach, and this is monitored through our nationally commended compact. Senior managers from the public and lead voluntary sector organisations meet regularly to oversee progress. Local councillors also play an important role in this process.

In line with our area focus with polysystems, we now have links through to ward councillors and stakeholders through local area committees. As community champions, we recognise that they have an important role to play. In the coming years we plan closer working to support their engagement in the polysystems.
We have formalised our partnerships through section 31 and 75 agreements for children’s services, the learning disability partnership, mental health commissioning and integrated community equipment. These enable closer working, pooled budgets and seamless services for service users. We have effective governance systems in place to oversee these arrangements and jointly commissioned services for mental health, vulnerable adults and children. This happens through collective involvement in the health and social care advisory committee and children’s trust advisory committee, both of which have Cabinet level membership.

We are engaged in a number of other joint fora – the transformation of adult social care and supporting people initiatives enable people to retain independence and exercise greater choice in the services they receive. Keeping people well in the community supports our vision.

We recently agreed a joint commissioning strategy with the local authority; this builds on our revised concordat and signals our continued intention to jointly commission services that meet people’s health, social care and wellbeing needs. We will develop an action plan with the full details of our intentions for integrated health and social care early in 2010. Our joint strategic needs assessment informs our decision making.

We recognise the importance of carers, and as mentioned earlier, together with the Council secured Department of Health funding for a pilot that focuses on supporting their health and wellbeing. We have also just been successful in securing a public service agreement regional grant to deliver a project that focuses on improving the wellbeing of vulnerable people including rough sleepers and ex offenders – groups that we know can experience poor health outcomes. This demonstrates our ability for bringing in resources by working collaboratively and we intend to do more such projects.

The voluntary and community sector provide many wellbeing services, and we fund a number of services and posts to enable close working with diverse communities. We recently funded a health partnerships and volunteering post in Redbridge Council for Voluntary Services. These will enable us to better understand the health needs of ‘hard to reach groups’, tap into the community to support healthy behaviour change and support us with the provision of volunteers.

Public and voluntary sector partners played a critical role in the development of and continue to be represented at Loxford polyclinic through the services they provide there. We expect this to be replicated as we develop new polyclinics and our polysystems.

5.6. Risk management

We have a strong approach to risk management with risks reported to the Board at every meeting.

The main risks to delivering the aspirations in this strategy are the following:

- A more challenging financial situation facing the NHS generally and our sector in particular
• The capacity and ability of our own and the wider primary and community healthcare workforce to deliver change at the pace and standard required
• Availability of providers that can deliver the changes in service that this plan proposes
• Significant growth in parts of the borough, particularly those in the most deprived parts with populations more likely to suffer poor health
• Participation by clinicians in change – it is their actions that will be significant in terms delivering Healthcare for London, Health for NEL and the shifts in activity

We have described in the sections above the mitigating actions that we have put in place to ensure that these risks are contained.

5.7. In year monitoring

We need to keep a close eye on how we are doing against our targets. We have a robust monitoring framework and use an online tool called Performance Accelerator. The Council also use the same tool, which enables a joined up approach to both local area agreement and NHS target monitoring.

From the start of 2010, we will bring detailed ‘performance scorecards’ for all strategic initiatives and goals to our Trust and Clinical Commissioning Board for further scrutiny.

Our measures for ensuring that we are delivering are outlined in the Healthcare for London pathway section in the previous chapter. Our projections for improvement on the world class commissioning outcomes is summarised on page 91.

5.8. Provider requirements and plurality of provision

We recently developed a market management strategy to support our aim of becoming a world class commissioner. The strategy sets out our plans to:

• Secure the appropriate procurement knowledge and expertise
• Understand and develop the provider market
• Develop and ensure strong clinical and user engagement in the process
• Procure new services

The Secretary of State for Health has given a clear direction that the NHS is the preferred supplier for health services. There is still however a significant role for the voluntary and independent sector, both of which have a strong track record in Redbridge.

We want residents to have real choice in the services they receive. We are leading a project and campaign on behalf of our sector to improve awareness of options and the ‘choose and book’ service.
Supporting people with long term conditions is a significant challenge and we have said how we intend to improve management of people in the community. This will require a different way of working, and is an area we are looking to expand provision and develop better partnership working for. We also intend to shift to more outcome focussed commissioning – so the benefits of provision to the patient can be clearly identified.

This autumn we held an event for local nursing home providers, which updated over 20 organisations on our vision, commissioning arrangements and procurement. It was well received and we intend to hold further market events to ensure that we have a pool of well informed local providers that can adapt to our needs.

### World class commissioning outcomes

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<tbody>
<tr>
<td>VSB10</td>
<td>Proportion of children who complete MMR immunisation (1st and 2nd dose) by their 5th Birthday</td>
<td>Proportion of children aged 5 who complete immunisation for MMR (1st and 2nd doses)</td>
<td>75%</td>
<td>90%</td>
<td>91%</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>VSB09</td>
<td>Prevalence of obesity in Reception children</td>
<td>Prevalence of obesity in Reception children, as measured by the National Child Measurement Programme</td>
<td>12.80%</td>
<td>12.60%</td>
<td>12.20%</td>
<td>11.80%</td>
<td>11.40%</td>
</tr>
<tr>
<td>VSB09</td>
<td>Prevalence of obesity in Year 6 children</td>
<td>Prevalence of obesity in Year 6 children, as measured by the National Child Measurement Programme</td>
<td>22.10%</td>
<td>21.90%</td>
<td>21.80%</td>
<td>21.70%</td>
<td>21.60%</td>
</tr>
<tr>
<td>VSC27</td>
<td>Diabetes controlled blood sugar</td>
<td>The percentage of patients with diabetes who have an HbA1c of 7 or less</td>
<td>51%</td>
<td>52%</td>
<td>55%</td>
<td>57%</td>
<td>60%</td>
</tr>
<tr>
<td>VSC15</td>
<td>Proportion of all deaths that occur at home</td>
<td>Proportion of all deaths that occur at home</td>
<td>16%</td>
<td>18%</td>
<td>20%</td>
<td>21%</td>
<td>22%</td>
</tr>
</tbody>
</table>

The following trajectories are set by calendar year

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>VSB03</td>
<td>Cancer mortality rate</td>
<td>Directly standardised rates from all malignant neoplasms (ICD-10 C00-C97). Premature mortality (under 75 years)</td>
<td>99.30</td>
<td>98.08</td>
<td>97.70</td>
<td>97.00</td>
<td>96.25</td>
<td>95.54</td>
</tr>
<tr>
<td>VSB02</td>
<td>CVD mortality</td>
<td>Directly standardised rates per 100,000 standard European population for all CVD mortality, (ICD10 I00-I99). Premature mortality (under 75 years)</td>
<td>78.50</td>
<td>77.42</td>
<td>77.35</td>
<td>72.71</td>
<td>72.11</td>
<td>70.80</td>
</tr>
</tbody>
</table>
6. Board declaration

This strategy builds on the one we developed last year following wide engagement. The Trust Board have been actively involved in and fully endorses these ambitious plans for the next five years. This Plan was formally approved and adopted by the Board in January 2010.
Acute: In this document, acute refers to emergency or urgent treatment provided in hospital.

Cardiovascular: Describes the body’s circulatory system consisting of the heart, blood and blood vessels.

Care management: A process whereby an individual’s needs are assessed and evaluated, eligibility for service is determined, care plans are drafted and implemented and needs are monitored and re-assessed.

Care pathway: A method of organising all of the care a person receives from different professionals and organisations, to make sure it is coordinated.

Clinicians: Clinicians are professionals who are engaged in the care of patients, such as doctors, nurses and therapists.

Consultant: The most senior type of doctor who is a specialist in a particular area of medicine.

Diagnostics: Medical tests used to identify a medical condition or disease.

Dementia: Loss of mental ability severe enough to interfere with normal activities of daily living. It is a group of symptoms caused by gradual death of brain cells.

Healthcare for London: Healthcare for London is an NHS programme, run on behalf of London’s primary care trusts, to improve the capital’s health and health services.

Independent provider: Any private, voluntary, or not for profit provider that physically delivers health or social care services.

Inner north east London: The area covered by the primary care trust of NHS City and Hackney, NHS Newham and NHS Tower Hamlets. This is also known as the East London and the City Alliance. This is one of six sectors in London in which primary care trusts are working together to commission and performance manage acute hospital trusts.

Joint Strategic Needs Assessment: A process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness. Joint Strategic Needs Assessment identifies ‘the big picture’ in terms of the health and wellbeing needs and inequalities of a local population.

Local Area Agreement: Three-year funding arrangement between central Government and a local area, as represented by a Local Strategic Partnership (LSP) The LSP will set out a plan of priorities for its area, in return for greater flexibility of funding streams.

North east London: The area of London comprising the following areas: Redbridge, Barking and Dagenham, Havering, Waltham Forest, Tower Hamlets, the City, Hackney and Newham.
Outer north east London: The area covered by the primary care trusts of NHS Barking and Dagenham, NHS Havering, NHS Redbridge and NHS Waltham Forest. This is one of six sectors in London in which primary care trusts are working together to commission and performance manage acute hospital trusts.

Polysystems: A polysystem is a way of delivering care locally. It has a primary care-led polyclinic hub at its heart, which can either be based in the community or at the front end of a hospital. Polyclinics offer a range of core services, such as GP appointments, blood tests, diagnostics and minor surgery, however the exact service offering will be determined by local need.

Polyclinic: A place where a wide range of health care services (including diagnostics) can be obtained without the need for an overnight stay.

Primary care trust (PCT): Primary care trusts buy and provide healthcare such as GP care, hospital treatments and prevention services for their local populations. There are 31 PCTs in London.

Sector: There are six sectors in north east London in which primary care trusts are working together to commission and performance manage acute hospital trusts. These include outer north east London and the East London and the City Alliance.
Appendix 1

1. Introduction

This section summarises the top level milestones for the key projects within each of the strategic initiatives outlined in Chapter 4.

These have been drawn up over recent months through engagement with PCT staff, primary, community and secondary care colleagues. The information here is subject to further refinement. Detailed project plans are currently being developed, but the timescales and direction of travel was agreed at the February Clinical Commissioning Board meeting.

The top level finances and metrics are included in Chapter 4, with some further detail below and more to follow in the final project plans. The detail on activity for 2010/11 is outlined in this year’s operating plan, which should be read in conjunction with this strategic plan.

The initiatives as described in both plans are listed below, with a summary of the associated projects and actions.

2. Initiatives

Each initiative is aligned to a Healthcare for London (HfL) care pathway as described in the Strategic Plan.

2.1 Initiative A: Health and well-being – staying healthy HfL pathway

2.1.1 Initiative projects

Project A1: Value for money and productivity review of all health and well being services, initially focusing on sexual health and obesity services

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commence value for money and productivity review of sexual health and obesity services</td>
<td>April 2010</td>
</tr>
<tr>
<td>Implement findings of above review in order to roll out across the whole borough</td>
<td>Oct 2010</td>
</tr>
</tbody>
</table>

Project A2: Use Health Analytics software to identify opportunities for prevention and early intervention

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Analytics software being used in all polysystems to proactively identify high risk patients and provide appropriate interventions</td>
<td>June 2010</td>
</tr>
</tbody>
</table>
### Project A3: Tailored communications and social marketing approach to specific communities including health and well being roadshows delivered across the borough

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Redbridge practices using Health Analytics software to proactively identify patients and provide appropriate interventions</td>
<td>June 2010</td>
</tr>
</tbody>
</table>

### Project A4: Development of polysystems as key delivery network for health and well being services and further development of Polyclinics as a focal point for health and well being services

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme of 2010 Redbridge Health and wellbeing roadshows published and detailed programme for campaigns established. The aim is to ensure that all opportunities for promotion of healthy lifestyles linked to local health and well being service delivery are exploited</td>
<td>July 2010</td>
</tr>
</tbody>
</table>

### Project A5: Health and well being checks for carers (caring for carers – C4C)

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring for Carers programme – first phase of identification of carers completed</td>
<td>April 2010</td>
</tr>
<tr>
<td>Caring for carers programme – first phase of health and well being checks completed</td>
<td>June 2010</td>
</tr>
<tr>
<td>Interim evaluation of programme evaluated and outcomes implemented</td>
<td>Dec 2010</td>
</tr>
</tbody>
</table>

### Project A6: Implementation of vascular screening programme

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commence vascular screening pilot – identify and offer interventions to patients at risk of developing a cardiovascular disease (CVD) event.</td>
<td>April 2010</td>
</tr>
</tbody>
</table>


**Appendix**

**Initiative metrics:** breast screening, bowel screening, cervical screening, all age all cause mortality, CVD mortality, smoking quitters, chlamydia screening, drug treatment, alcohol prevention/harm prevention, dental services and access, childhood obesity, immunisation (MMR).

### 2.2 Initiative B: Condition Management - Planned Care HfL Pathway

#### 2.2.1 Initiative projects

**Project B1:** Care pathway design – focussed on top five specialities - ear, nose and throat (ENT); ophthalmology; gynaecology; rheumatology and trauma and orthopaedics (T&O). This project will contribute to the delivery of B2, B3, B4 and B5 and links to projects in the long term conditions initiative,

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ophthalmology</strong> care pathway redesign – develop a borough wide pathway in order to reduce inappropriate referrals to secondary care, increase efficiency and move care closer to home</td>
<td>May 2010</td>
</tr>
<tr>
<td>Pilot the revised pathway in one polysystem in order to test the effectiveness of the system</td>
<td>June to Sept 2010</td>
</tr>
<tr>
<td>Review the pilot in order to ensure that the pathway meets the objectives set, is clinically safe and produces improved outcomes</td>
<td>Oct 2010</td>
</tr>
<tr>
<td>Implement the revised pathway across the whole borough, realising savings by reducing referrals to secondary care</td>
<td>November 2010</td>
</tr>
<tr>
<td><strong>ENT</strong> care pathway redesign – develop a borough wide pathway in order to reduce inappropriate referrals to secondary care, increase efficiency and move care closer to home</td>
<td>July 2010</td>
</tr>
<tr>
<td>Pilot the revised pathway in one polysystem in order to test the effectiveness of the system</td>
<td>Aug to Oct 2010</td>
</tr>
<tr>
<td>Review the pilot in order to ensure that the pathway meets the objectives set, is clinically safe and produces improved outcomes</td>
<td>November 2010</td>
</tr>
<tr>
<td>Implement the revised pathway across the whole borough, realising savings by reducing referrals to secondary care</td>
<td>Dec 2010</td>
</tr>
<tr>
<td><strong>Rheumatology</strong> care pathway redesign – develop a borough wide pathway</td>
<td>April 2011</td>
</tr>
<tr>
<td>Pilot the revised pathway in one polysystem in order to test the effectiveness of the system</td>
<td>May to July 2011</td>
</tr>
<tr>
<td>Review the pilot in order to ensure that the pathway meets the objectives set, is clinically safe and produces improved outcomes</td>
<td>August 2011</td>
</tr>
<tr>
<td>Implement the revised pathway across the whole borough, realising savings by reducing referrals to secondary care</td>
<td>Sept 2011</td>
</tr>
<tr>
<td><strong>T &amp; O</strong> care pathway redesign – develop a borough wide pathway in order to reduce inappropriate referrals to secondary care, increase efficiency and move care closer to home</td>
<td>January 2012</td>
</tr>
<tr>
<td>Action</td>
<td>Dates</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Pilot the revised pathway in one polysystem in order to test the effectiveness of the system</td>
<td>Feb to April 2012</td>
</tr>
<tr>
<td>Review the pilot in order to test the effectiveness of the system</td>
<td>May 2012</td>
</tr>
<tr>
<td>Implement the revised pathway across the whole borough, realising savings by reducing referrals to secondary care</td>
<td>June 2012</td>
</tr>
</tbody>
</table>

**Project B2: Implement best practice model of planned surgical care**

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of reconfiguration of local services to deliver agreed savings. Work with the ACU to deliver through contract management reducing capacity in the acute sector</td>
<td>December 2010*</td>
</tr>
<tr>
<td>*A core component of H4NEL is acute reconfiguration which is currently at a consultation phase. Decision following is expected later in 2010, subject to Independent Review Panel requests and electoral timetables</td>
<td></td>
</tr>
<tr>
<td>Further implementation of reconfiguration of local services to deliver savings of £4.2 million</td>
<td>Continuous</td>
</tr>
</tbody>
</table>

**Project B3: Improve admission and discharge planning and process**

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
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</thead>
<tbody>
<tr>
<td>Review admission and discharge planning by specialty and provider, along with local clinical leaders</td>
<td>May 2010</td>
</tr>
</tbody>
</table>

**Project B4: Increase productivity in primary and community care**

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct full review of GPsWI services</td>
<td>April 2010</td>
</tr>
<tr>
<td>Open a new polyclinic for the Seven Kings polysystem, based at the KGH site</td>
<td>End 2010</td>
</tr>
<tr>
<td>Open three further polyclinics</td>
<td>2012/13</td>
</tr>
</tbody>
</table>

**Project B5: Referral management – ensure best practice and consistency across PCT pathway redesign**

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polysystems making full use of Health Analytics to monitor referrals, using the information to standardise processes across Redbridge</td>
<td>April 2010</td>
</tr>
</tbody>
</table>

**Initiative metrics:** GP access, GP extended hours, patient experience, access to crisis services, CVD mortality, drug users in treatment, alcohol reduction / harm prevention, stroke deaths within 30 days, cancer mortality
2.3 Initiative D: Condition Management – *Long Term Conditions HfL Pathway*

2.3.1 Initiative projects

**Project D1:** Pathway redesign (diabetes, CHD, stroke rehab, COPD, asthma) building on Kaiser Permanente CHD pathway redesign workshop

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
</table>
| Appoint a multiagency team to redesign the integrated care pathways with a primary care focus for doing much more within the community for each of the five LTCs. To involve GPs from every polysystem, hospital clinicians and patients | CHD – Jan 10  
Diabetes – Mar 10  
Stroke Rehab – May 10  
COPD – July 10  
Asthma – Oct 10 |
| CHD care pathway redesign – develop a borough wide pathway in conjunction with clinicians and experts from BHRUT, Whipps Cross, the London Chest Hospital, and others | April 2010 |
| Review the Loxford pilot for CHD pathway in order to inform future service delivery | June 2010 |
| Implement the borough wide pathway for CHD | Aug 2010 |
| Modify Diabetes, Stroke Rehab, COPD and Asthma care pathways and include innovations: e.g. coaching pilot and the 'Do It' project. | Diabetes – May 10  
Stroke Rehab – Nov 10  
COPD – Jan 11  
Asthma – June 11 |
| New integrated pathways agreed by Clinical Commissioning Board (CCB) and ready for implementation pilot phase (£176,000 savings) | CHD – June 10  
Diabetes – July 10  
Stroke Rehab – Jan 11  
COPD – Mar 11  
Asthma – May 11 |
| Identification of where skills development is required through training and recruitment | May 2011 |
| **Full implementation of new care pathways:**                          | CHD – 2011  
Diabetes – 2012  
Stroke Rehab – 2013  
COPD – 2014  
Asthma – 2015  
Stroke Rehab – 2013  
COPD – 2014  
Asthma – 2015 |

**Project D2:** Better management of LTC patients in primary and community care including
- personalised care plans
- tele-health

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of high risk patients using Health Analytics tool to prevent emergency admissions through targeted primary care intervention</td>
<td>Oct 2010</td>
</tr>
</tbody>
</table>
Appendix

### Action Dates

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCB and the five Polysystem Development Boards committed to personalised care plans for all LTC patients, particularly the high risk patients initially</td>
<td>Oct 2010</td>
</tr>
<tr>
<td>Implementation of personalised care plans pilots, expert patient training, MDTs for all LTCs. Aim is for fewer A&amp;E visits and hospital admissions (£4,288,000 savings)</td>
<td>March 2011</td>
</tr>
<tr>
<td>Pilot tele-health supported self managed care at home and remote compliance and data recording</td>
<td>Oct 2011</td>
</tr>
<tr>
<td>Identify high risk patients using risk stratification tool</td>
<td>Oct 2010</td>
</tr>
<tr>
<td>Pilot active management of high risk patients using targeted interventions to prevent emergency admissions</td>
<td>Nov 2010</td>
</tr>
<tr>
<td>Roll out active management of high risk patients using targeted interventions to prevent emergency admissions (£956,000 savings)</td>
<td>March 2011</td>
</tr>
<tr>
<td>Full roll out of personalised care plan for five LTCs</td>
<td>2012</td>
</tr>
<tr>
<td>Tele-health roll out</td>
<td>2013</td>
</tr>
</tbody>
</table>

**Project D3: Improve self care, including medicines compliance**

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
</table>

*Initiative metrics:* patients with diabetes, drug users in treatment, CVD mortality, alcohol reduction / harm reduction, stroke deaths within 30 days, diabetes controlled blood sugar

### 2.4 Initiative E: Condition Management – *End of Life HfL Pathway*

#### 2.4.1 Initiative projects

**Project E1:** Implement End of Life (EoL) pathway including patients having choice of place for EoL

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure Clinical Commissioning Board and all Polysystem Development Boards signed up to all GP surgeries practicing gold standard framework (GSF) and Liverpool Care Pathway (LCP) and that preferred place of care (PPC) for an EoL patient is included in care plan</td>
<td>Oct 2010</td>
</tr>
<tr>
<td>To ensure that the EoL register contains PPC (Choice of place to die) information if available</td>
<td>Oct 2010</td>
</tr>
<tr>
<td>To ensure that all Community Matrons and District Nurses are trained in palliative care and the GSF and LCP</td>
<td>Dec 2010</td>
</tr>
</tbody>
</table>
### Action

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>To work closely with ONEL in ensuring that Redbridge delivers on the</td>
<td>Ongoing</td>
</tr>
<tr>
<td>five HfL principles for excellent EoL care</td>
<td></td>
</tr>
<tr>
<td>To train all nurses in nursing homes in palliative care so that they</td>
<td>Dec 2010</td>
</tr>
<tr>
<td>can practice GSF and LCP</td>
<td></td>
</tr>
<tr>
<td>To develop a training programme to ensure that as many as possible</td>
<td>Dec 2010</td>
</tr>
<tr>
<td>of the Redbridge care homes have staff trained in palliative care</td>
<td></td>
</tr>
<tr>
<td>and the principles of GSF and LCP</td>
<td></td>
</tr>
<tr>
<td>To achieve the objective of 18% of people dying at home or their</td>
<td>April 2011</td>
</tr>
<tr>
<td>place of choice</td>
<td></td>
</tr>
<tr>
<td>To work with hospitals to ensure EoL patient’s not admitted or</td>
<td>Oct 2010</td>
</tr>
<tr>
<td>promptly returned to preferred place to die</td>
<td></td>
</tr>
<tr>
<td>To improve support EoL carers and improve bereavement support</td>
<td>Oct 2011</td>
</tr>
<tr>
<td>To provide 24/7 specialist palliative care advice</td>
<td>Oct 2011</td>
</tr>
<tr>
<td>GSF and LCP in all nursing homes and 80% of care homes</td>
<td>2013</td>
</tr>
<tr>
<td>All GPs and community matrons familiar with GSF and LCP</td>
<td>2014</td>
</tr>
<tr>
<td>To achieve at least 22% of people choosing to die at home</td>
<td>2015</td>
</tr>
<tr>
<td>At least 50% of EoL patients have been offered PPC discussion one</td>
<td>2015</td>
</tr>
<tr>
<td>year earlier</td>
<td></td>
</tr>
</tbody>
</table>

### Initiative metrics: deaths at home

#### 2.5 Initiative F: Condition Management - Mental Health HfL care pathway

#### 2.5.1 Initiative projects

**Project F1: Improving services for people with dementia**

This project will focus on how we will implement effective interface services to enable coordinated and supported discharge, reduced length of stay and improved patient experience.

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia baseline assessment undertaken</td>
<td>April 2010</td>
</tr>
<tr>
<td>5% increase in people with dementia being cared for at home</td>
<td>March 2011</td>
</tr>
<tr>
<td>Review of Dementia Strategy Implementation completed</td>
<td>March 2012</td>
</tr>
</tbody>
</table>
**Project F2:** Improving BME community mental health awareness
We will work with partners to implement a range of projects to raise awareness and promote positive mental health for BME groups through local community leaders and media

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME community awareness delivery plan fully initiated within each polysystem</td>
<td>Aug 2010</td>
</tr>
</tbody>
</table>

**Project F3:** Developing IAPT services. Further developing and improving access to psychological therapies focussed on increasing the number of people with serious and long-term mental health problems finding employment

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of current IAPT employment project completed</td>
<td>Sep 2010</td>
</tr>
<tr>
<td>IAPT business case and development plan agreed</td>
<td>March 2011</td>
</tr>
</tbody>
</table>

**Project F4:** Improving physical activity of people with mental health needs

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service review of mental health and wellbeing services completed</td>
<td>July 2010</td>
</tr>
<tr>
<td>Health and wellbeing improvement plan initiated</td>
<td>Oct 2010</td>
</tr>
</tbody>
</table>

**Project F5:** Reducing acute hospital A&E attendances and admissions by proactively care managing patients and developing improved urgent care access within polysystems.

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk of admission patients identified</td>
<td>April 2010</td>
</tr>
<tr>
<td>Early intervention depression service tested on 10 high risk patients</td>
<td>July 2010</td>
</tr>
<tr>
<td>Early intervention spec developed, service procured and initiated</td>
<td>Sep 2010</td>
</tr>
<tr>
<td>Early intervention service benefits delivered</td>
<td>March 2011</td>
</tr>
<tr>
<td>Early intervention service benefits delivered</td>
<td>March 2012</td>
</tr>
</tbody>
</table>

**Initiative metrics:** cases of psychosis served by early intervention teams, access to crisis services, increase the number of people with mental health needs in employment, drug users in treatment, alcohol prevention/harm reduction, suicide levels.
2.6 Initiative G: Unscheduled Care – *Acute Care HfL care pathway*

### 2.6.1 Initiative projects

**Project G1:** Management of minor ailments in community settings.

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Pharmacy Minor Aliments Scheme, GP extended Hours and UCC (£28,000 saving shift)</td>
<td>April 2010</td>
</tr>
<tr>
<td>New Polyclinic in Fairlop Polysystem</td>
<td>2012</td>
</tr>
<tr>
<td>New Polyclinic in Cranbrook Polysystem</td>
<td>2013</td>
</tr>
<tr>
<td>New Polyclinic in Wanstead Polysystem</td>
<td>2014</td>
</tr>
</tbody>
</table>

**Project G2:** Improve navigation through pathway including London Ambulance Service (through transformational Programme) and social marketing to target patients and GPs

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Discharge co-ordination (£25,000 saving shift)</td>
<td>May 2010</td>
</tr>
<tr>
<td>Implement the choose well campaign (£15,000 saving shift)</td>
<td>Aug 2010</td>
</tr>
<tr>
<td>Expand community rehabilitation and re-ablement (£40,000 saving shift)</td>
<td>Jan 2011</td>
</tr>
<tr>
<td>Implement a single point of access for urgent care (£3000 saving shift)</td>
<td>Feb 2011</td>
</tr>
<tr>
<td>New Polyclinic in Fairlop Polysystem</td>
<td>2012</td>
</tr>
<tr>
<td>New Polyclinic in Cranbrook Polysystem</td>
<td>2013</td>
</tr>
<tr>
<td>New Polyclinic in Wanstead Polysystem</td>
<td>2014</td>
</tr>
</tbody>
</table>

**Project G3:** Implement Unscheduled Care pathway including shift from Accident & Emergency to Urgent Care Centre (UCC), Walk In Centre and Polyclinic; Single point of access; direct access to appointments

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simplify urgent and out of hours provision</td>
<td>June 2010</td>
</tr>
<tr>
<td>Telephone support for LTC patients provided through Polysystem</td>
<td>Oct 2010</td>
</tr>
<tr>
<td>Implement and expand King George Hospital UCC</td>
<td>Nov 2010</td>
</tr>
<tr>
<td>Increase primary care diagnostics (£20,000 saving shift)</td>
<td>Nov 2010</td>
</tr>
<tr>
<td>New Polyclinic in Fairlop Polysystem</td>
<td>2012</td>
</tr>
</tbody>
</table>
### Project G4: A project to expand rapid response initiatives develop in neighbouring PCT

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve London Ambulance Service (LAS) understanding of local services and the  assessment capability of LAS employees (£28,000 saving shift)</td>
<td>July 2010</td>
</tr>
</tbody>
</table>

**Initiative metrics:** CVD Mortality, patients with diabetes

### 2.7 Initiative H: In Hospital – Planned Care HfL care pathway

#### 2.7.1 Initiative projects

**Project H1:** Acute contract and performance management through the Acute Commissioning Unit

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm criteria based upon evidence based practice for agreed procedure list</td>
<td>April 2010</td>
</tr>
<tr>
<td>Develop communication plan to communicate to all GPs and Consultants</td>
<td>April 2010</td>
</tr>
<tr>
<td>Establish dialogue by specialty between primary and secondary care to agree an approach to managing conditions/symptoms in Primary Care</td>
<td>May 2010</td>
</tr>
<tr>
<td>Establish process to monitor referrals from primary care</td>
<td>June 2010</td>
</tr>
<tr>
<td>Monitor procedures through contract management process</td>
<td>June 2010</td>
</tr>
<tr>
<td>Implement primary care gateway process</td>
<td>June 2010</td>
</tr>
<tr>
<td>Implement secondary care gateway process</td>
<td>Dec 2010</td>
</tr>
<tr>
<td>Develop an ongoing clinical effectiveness programme to review nationally published guidance i.e. Royal Colleges, NICE, NHS Evidence</td>
<td>Jan 2011</td>
</tr>
<tr>
<td>Review procedure list annually to reflect most recent evidence</td>
<td>Jan 2011</td>
</tr>
<tr>
<td>Develop regular dialogue between clinical directors and secondary consultants to monitor implementation</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Review procedure list annually to reflect most recent evidence</td>
<td>Jan 2012</td>
</tr>
</tbody>
</table>
Project H2: Maximise use of the ISTC contract in order to reduce activity within acute trust

<table>
<thead>
<tr>
<th>Action</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feed learning into elective strategy and future plan for ISTC</td>
<td>Sept 2010</td>
</tr>
<tr>
<td>Marketing strategy to GPs and other stakeholders</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Ongoing review of casemix to ensure maximum number of patients being transferred and extending where appropriate (e.g. endoscopy)</td>
<td>April 2010</td>
</tr>
<tr>
<td>Ensuring maximum referrals from other providers</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

2.8 Maternity and Children and Young People pathways

Here we also summarise the priorities against the above pathways. These do not have high activity shift or decommissioning projects, but do have separate programme plans with further detail. The outline projects and metrics for each are summarised below. Further details are being fleshed out through the project planning process, but are described in more detail in the operating plan.

CM - Maternity HfL care pathway

Detailed milestones being developed to cover:
- Enabling choice in place of birth
- Supporting midwife led births and strong pre and antenatal care support through polysystems
- Using health analytics to target expectant mothers most at risk of birth complications
- Encouraging and supporting breast feeding and immunisation
- Tackling teenage pregnancy

**Metrics:** access to maternity services, teenage pregnancy, breastfeeding

CM - Children and Young People HfL care pathway

Detailed milestones being developed to cover:
- Working in partnership to support children with long term conditions
- Tackling obesity
- Commissioning integrated and seamless services across not only health and social care, but range of specialisms
- Reducing use of A&E through providing increased and better signposted urgent care in community
- Building ‘you’re welcome’ young people friendly quality standards into commissioning structures for young people’s services

**Metrics:** teenage pregnancy, childhood obesity, immunisation (MMR), breastfeeding, child and adolescent mental health services