NHS Havering
Commissioning Strategic Plan

2009/10 – 2013/14

PCT Name: NHS Havering
Date: 20 November 2008
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### PCT Details

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**Commissioning Strategic Plan Final Version – 20 November 2008.**
1. Chair/Chief Executive’s Foreword

1.1 Who are we?

Havering is a large Borough situated in the Outer North East London (ONEL) Sector of London with a resident population of 227,338 (2008). NHS Havering is co-terminus with the London Borough of Havering (LBH) and both organisations are committed to working together to address prioritised health and social care needs through the Havering Strategic Partnership (HSP) and the delivery of Local Area Agreements (LAAs). There are a number of Partnership Boards and joint arrangements in place including the Havering Children’s Trust, Mental Health Partnership Board, Learning Disabilities Partnership Board, Physical and Sensory Disabilities Partnership Board, Drug and Alcohol Team Partnership Board, Older People Partnership Board and a Local Safeguarding Children Board.

The Vision, Goals and Initiatives described in this Commissioning Strategic Plan (CSP) are shared with our partners and take account of a number of strategic and local developments.

NHS Havering’s CSP 2007/08 has been refreshed to take account of a number of Strategic and local developments including:

- A revised PCT Strategic Plan 2009-14.
- Updated Joint Strategic Needs Assessment (JSNA) findings.
- New Local Area Agreements (LAA2) targets.
- Local and Collaborative Commissioning Initiatives (CCI) including those across Outer North East London (ONEL), and North East London (NEL).
- Health Care for London key themes and priorities.

1.2 Where have we been, where are we now and where are we aiming to get to?

In its recent past NHS Havering has experienced financial difficulties, which has impacted on its ability to drive forwards new plans. However, having achieved breakeven in 2007/08 and repaid its historic deficit NHS Havering plans to concentrate on developing the services at both a strategic and operational level.

NHS Havering is making steady progress against national targets as well as innovating in some key areas – for example achieving Autonomous Provider Organisation (APO) status for its provider arm and recently agreeing a formal relationship with London South Bank University.

This plan describes the key strategic aims and objectives for the next 5 years and will enable when taken together, the population of Havering to experience better health outcomes and improved access to services (e.g. the provision of a Polyclinic system).

There are of course risks with this plan. We know that significant financial pressures still exist in London in relation to historic debts and ongoing deficits in a number of Acute Trusts and need addressing. NHS Havering will play its part to address these but it must be recognised that supporting such pressures will impact on local plans and developments. Therefore, we will endeavour to keep as much flexibility in our plans as possible by constantly reviewing it in light of any local and London wide pressures.
During this next phase of strategic development significant improvements will be made to our commissioning capability. Locally we are working closely with our Local Authority to enable joint commissioning to become a reality. We are fully supportive of the ONEL ‘Strengthening Commissioning’ agenda, particularly for around acute services and have detailed action plans to develop our competencies as determined by the ‘World Class Commissioning’ framework.

The NHS Havering Board is fully committed to this plan as are other local stakeholders. NHS Havering will work in close collaboration to deliver what it believes are the key objectives to achieve the appropriate health benefits for the Havering population.

1.3 Our vision

The Trusts strategic vision is to increase life expectancy and quality of life for all the people living in Havering and to reduce inequalities in health outcomes.

In order to achieve this vision over the next five years, NHS Havering has set out five goals and six key initiatives to deliver agreed priorities for health improvement and well-being. NHS Havering will work collaboratively with its Sector Partners on four additional initiatives, which will contribute to our populations health and well-being.

1.4 What are our key health needs?

The health of Havering residents is generally good compared to neighbouring Boroughs. Life expectancy is higher than in England as a whole and continues to increase. However, there are inequalities within Havering particularly in Heaton, Gooshays, South Hornchurch and Havering Park wards. The gap in life expectancy between the most prosperous ward and the most deprived wards is: 5.9 years for men and 4.6 years for women.

In Havering, Cardiovascular Disease (CVD) is the largest cause of all death (36% of all deaths) and Cancer is the largest cause of all premature deaths (41% of all premature deaths).

However, over the last ten years, Havering has seen a significant improvement in early death rate from heart disease and stroke, early death rate from cancer, and all-age, all-cause mortality. In each case, the improvement has been equivalent to or better than the national average improvement.

Breastfeeding initiation is lower than average and fewer adults and children are physically active than the England average.

Havering has a high proportion of people aged 65 and above, particularly those aged over 85, in London and this is set to rise steeply in the future. There is expected to be a 10% growth in people aged 65 and above by 2013, rising to 24% growth by 2023.

The Havering Health and Lifestyle survey showed that 54% of the population are either overweight or obese and this is a particular problem for adults. Obesity among children is slightly higher than the national average.
1.5 Our current service quality/performance

NHS Havering has improved its overall performance during the last two years according to the latest assessment by the Healthcare Commission. NHS Havering has achieved a rating of fair for both quality of services and use of resources. On quality of services we met 21 out of the 24 Core Standards for Better Health. Nearly two thirds of the national targets monitored by the Healthcare Commission were achieved, including waiting times for diagnosis and treatment of cancer patients, access to Primary Care Professionals and booking appointments. A number of areas to be improved such as maternity, Children and Young People (CYPP), Older People Services, Cardiovascular, Stroke and Diabetes services are identified in six key initiatives described below.

1.6 Our goals

The Strategic Goals in the 2007-08 CSP remain part of the NHS Havering Strategic Plan 2009-14. These goals were selected in a workshop involving NHS Havering’s Trust Board. They were considered to be core to achieving our strategic vision. These goals were signed off at stakeholder events, agreed by the Professional Executive Committee (PEC) and approved by the Trust Board in 2007.

The five strategic goals agreed in the last CSP were reviewed by the Priorities Forum in September 2008 and were revised to shift emphasis to prevention, cost effectiveness and responding to needs.

The five revised strategic goals are: -

- **Goal 1** – To improve the health and well-being of the people of Havering so that life expectancy and quality of life compares with the best in Europe (EU) and health inequalities are reduced.
- **Goal 2** – To change the pattern of healthcare to reflect the needs of the local people and requirements of Health Care for London, so that, wherever appropriate, care is provided outside hospital, and to ensure the quality of care is of the highest standard wherever it is provided.
- **Goal 3** – To make the most cost effective use of the resources available to the Trust, and in doing so, shift a proportion of spend from treatment to prevention.
- **Goal 4** – To establish partnerships or strengthen existing partnerships to respond to the JSNA and work towards joint commissioning of services to achieve these aims.
- **Goal 5** – To ensure that the Trust is fit for purpose in terms of World Class Commissioning (WCC) and is compliant with all requirements of governance and national standards for better health.
1.7 Our chosen initiatives

The Executive Board Members including the Chair of the PEC and Leads for Practice Based Commissioning (PBC) prioritised initiatives that will contribute in delivering our goals.

Two of the original seven initiatives namely Eating Disorders and Brief Intervention for Alcohol, were removed from the list as they have been successfully commissioned in 2008 and are being performance managed by NHS Havering. The Stroke Care Pathway and Diabetes initiatives have been merged into a single Cardiovascular Disease initiative incorporating Stroke, the Diabetes Improvement Plan and Vascular Risk Reduction.

NHS Havering chose these six initiatives because they are the right ones to address Havering’s Key Health needs and also address current performance problems in existing services.

The revised six initiatives (which share equal priority) were presented to a Priorities Forum which includes patients, members of the public, clinicians, local partners and NHS Havering in September 2008 and a Stakeholder event in October 2008 and were supported. Also, the PEC endorsed this plan in October 2008. The six initiatives are as follows:

Initiative 1 – Staying Healthy

- To reduce the gap in the life expectancy and well-being between the most prosperous ward and the most deprived ward.
- To develop Staying Healthy programmes to improve the health of the population and shift focus from treatment to prevention.

Initiative 2 – Maternity Services

- To improve Maternity Services in order to promote breastfeeding, offer choice of place of birth, access to antenatal classes and offer quality support in caring for babies and mothers after discharge.

Initiative 3 – Children and Young People Services

- To support Children and Young People to improve their preparation for early years education, to access key services such as, speech and language therapy (SALT), alcohol harm reduction and family support.

Initiative 4 – Older People Services

- To support Older People to remain independent and retain as good a quality of life as possible through appropriate use of Primary and Community services.

Initiative 5 – Care Outside Hospital – Urgent Care/Rapid Response, Interface Discharge Co-ordination, Telehealth and Polyclinics

- To develop a System to enable improved local access to services.

Initiative 6 – Cardiovascular Disease – Incorporating Stroke, Diabetes and Cardiovascular Risk

- To reduce avoidable death and disability from vascular disease, improve patient experience, and narrow inequalities through a Cardiovascular programme.
As part of an agreed Care Outside Hospital Strategy by the four Outer North East London PCT’s, NHS Havering has committed to the Collaborative Commissioning of Urgent Care/Rapid Response, Interface Discharge Co-ordination and Telehealth.

NHS Havering along with LBH is reviewing Intermediate Care Provision, Telecare Services and Community beds.

There are four further initiatives NHS Havering will be commissioning in collaboration with the North East London Sector as part of Health Care for London Priorities. They are as follows: -

1. **End of Life Care**
2. **Stroke**
3. **Tuberculosis**
4. **Redesign of the acute provider landscape**

1.8 **Health Outcomes**

In July 2008 NHS Havering’s Clinical Standards and Quality Committee, which included a Non-Executive Director (chair), the Director of Public Health and Medical Director, the Director of Healthcare Procurement and Performance, a representative from the (PEC), a representative from the staff side and a risk manager, short-listed from the Department of Health (DoH) World Class Commissioning Assurance Handbook, 11 Health Outcome measures from the list of 54, based on the following criteria: -

- Need to fit with our local priorities and needs.
- Need to be outcomes based.
- Need to fit our strategy.

The Priorities Forum then chose 8 Health Outcomes from the list of eleven. The final 10 Health Outcomes which included two recommended compulsory ones, namely all age, all cause mortality and Index of multiple deprivation have been mapped into our investment plan. Our six key initiatives and the CCI’s are described in this CSP. They will be used to track the performance of the Commissioning Strategy as a whole.
The 10 Health Outcomes and the initiatives they are mapped against are as follows:

<table>
<thead>
<tr>
<th>WCC Health Outcome</th>
<th>Link Initiative</th>
<th>NHS Havering Current Performance</th>
<th>How NHS Havering Compares Nationally</th>
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<tbody>
<tr>
<td>All age, all cause mortality</td>
<td>Staying Healthy and Cardiovascular</td>
<td>HAV: 585.8 ENG: 610.47</td>
<td>Better</td>
</tr>
<tr>
<td>Index of multiple deprivation</td>
<td>Staying Healthy and Cardiovascular</td>
<td>HAV: 16.07 Rank 200 out of 354 (1 being the most deprived)</td>
<td>Better</td>
</tr>
<tr>
<td>Low birth weight - births under 2500 grammes</td>
<td>Staying Healthy and Maternity</td>
<td>HAV: 7.4% ENG: 7.9%</td>
<td>Average</td>
</tr>
<tr>
<td>Cancer mortality rates (under 75 years)</td>
<td>Staying Healthy</td>
<td>HAV: 116.5 ENG: 117.1</td>
<td>Average</td>
</tr>
<tr>
<td>Self reported experience of patients and users</td>
<td>All initiatives</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Mortality rate from causes considered amenable to healthcare</td>
<td>Care Outside Hospital, Older People and Tuberculosis</td>
<td>HAV: 103.5 ENG: 111.8</td>
<td>Better</td>
</tr>
<tr>
<td>Stroke deaths within 30 days</td>
<td>Cardiovascular, Stroke</td>
<td>HAV: 26054 ENG: 23657.38</td>
<td>Average</td>
</tr>
<tr>
<td>Rate of hospital admissions for alcohol related harm</td>
<td>Staying Healthy</td>
<td>HAV: 1330.6 ENG: 1400.4</td>
<td>Better</td>
</tr>
<tr>
<td>Cardiovascular mortality rates (under 75 years)</td>
<td>Cardiovascular.</td>
<td>HAV: 76.13 ENG: 84.24</td>
<td>Better</td>
</tr>
<tr>
<td>Percentage of deaths that occur at home</td>
<td>Care Outside Hospital and End of Life Care</td>
<td>HAV: 17.2% ENG: 18.9%</td>
<td>Average</td>
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1.9 Impact Assessment

1.9.1 Health Impact Assessment

Each of the initiatives has been taken through a health impact assessment. The appraisal sought to assess the potential health impact of each initiative, the distribution of these impacts in the Havering population, and in so doing, to identify their risk of widening health inequalities. All the initiatives have been scored as having an overall positive impact on health and not having a negative effect on vulnerable and deprived groups. Moreover, they all have the potential to reduce health inequalities.

1.9.2 Equality Impact Assessment

An Equality Impact Assessment has been undertaken for each of the initiatives, and for the overarching CSP. NHS Havering’s Race and Equality office led the process to assess potential for adverse effects because of race, ethnicity, disability, gender, age, religious beliefs and sexual orientation. This has informed the final version/presentation of the CSP.
1.10 Delivery and Risk

NHS Havering’s milestone plans for delivery of each of these initiatives is shown in Section 4.2. The PCT has assessed risks for the delivery of these initiatives in Section 5.2.

Delivery of the initiatives is dependant on significant financial investment at a PCT, Sector and London wide level. If this risk was to materialise NHS Havering would have to rephase its implementation plans.

The initiatives and NHS Havering’s Organisational Development plan map to its goals as shown in the Table below:

<table>
<thead>
<tr>
<th>Initiative 1</th>
<th>Goal 1</th>
<th>Goal 2</th>
<th>Goal 3</th>
<th>Goal 4</th>
<th>Goal 5</th>
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<tr>
<td>Staying Healthy</td>
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<td>Initiative 2 Maternity Services</td>
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<tr>
<td>Initiative 3 Children and Young People Services</td>
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<td>✩</td>
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<tr>
<td>Initiative 4 Older People Services</td>
<td>✩</td>
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<tr>
<td>Initiative 5 Care Outside Hospital</td>
<td>✩</td>
<td>✩</td>
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<tr>
<td>Initiative 6 Cardiovascular</td>
<td>✩</td>
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<tr>
<td>End of Life Care</td>
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<tr>
<td>Stroke/Trauma</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Redesign of the acute provider landscape</td>
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<tr>
<td>Organisation Development Plan</td>
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1.11 Finance

The NHS Havering financial position has been under a range of pressure since 2004/05. The Trust achieved all key financial targets in 2007/08 including the break-even requirement and ended the year with a surplus of £285k against its Revenue Resource Limit. The Trust also paid off its deficit of £6.3m from 2006/07. This was a very positive result and required the implementation of a range of demand management schemes and financial recovery savings measures totalling over £9m.

NHS Havering has developed a Medium Term Financial Strategy alongside the Commissioning Strategic Plan covering the period of 2009/10 to 2012/13. The Strategy is based on the assumptions for growth, tariff uplifts etc. laid out in the latest NHSL guidance. It lays out the investment plans to meet national targets and progress local and Collaborative Commissioning Initiatives over the four year period whilst achieving a small surplus in each year.

In 2008/09 the Trust is forecasting a small surplus of £695k, of which Commissioning is £475k and the Autonomous Provider Organisation APO £220k. The ability to afford the delivery of this Strategy over the period of the CSP will be heavily dependant on the financial impact of any support required to clear historic deficits across London plus the outcome of discussions regarding support for our local financially challenged Trusts viability particularly in relation to Non Payment by Results uplifts.
2. Vision

The Trust’s strategic vision is to increase life expectancy and quality of life for all the people living in Havering and to reduce inequalities in health outcomes.

In deriving the NHS Havering’s Strategic Vision, a consideration of the local demographic issues and JSNA have helped to shape this for the next five years.

To achieve this Vision NHS Havering will commission services based on the needs of the whole population and will focus emphasis on quality, prevention and outcomes, in order to improve the health and the well-being of the population.

NHS Havering is committed to working in partnership with the London Borough of Havering (LBH) via the Havering Strategic Partnership (HSP), the Havering Children’s Trust, the Outer North East London Health Economy (ONEL), the North East London Sector, and the NHS Organisations throughout London through established collaborative commissioning and clinical networks.

2.1 Medium to long-term aims

Over the next five years we aim to increase life expectancy and quality of life for people in Havering and reduce inequalities in health outcomes. Using the early findings of the JSNA, National policy and Healthcare for London (HfL) key themes, NHS Havering has identified 5 strategic goals to deliver its vision.

Each Goal has a description of the aspirations for improvement, and identifies various strategies to underpin each strand of work providing a coherent framework for future development. In addition there are six local and four sector wide key initiatives aimed at contributing to the delivery of these Goals.

We strongly believe these goals are specific in their description, measurable in where we want to be and what success will look like, achievable in term of capacity and resources that have been identified and realistic in terms of the target we have set within a five year timeframe.

2.1.1 Strategic Goals

Our five strategic goals are:

Goal 1 - To improve the health and well-being of the people of Havering so that life expectancy and quality of life compares with the best in Europe and health inequalities are reduced.

Where we want to be by 2014:

- To reduce gap in life expectancy between wards with highest and lowest levels of deprivation from the current 4 years to 3.7 years.
- Increase life expectancy for women from 81.9 years to 84 years.
- Increase life expectancy for men from 78.2 years to 80.5 years.
- Improve the quality of life and well-being of Havering residents, as measured by Euroqol EQ 5D utility (the most common generic tool to measure quality of life) by 5% i.e. against the 2007 baseline.
- Halt the year on year increase in obesity, prevalence, and reduce average blood pressure (BP) in the population by 2mm/1mm from the current baseline.
Goal 2 - To change the pattern of healthcare to reflect the needs of local people and requirements of Healthcare for London, so that, wherever appropriate, care is provided outside hospital, and to ensure the quality of care is of the highest standard wherever it is provided.

Where we want to be by 2014:
- Fully integrated health and social care outside hospital for adults, children and young people.
- Primary care and modern facilities providing general and specialised services within a Polysystem.
- Reduced emergency hospital admissions for Long Term Condition (LTC) by 7%.
- Reduced Accident and Emergency (A&E) attendance by 10%.
- Reduced hospital outpatient attendance by 20%.
- Developed improved services such as Stroke and Trauma.

Goal 3 - To make the most cost effective use of the resources available to the Trust, and in doing so, shift a proportion of spend from treatment to prevention.

Where we want to be by 2014:
- There is evidence on the shift of focus from treatment to prevention.
- A year on year development and delivery of prevention strategies.
- Evidence in resource, shifted to prevention over the next 5 years.
- Commissioning on the basis of Value for Money (VfM) using Programme Budgeting and other techniques.
- Using the market to assure efficiency and economies of scale.
- Avoid any duplication of services.

Goal 4 - To establish partnerships or strengthen existing partnerships to respond to the Joint Strategic Needs Assessment (JSNA) and work towards joint commissioning of services to achieve these aims.

Where we want to be by 2014:
- Shared aims, budgets, posts, including within the Children’s Trust.
- Joint Health and Well-being strategy agreed, resourced and implemented.
- Joint Literacy Strategy agreed and implemented.
- Local Area Agreement 1 and 2 targets are met.

Goal 5 - To ensure that the Trust is fit for purpose in terms of World Class Commissioning (WCC) and is compliant with all requirements of governance and national standards for better health.

Where we want to be by 2014:
- An agreed Organisational Development plan towards becoming a World Class Commissioning (WCC) organisation.
- Assessed as ‘excellent’ for Healthcare Commission Standards (including developmental standards) and other inspections.
- Compliant with Civil Contingencies Act 2005.
2.2 Addressing local population health needs

Through the Needs Assessment undertaken by NHS Havering including the JSNA, we have identified six priority areas for development to improve overall health and well-being in the Borough. Our Annual Operating Plans will set out further detail in terms of how these areas of focus will demonstrate health improvement.

However, to optimise the benefit of investment in line with our strategic goals, NHS Havering will ensure that new initiatives increase the focus on those areas of strategic importance for the population. Therefore, this CSP outlines the six initiatives where NHS Havering will give added focus and funding to achieve our aims. There are many areas where we will be formulating service specifications to deliver programmes locally and on others we will work in collaboration with ONEL and North East London Sector as part of commissioning NFL priorities. NHS Havering has committed to work with the London Procurement Project (LPP) on Commissioning Continuing Care Services.

The six initiatives are: (not in order of priorities)

1. Staying Healthy.
3. Children and Young Peoples Services.
4. Older Peoples Services.
6. Cardiovascular Disease incorporating Stroke, Diabetes and Vascular Risk.

Collaborative Commissioning Initiatives as part of North East London Sector:

1. End of Life Care
2. Stroke
3. Tuberculosis
4. Redesign of the Acute Provider Landscape

2.3 Local and national context, including Healthcare for London

The CSP is informed by the early findings of the JSNA and has taken into consideration national, Pan London and North East London Sector, policy Strategy and Programmes. This plan is therefore locally driven but in line with national, regional and sector wide priorities.

These include:

2.3.1 NHS Operating Framework 2009-10

2.3.2 Health Care for London - A Framework for action (2007)

NHS Havering’s strategic plans reflect the Healthcare for London framework and are also reflective of the Next Stage Review. This report is about reshaping of services and outlines how healthcare in London will be improved. The principle emphasis and explicit requirement overarching NHS performance will be on quality rather than quantitative targets. Therefore the services commissioned by PCTs will need to address any nationally determined quality targets as well as considering the need for setting out its own local quality targets.
The main areas for action are: -

- Maternity care and care of the newborn: giving women choice about where they have their baby and providing more midwifery units.
- Staying healthy: providing a focus on prevention of ill health, through activities to improve nutrition, activity, sexual health, TB and immunisation.
- Mental health: local treatment with specialist inpatient help where necessary, and more ‘talking therapies. A new Service for Primary Care Psychological Therapies has been commissioned in 2008/09.
- Acute care: better trauma, stroke and emergency care in specialist centres.
- Planned care: ensure people can see a General Practitioner (GP) outside of working hours. Provide specialist outpatient and diagnostics closer to home.
- Long term conditions: enabling people to be in control of their condition.
- End of Life: personalised care ensuring preferences are taken into account.

2.3.3 Strengthening Commissioning in North East London (the proposal from the sector – July 2008)

Recent plans have been proposed to strengthen commissioning with the aim of, amongst other things, improving the relatively poor health status of the population in London (as compared to England) and enabling local health services to deliver in line with the requirements of the “A framework for Action”. The strategic context of the PCTs, is to deliver against the requirements of this report and the main objectives are: -

- Improve the health of Londoners
- Better meet public expectations of the NHS
- Reduce health inequalities
- Reduce reliance on hospitals
- Improve specialist care
- Develop London as a research centre.

The strategic developments in this report may necessarily evolve in the context of the proposed reconfiguration of the NHS in North East London. To maintain a local focus and ensure the needs of Borough populations are met, there is a proposal for Borough based Health Commissioning function.

To enable the reorganisation of Commissioner functions to begin, a Joint Committee of the four PCTs in Outer North East London has been created. Its primary initial function is to find ways to strengthen Acute Commissioning. It is anticipated that for 2009-10 responsibility for commissioning remains with current PCTs but for 2010-11 Acute Commissioning in particular will be delivered through an ONEL PCT configuration.

2.3.4 Commissioning for health and well-being (DH 2007)

This document sets out the steps that health and social care should take in partnership to commission more effectively for personal, sensitive individualised services with an emphasis on a strategic shift to the long-term prevention of ill health. The focus is on everybody, not just those who are ill, but with an emphasis on effective outcomes.
2.3.5 Child Health Promotion Programme (CHPP) (2008 DH)

This programme will enable delivery of certain aspects of the National Children’s Plan and is intended to provide preventative services tailored to the individual needs of children and families, acting as a best practice guide for children’s services. The CHPP will strengthen support for all families during the formative years of children’s lives and help parents to ensure that children are ready for early years education, school and later life. The CHPP is central in the NHS Havering Children’s Service Specifications for health visiting and school nursing to ensure that we are commissioning the best services for our local population.

The programme aims to:

- Provide greater emphasis on promoting the health and well-being of children in the early stages – pregnancy and the first five years of life
- Support a model of progressive universalism – a core programme for all children, with additional services for children and families with particular needs and risks
- Encourage partnership working between different agencies on local service development (e.g. general practice and SureStart Children’s Centres)
- Focus services on changing public health priorities - obesity, breast feeding, social and emotional development
- There is a requirement for a greater emphasis on the role fathers play in the child/family health and development through positive parenting.

2.3.6 Standards for Better Health

Standards for Better Health represents the Government’s response to the consultation on the health care standards (2004). It puts quality at the forefront of the agenda for the NHS and for private and voluntary providers of NHS care. The standards describe the level of quality that health care organisations, including NHS Foundation Trusts, and private and voluntary providers of NHS care, will be expected to meet in terms of safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health.

2.3.7 Our Health Our Care Our Say

This paper, produced in January 2006, advocated:

- Greater integration of health and social care services outside hospitals with greater joint working through new commissioning partnerships between Local Authorities and reformed PCTs.
- More control for individuals over their local health services to satisfy local need.
- More involvement of patients in local commissioning decisions.
- A shift in services towards prevention, for both ill-health and admissions and greater support for self-care.
- Services are provided closer to people's home.

Among the mechanisms for achieving this are PBC and Joint Commissioning Posts with LBH.

Health services in Havering are located within primary and secondary care, and in the community. A new hospital (Queens) has been built to replace Oldchurch Hospital. A number of primary care facilities have been upgraded through the Local Investment Finance Trust (LIFT) programme and further primary care developments are planned in the Harold Wood and Rainham areas.

Further primary care developments will be outlined within the forthcoming Primary Care Strategy.
2.3.8 Pan NE London Developments – Care Outside Hospital

The Outer North East London Care Outside Hospitals Initiative led by the Chief Executive of Redbridge PCT has consulted and specified on the procurement of a range of Out of Hospital services. NHS Havering is committed to collaboratively commissioning the following developments:

- Interface Discharge Co-ordination Service
- Urgent Care Services/Rapid Response
- Telehealth

2.3.9 Local Area Agreements (LAA)

The HSP leads the development of LAA for each three year period. The LAA set out the local priorities agreed between Central Government and the HSP along with other key partners at a local level. The intention is that LAAs provide local authorities and partners with the flexibility and capacity to deliver the best solutions for their areas through the identification of local issues and plans to address those issues.

Implicit in this is a new performance framework whereby local partners agree a maximum of 35 local targets from a list of 200. Havering has agreed 32 National Indicators (NI) as local targets for LAA2 (2009-2012), of which NHS Havering is leading on 4 and supporting on 6.

The 4 targets that NHS Havering is leading on are:

NI 39 – Alcohol harm related hospital admission rates.
NI 55 – Obesity among primary school age children in Reception Year.
NI 119 – Self-reported measure of people’s overall health and well-being.
NI 124 – People with a long-term condition supported to be independent and in control of their condition.

NHS Havering is supporting the following 6 targets:

NI 4 – % of people who feel they can influence decisions in their locality.
NI 110 – Young people’s participation in positive activities.
NI 131 – Delayed transfers of care from hospitals.
NI 139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently.
NI 149 – Adults in contact with secondary mental health services in settled accommodation.
NI 152 – Working age people on out of work benefits.
2.4 Investment plan and priority needs

NHS Havering faces many pressures for investment in healthcare and patient expectations are high. The PCT has to strike the right balance between long-term health improvements and well-being, improvements in specific measures of disease control, improvement in patient access and experience and infrastructure to support effective delivery of care. The ability to invest in developments also needs to be balanced against the expected increases in activity caused by population increases, increases in elderly patients and the need to fund unavoidable new cost pressures.

Our investment plan is therefore targeted on the highest priority needs deriving from the JSNA, London and national key themes that will contribute in achieving our overall vision goals and outcomes. NHS Havering has developed a Priorities Framework in 2008, which has been approved by the Board and has been incorporated in our Investment Programme.

This approach will be underpinned by analysis of programme budgets for different conditions and the opportunities for achieving better value for money in terms of increased Quality of Life.

More services has been jointly commissioned with the London Borough of Havering, the Outer North East London sector and the North East London sector.

Over the next five years we anticipates that the priority investments will be on the six identified initiatives in addition to those that we will be working in close collaboration with NEL and ONEL.

2.5 PCT core values

- Committed to Quality of Care and continuously strive for the best outcomes for patients, to improve health and well-being and people’s experience.
- Maintain equitable access to health and social care for all Havering people.
- Treat people with dignity and respect and compassion.
- Be clinically led and managerially supported.
3. **Context**

Havering has a resident population of 227,338 (2008).

Ninety-three percent (93%), of the population in Havering is from the white ethnic group compared to 71% in London as a whole. However, this is likely to change as Thames Gateway develops, with more residents from Black and Minority Ethnic groups moving to Havering as part of this development. One in five residents are pensioners compared to one in seven in London. Havering has a high number of people over the age of sixty-five in London and the proportion of people aged eighty-five or more is set to rise steeply in the future. There is expected to be a 10% growth in people aged sixty-five and above by 2013, rising to 25% growth by 2023.

It is vital that before services are provided through the commissioning process, we have a full appreciation of our populations needs. This section of the CSP describes those needs as a consequence of a set of analyses borne out of for example the JSNA. Health inequalities impact assessment is embedded into the commissioning strategy in order to reflect the range of action needed to reduce health inequalities in Havering.

It is also the case that external drivers influence the priorities for Commissioners at a PCT level e.g. the need for PCTs working collaboratively to address generic service deficiencies e.g. Stroke Services in ONEL.

The development of the NHS London (NHSL) ‘Central Hub’ will enable PCTs to receive/access centrally held information. At a London level significant benefits should be achieved by producing high quality, detailed and accurate analysis that enable PCTs to better plan for their population. The four PCTs in ONEL will, in mutual support of one another, work together to develop joint plans using the ‘hub’ resource as its key planning reference service.

The views and concerns of service users in particular form part of our thinking process and have helped to shape our strategic direction.
3.1 Population demographics, health needs and clinical quality

3.1.1 Joint Strategic Needs Assessment (JSNA)

Havering Primary Care Trust and the London Borough of Havering have undertaken a Joint Strategic Health and Social Care needs assessment for the population. This enabled NHS Havering to ensure that the services commissioned are based on assessed need, and that these services will deliver the health outcomes that it expects.

An easy to read version of the JSNA is enclosed in Appendix 1.

The JSNA can be accessed at www.healthandwellbeing@haveringpct.nhs.uk

3.1.2 Demographic Trends

The demographic trend for NHS Havering including current population health status, projected needs, health outcomes and health inequalities are enclosed in Appendix 2.
3.1.3 Access

A worthwhile objective is to improve access to health services for the most vulnerable groups in Havering.

Havering is an under-doctored area. The map shows an approach to access to health services, that of population weighted distance to a GP. Using this measure some of the most vulnerable groups in the Borough, including persons in the most deprived areas in South Hornchurch (notably the most deprived SOA) and Havering Park, and older people in Cranham have the worst access indices.

In order to improve access we are aware that we will need to increase the provision and promote accessibility to primary care. Opening hours and skill in delivering Primary Care services will need to radically change over the next five years.

The PCT intend to improve access through
- Extend opening hours of existing GP Surgeries through Local Enhanced Services.
- Open an additional three GP Surgery in Harold Wood as part of the national initiative to support under-doctored areas.
- Improve access via Polycentre and Polyclinic in Harold Wood and Rainham, which will be accessible to patients when their own GP is closed, twelve hours a day, three hundred and sixty-five days a year.
- Increase access to NHS Dentistry.
- Involve Community Pharmacists in developing further Local Enhanced Services.
- Improve Out of Hours provision.

![Population Weighted Distance to GP Map](image-url)
3.2 How the public, patients and clinicians have shaped and influenced our goals, initiatives and outcomes

One of the main ways we ensure that public, patients and clinicians influence the goals, initiatives and outcomes of our business is through the Priorities Forum. This was set up in 2006 to provide a means of ensuring that the public could influence the whole commissioning agenda and become involved in the prioritisation process.

In recognition that NHS organisations are required to make difficult decisions on spending allocations, it was felt important to agree a prioritisation framework which would enable commissioning decisions to be open, transparent and based on evidence of need. Through a series of workshops, local people agreed the following list of priority areas and allocated a 'weighting' to these.

The table below shows three areas as being more highly weighted than others. These are:

- Intervention/service is preventative.
- Based on identified need.
- Based on evidence of effectiveness.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the intervention/service preventative?</td>
<td>40</td>
</tr>
<tr>
<td>Based on identified need?</td>
<td>80</td>
</tr>
<tr>
<td>Based on evidence of effectiveness?</td>
<td>70</td>
</tr>
<tr>
<td>Cost-effective?</td>
<td>20</td>
</tr>
<tr>
<td>Most efficient way of meeting the need?</td>
<td>20</td>
</tr>
<tr>
<td>Already an area of investment?</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
</tr>
</tbody>
</table>

This prioritisation criteria has helped inform the Trust’s goals. Goals 1, 2, 3 and 4 have been refined to reflect the above criteria with a focus on prevention, cost effectiveness, and responding to need.

When determining the initiatives to operationalise the goals, local people have also been involved in this process. A Priorities Forum held in September 2008, helped to select eight World Class Commissioning Health Outcomes and supported six initiatives what would contribute in delivering the five Strategic Goals.

In addition, the Priorities Forum has been involved in shaping the Vision around public engagement, particularly in relation to strengthening the interface with patients. A workshop was held on mapping the patient journey with a view to identifying the factors that enhance health outcomes. This links to two of our LAA2 objectives, “NI 119 Self reported measure of health and well-being” and “NI 124, People with a long term condition supported to be independent and in control of their condition”.

23
The development of the initiatives for LAA2 involves strands of work on:

- Health literacy
- Development of a Diabetes booklet devised by patients/carers
- Provision of extra expert patient courses

Our intention is to evaluate the effectiveness of the existing approach to prioritisation during 2009 with a view to improving the public, patients, clinicians and local partners in shaping and influencing our future Vision, Goals, Initiatives and Outcomes.

In addition to working with the Priorities Forum NHS Havering has engaged with stakeholders in a number of other ways. Some examples are as follows:

- Equalities and Public Involvement Forum – membership from a cross-section of the community.
- Outreach work – carried out by the Equalities Advisor and Communication Manager to gather views from the community and feedback local and national key health issues.
- Collating Patient, Advice and Liaison Service (PALS) enquiry reports – used to support commissioning needs.
- Road show and targets briefings covering Healthcare for London and our local plan.
- National Patient Survey - recommendations from the report are fed into an action plan.
- We held ‘Thinking Ahead, Thinking Aloud’ events in the local communities and have incorporated the findings into its Healthy Communities Programme.
- The Local Authority has led a local consultation called ‘Harold Hill Ambitions’ in one of the relatively deprived areas in Havering and it is about to embark on an ambitious regeneration programme for the next fifteen years.
- We carried out a local Health and Lifestyle survey in 2007, which gave us information on lifestyle, and well-being issues for the first time – our staying Healthy initiative will respond to these findings.
- Views from Clinicians were collected in 2007 on the need for high quality holistic and health care responding to need.
- Briefing at Protected Time Initiative (PTI) by NHS Havering’s directors.
- Update to the Havering Overview and Scrutiny Committee (OSC).
- Primary Care Stakeholder events in October 2008, including members of the NHS Providers, Local Authority, Voluntary Sector and the Trust Board.
3.3 Existing targets and local and national health priorities

3.3.1 Current performance

NHS Havering has improved its overall performance during the last two years according to the latest assessment by the Healthcare Commission. NHS Havering has achieved a rating of fair for both quality of services and use of resources. On quality of services we met 21 out of the 24 “Core Standards”.

We achieved nearly two thirds of the national targets assessed by the Healthcare Commission, including waiting time for diagnosis and treatment of Cancer patients, access to Primary Care Professionals and booking appointments. NHS Havering is the fourth best-performing healthcare trust in the country in the use of the Choose and Book system, which means patients received confirmation of their first out-patient appointment within three days.

There are however five areas of greatest risk to the delivery our targets and are summarised below: -

(i) Access to a GP

Across England there has been a dramatic decline in the number of PCTs meeting the target that every patient should be able to see a GP within two working days. The Healthcare Commission has indicated that the drop is the result of a significant change to the way the target was assessed. Results from patient survey are now included as well as GP Practices to give a more accurate figure. In addition to a new GP Practice with capacity to register 6,000 patients, we are planning a new GP led health centre, open 365 days a year, which will provide a full range of GP services and treat minor injuries. These facilities are expected to be open in the Summer of 2009.

(ii) 18 weeks

We had a mixed performance on the 18 week Referral and Treatment target, with the 18 week waits for admitted patients being at most risk. We are engaging on a whole economy approach to deliver and sustain the target. We are working very closely with our main Acute Provider Barking, Havering, and Redbridge Trust (BHRT) to monitor and performance manage this target. To sustain the, 18 weeks target there are a range of initiatives: -

• To agree a realistic and deliverable plan with BHRT as part of the capacity planning for 2009/10.
• Through Practice Based Commissioning (PBC) we undertake performance management of referrals and advise on use of alternative providers, thus maximising GPs with Special Interests (GPwSI) services, the use of the Independent Sector Treatment Centre (ISTC) and creating other commissioning opportunities.
• We are also requiring BHRT to achieve improved new to follow up ratios of outpatients and reduce average lengths of bed stays in order to free capacity for elective care.
(iii) A &E - 4 hours

BHRT consistently achieves the target at King Georges Hospital (Goodmayes, Redbridge) but struggles to deliver the same performance at Queens Hospital (Romford, Havering). For its part the Trust is focusing on its internal processes and we are focusing on initiatives such as, rapid response and improved Urgent Care Centre (UCC) interventions via the Care Outside Hospitals initiatives, which forms part of the ONEL strategy.

(iv) Stroke

NHS Havering average mortality for stroke within thirty days of admission is about 30%, whereas in the best health system in England this is around 15%. Acute stroke services have been centralised on the Queens Hospital site in 2008/09 (this was supported by ONEL, North East London Stroke Network and BHRT). Rehabilitation services are also being reviewed and there are opportunities through clinicentres (Preferred Provider status by DoH) to provide intensive rehabilitation that compliments the strategy. It is intended that the combination of these changes will enable BHRT to achieve comparable mortality rates and delivery sustainable improvement in acute stroke outcomes. This will enable the PCT’s to develop a credible bid for the provision of a Hyper Acute Unit, which will benefit from the co-location with the Neurosciences Centre on the Queens site. The commissioners will be supportive of this strategy for two reasons: -

- Good local access and improved and sustainable health outcomes for patients.
- Comprehensive acute stroke services for ONEL patients.

(v) London Ambulance Service

The London Ambulance Service (LAS) continues to under-achieve in respect of response times with problems associated with the new Call Connect system. It is a London wide requirement for LAS to achieve all of its targets from 2009/10. PCTs have already contributed additional resources in 2008/09 to support achievement of the Category B (non life threatening) response time.
## 3.4 Provider landscape

### 3.4.1 Current Provider Summary

<table>
<thead>
<tr>
<th>Current key providers</th>
<th>Provider/Number of providers</th>
<th>Amount/value of activity commissioned £000’s</th>
<th>Provider-specific commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>52 GP Practices</td>
<td>£31,019</td>
<td>There are currently 122.91 WTE GPs. OOH is provided by PELC</td>
</tr>
<tr>
<td></td>
<td>34 Dental Practices</td>
<td>£12,444</td>
<td></td>
</tr>
<tr>
<td></td>
<td>40 Optometry = 20 Mandatory &amp; 20 Additional</td>
<td>£1,768</td>
<td></td>
</tr>
<tr>
<td></td>
<td>44 Pharmacy practices</td>
<td>£1,178</td>
<td></td>
</tr>
<tr>
<td>Community services</td>
<td>Provider “arm” of the PCT</td>
<td>£47,431</td>
<td>This covers current Community Nursing, Therapy, Specialist Nursing, bed based services at St Georges Hospital, and Intermediate Care, Community Child Health Services and Disablement Service Centre provisions.</td>
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<tr>
<td>Mental Health</td>
<td>North East London Foundation Trust (NEFLT)</td>
<td>£24,352</td>
<td></td>
</tr>
<tr>
<td></td>
<td>East London Foundation Trust (ELFT)</td>
<td>£931</td>
<td>Specialist Forensic provision</td>
</tr>
<tr>
<td></td>
<td>Specialist accommodation provided by 4 voluntary organisations</td>
<td>£1,141</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shaw Trust</td>
<td>£394</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care UK</td>
<td>£1,164</td>
<td></td>
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</table>
### Secondary care

<table>
<thead>
<tr>
<th>Provider</th>
<th>Description</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking, Havering and Redbridge Trust (BHRT)</td>
<td>Barking, Havering and Redbridge Hospitals</td>
<td>£98,287</td>
</tr>
<tr>
<td>Barts and London Hospitals Trust (BLT)</td>
<td></td>
<td>£14,814</td>
</tr>
<tr>
<td>Independent Sector Treatment Centre</td>
<td>Located at the King Georges Hospital site in Redbridge</td>
<td>£10,732</td>
</tr>
<tr>
<td>Other – 25 Providers</td>
<td></td>
<td>£21,352</td>
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</table>

### Tertiary and specialist commissioning

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Specialist Consortia</td>
<td></td>
<td>£3,473</td>
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<tr>
<td>Collaborative</td>
<td></td>
<td>£1,803</td>
</tr>
<tr>
<td>Other</td>
<td>Tertiary - Consultant to Consultant referrals are included within Secondary Care</td>
<td>£280</td>
</tr>
</tbody>
</table>

| Other | | £3524 |

### 3.4.2 Provider Landscape Commentary

#### Primary Medical Services

NHS Havering holds contracts with 52 GP Practices, with 36 Practices holding General Medical Service contracts, and 16 holding Personal Medical Services contracts. The average list size is 2,000 patients per GP. We have a significantly high proportion of GPs working as single handed (54%), with 31% of Practices having 2 or 3 GPs and 15% with more than 3 GPs. We face additional pressures with approximately 25% of GPs over 55, which means that the potential impact of this will have a marked effect on the future pattern of primary care services and how and when it needs re-providing. Distribution of GP surgeries including 6 branch surgeries are as follows:

- Romford – 16
- Upminster – 9
- Harold Wood/Harold Hill – 10
- Hornchurch – 15
- Rainham – 8

#### Out of Hours (OoH) services

NHS Havering commission from the Partnership of East London Consortium (PELC) for the provision of OoH primary medical services. Activities for 2007/08 are as follows:
- Telephone doctors advice- 10,401, Home visits – 3,312 and face to face contacts at the Primary Care Centre, - 13,302. which is adjacent to A&E at Queen Hospital.
Dental Services

There are thirty-four NHS Dental Practices in the NHS Havering area with a contract value of £9.8m. 81% of the practices commissioned are currently accepting new NHS patients. The PCT commissions 316,926 Units of Dental Activities (UDAs) and 38152 Units of Orthodontic Activities (UOAs). In 2007/08 dental practices delivered 96% of activities commissioned. The practices are geographically well located throughout Havering. Romford-twelve, Upminster-six, Harold wood/Harold Hill-five, Hornchurch-nine and Rainham-two. A new Dental Practice providing a minimum of 85% NHS dental care has been commissioned to be opened in early 2009.

In addition to these Practices we also have an Out of Hours (OoH) Dentistry Service and a community Dental Service (CDS). The CDS is managed by Barking and Dagenham PCT on behalf of NHS Havering through a Service Level Agreement (SLA), to support people who are unable to obtain care from general dental services. An average of 3000 UDA's are contracted yearly, for the CDS.

A dental health needs assessment will be undertaken as part of implementing our Oral Health Strategy. This will ensure future commissioning of dental care is based on identified needs.

Optometry

Effective from 1 August 2008 General Ophthalmic Service’s contracts were issued to twenty contractors providing Mandatory services and twenty contractors providing Additional services. Provision of Mandatory services is not well distributed throughout Havering, with Rainham only having one High Street service. Romford-nine, Upminster-three, Harold wood/Harold Hill-three, Hornchurch-four and Rainham-one.

Clinical governance, infection control and Health and Safety visits will take place in all Optometry practice to ensure compliant with acceptable standard and quality in services.

Pharmacy

There are forty-four pharmacy contracts in the PCT. Forecast activities are valued for 2008/09 at £1.18m. The pharmacies are geographically well located across Havering. Romford-sixteen, Upminster-seven, Harold wood/Harold Hill-three, Hornchurch-thirteen and Rainham-five.

Family Health services

The Family Health Service Consortium (FHSC) is a shared service organisation hosted by Waltham Forest PCT on behalf of the seven PCTs in the North East London Sector. The FHSC provides a range of services to NHS Havering and its Independent contractors. Transition from FHSC to the Shared Business Services (SBS) was completed on 1 November 2008. NHS Havering now has an individual contract with SBS, with a value of 2008/09 is £502,000.
Community Services

NHS Havering’s Provider Arm, an Autonomous Provider Organisation (APO) currently provides a range of services including community nursing, health visiting, community rehabilitation and speech and language therapy, Podiatry and NHS Funded Care assessments. The APO also provides specialist nursing services including continence, tissue viability, Child Protection, HIV/AIDS, Respiratory, Heart Failure, Diabetes, Epilepsy, Parkinson’s disease, Motor Neurone Disease, as well as school nursing and children’s community services.

We have commissioned a range of services including an Urgent Care Centre (Queens Hospital), twenty-four hour single point of access, rapid response services, and enhanced intermediate care services aimed at reducing unnecessary acute hospital attendances/admissions. Following the implementation of the agreed Adult Model of Care, our inpatient provision has been redeveloped to provide greater emphasis on medical assessment and streamed rehabilitation according to surgical/medical care group. Further work is ongoing to develop nurse/therapy led discharge and increased community based rehabilitation.

Recent commissioning developments include Heart Failure and Pulmonary Rehabilitation services.

We are strengthening our commissioning focus on provider services to ensure the activity it commissions reflects value for money as well as delivering higher service standards. Our Provider arm has invested in business support to enable it to operate on a semi-autonomous basis and to benchmark its own performance as a provider on an equal footing with other commissioned services. Further work is planned to develop a range of provider quality measures and re-profile its workforce to meet future demand.

The APO manages the Estate, Information Technology (IT) and HR Functions on behalf of the NHS Havering as well as for its own services.

Learning Disabilities (LD)

NHS Havering and LBH have a pooled budget arrangement for Adult Learning Disabilities clients. The commissioning is undertaken by a jointly funded commissioning manager, and the clinical team is managed through our Provider Arm. The strategy for Learning Disability is overseen by the LD Partnership Board with representatives from NHS Havering, LBH, clients/carers and voluntary organisations.
Mental Health Services

The main provider of general and community mental health services is North East London Foundation Trust (NELFT). As part of preparing to move current inpatient services from Mascalls Park in Brentwood, a new pan-trust service model has been developed to support the continued emphasis on expanding community provision as the main focus of Mental Health services. The service model has been developed through a number of local workshops and stakeholder meetings, with significant service user input.

NHS Havering is part of the North East London Specialist Commissioning consortium, which includes a contract with East London Foundation Trust (ELFT) for Forensic Services, Rampton Hospital for High Secure provision, Barnet Enfield Haringey NHS Trust for specialist eating disorder services, and South London and the Maudsley for patients receiving long term treatment in specialist out of area facilities, NHS Havering has developed a contract with the Priory Group for low secure and specialist continuing care / rehabilitative provision. In order to promote good clinical management, responsibility for managing all under sixty-five years old, Individual Service Agreements (ISAs) has now been devolved to North East London Foundation Trust. Bringing financial responsibility closer to clinical case management aims to speed up and simplify the process by which individual placements are agreed, arranged, and brought back into local services wherever possible.

NHS Havering is a high user of independent sector provision, having contracts with MIND, Rethink, Shaw Trust, Outlook Care, Care UK, The Avenues Trust, Age Concern and English Churches Housing Group for a range of accommodation and local community services.

Following a Tender process for the delivery of Psychological Therapies in Primary Care, a new contract has been awarded to KCA, a charitable organisation (committed services provider), as the new provider of this service. KCA will be working in partnership with NHS Havering and NELFT to deliver a stepped care model for people with mild to moderate mental health problems, primarily, anxiety and depression. The service re-design and tender process has been led by a psychological therapies steering group with strong GP and service user representation. NHS Havering is seeking to expand this new model under the Improving Access to Psychological Therapies (IAPT) programme. In addition to the new funding committed to modernising primary mental health care, a bid for additional resources will be made to the London IAPT Programme Board in December 2008.
Acute Services

Barking, Havering and Redbridge Trust (BHRT) is the main Acute Trust and provides acute services at Queens Hospital in Romford and at King Georges Hospital in Goodmayes.

In the short to medium term we are focusing on the achievement of all existing key national and local targets. For acute services during 2009-10 a key challenge is to achieve and maintain the 18 week target and the 4-hour A&E target at Queens Hospital.

NHS Havering continues to commission: -

- The use of a Clinical Assessment Service to ensure routine GP referrals are routed to the most appropriate service. This is supported by a network of PBC commissioned initiatives across a number of elective services, including Dermatology, Gynaecology, Ear, Nose and Throat (ENT), Ophthalmology, Urology and Neurology.

- Upper quartile new to follow up outpatient ratios from BHRT from Quarter three in 2008/09.

- The removal of low-priority procedures from routinely commissioned activity and the re-routing of those through the exceptional treatment process where needed.

- Increasing the range and availability of Diagnostics in a Community Care setting.

We have reviewed several procedures, which have been documented as having limited clinical value, and placed detailed restrictions on their use. This will free up some capacity within BHRT in order to address the 18-weeks target. The Independent Sector Treatment Centre (ISTC) on the King George Hospital site, has increased elective capacity and will be offering from this year Outpatient capacity within North East London which will significantly support the maintenance of the 18 week care pathway.

A continuing challenge remains the financial position of BHRT, particularly in regards to cost pressures attributed to Payment by Result (PbR) and non-PbR. Whilst the Provider is responsible for the financial viability of their organisation NHS Havering in its commissioning capacity needs to ensure that its population is able to have appropriate access to the necessary Acute services in its local area. We are also seeking to Commission improved services in Maternity.

From 2009/10 onwards the commissioning relationship with BHRT will significantly change as a consequence of the ONEL acute commissioning function. Currently it is intended that from 2010/11 a single commissioning team under ONEL arrangements will take responsibility for all acute commissioning. Allied to this is the emerging strategy for North East London to develop acute trust to become sustainable foundations trusts by 2011.

The main specialist acute services provider is the Barts and London Hospitals NHS Foundation Trust (BLT), which has close academic and research links with BHRT.
London Ambulance Services (LAS)

The London Ambulance Service continues to under-achieve in respect of response times with problems associated with the new Call Connect system. It is a London wide requirement for LAS to achieve all of its targets from 2009/10. PCTs have already contributed additional resources in 2008/09 to support achievement of the Category B (non life threatening) response time.

Tertiary and Specialist Services

We are part of London wide Tertiary and Specialist Services commissioning for a range of highly specialised and complex services.

Voluntary Sector

We have has close working links with the local umbrella body for voluntary and community organisations, Havering Association of Voluntary and Community Organisations (HAVCO). These links are strengthened through the work of the Local Strategic Partnership, (LSP) particularly within the Health and Well-being Group, which is a sub-group of the LSP. HAVCO has been commissioned by NHS Havering to provide two different pilot projects for Health Trainers within Havering, building local capacity and skills. Another key Voluntary Sector Provider is Age Concern Havering.

Commissioning Palliative and End of Life Care

We have invested in the provision of community based Palliative and End of Life Care Services with St Francis Hospice, Little Haven, and Marie Curie Nursing. The APO provides, District Nursing, Macmillian Nursing Care and a specialist nurse to promote the Liverpool Care Pathway in St Georges Hospital and in the community.
### 3.4.3 Strengths and weaknesses and capacity constraints

The following sets out in broad terms the strengths, weaknesses and capacity constraints of the main providers.

<table>
<thead>
<tr>
<th>Providers</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Capacity Constraint</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care (GPs, Dentists, Pharmacists and Optometrists)</strong></td>
<td>Well established Independent Contractor Practices providing good access to patients in seven clusters across Havering.</td>
<td>High proportion of small practices.</td>
<td>Under – doctored areas – being addressed by proposals for Polysystem.</td>
</tr>
<tr>
<td></td>
<td>Very experienced Practitioners and GP Surgeons providing standard minor surgery.</td>
<td>High number of practitioners over 55 coming up to retirement and will be a recruitment challenge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increasing development of Locally Enhanced Schemes (LES) to address gaps in provision.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good progress on PBC Development. At 100% of Practices participating in PBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Successful pilot for Dental extraction under Surgical Procedure</td>
<td></td>
<td>Insufficient availability of NHS Dentistry</td>
</tr>
<tr>
<td><strong>Havering APO</strong></td>
<td>A national pilot for Autonomous Provider Organisation.</td>
<td>Ageing estate with significant lack of maintenance issues.</td>
<td>Estate strategy being implemented through LIFT Co and proposals for Polysystem development.</td>
</tr>
<tr>
<td></td>
<td>Well established Community Hospital and Community Nursing and Therapy Services.</td>
<td>High level of community nursing staff over 50 – may present difficulties in recruitment in future.</td>
<td>A constraint on lack of robust performance information. APO has become National Pilot for a new Community Services Information System.</td>
</tr>
<tr>
<td></td>
<td>Very experienced and well developed workforce.</td>
<td>Lack of good information systems to support clinical activity and management.</td>
<td></td>
</tr>
<tr>
<td>North East Mental Health London NHS Foundation Trust (NELFT)</td>
<td>Foundation Trust from 1 June 2008.</td>
<td>Poor management information and utilisation of new technologies.</td>
<td>Ability to implement changes to deliver new services being commissioned quickly. (Examples of slippage on 08/09 investments).</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Achieved full compliance with NHS Standards for Better Health.</td>
<td>Significant organisational challenges to develop skills for new FT status and environment.</td>
<td>To date, slow in developing community and primary care focused services (per model of care).</td>
<td></td>
</tr>
<tr>
<td>Positive financial position.</td>
<td>Perceived lack of engagement with Havering GPs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large asset base to exploit new investments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High market share in core business of mental health (90%).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competent staff group delivering quality services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good collaborative working with LBH, NHS Havering and Voluntary Sector.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some significant achievements in key targets such as response to cancer and access to chest pain referrals.</td>
<td>Rated least well-performed score by Health Care Commission (HCC) for Maternity Services (Jan 2008).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCC Review of Heart Failure services rated good (July 2007).</td>
<td>Ability to achieve and sustain the 4-hour A&amp;E targets and 18-week target.</td>
<td>NHS London and PCT’s focus on BHRT’s Turnaround Programme and service plans may affect responses to shifts service provision from acute to primary and community settings.</td>
<td></td>
</tr>
<tr>
<td>Both Queens and King George Hospitals rate clean and hygienic (Aug 08) – BHRT is the best organisation of its size in England, for tackling Clostridium Difficile (July 08)</td>
<td>Need to improve clinical services for Orthopaedics and Gynaecology.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHRT have achieved the 6-week wait target for Digital Hearing and GP direct referrals for hearing and assessments (March 08).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Barts and Royal London NHS Trust (BLT)</strong>&lt;br&gt;St. Barts - Royal London - London Chest</td>
<td><strong>Contracted by DOH to carry out Research in Oncology, Neuroscience, Rheumatology, Pre-Natal Screening, Cardiology and communicable Diseases.</strong>&lt;br&gt;Comprehensive portfolio of specialist clinical services with demonstrably good clinical outcomes.&lt;br&gt;Good track record of delivery of operational and financial target.&lt;br&gt;Effective clinical networks and strong relationships with research and education partners.&lt;br&gt;Committed and expert workforce and extensive leadership programme.</td>
<td>Relatively poor physical infrastructure in many areas and some ageing IT systems.&lt;br&gt;Excessive length of stays, outpatients follow up rates and Did Not Attend (DNA) rates in some areas.&lt;br&gt;Trust not identified as a bio-medical research centre under “Best Research for Best Health”.&lt;br&gt;Capacity to expand services limited to availability of estate and physical space.</td>
<td>BLT faces competition from other Teaching Hospital in their vicinity but Havering patients are very familiar with their services and continue to choose BLT.</td>
</tr>
<tr>
<td><strong>Voluntary Sector Providers</strong></td>
<td>Some very well established locally based Providers such as Age Concern, Crossroads, Shaw Trust and Care UK.&lt;br&gt;Access to a very large volunteers and careers cohort.</td>
<td>Lack of good performance management information.&lt;br&gt;Vulnerability in access to funding in times of financial pressure faced by statutory bodies and other sources.</td>
<td>Local groups faced with competition from other Third Sector Providers from outside Havering.</td>
</tr>
<tr>
<td><strong>London Ambulance Service (LAS)</strong></td>
<td>Long established cross London Provider.&lt;br&gt;Continuing challenge to recruit and retain skilled staff.</td>
<td>LAS has seen a 4% year on year increase in calls, which is adding further pressure on its services.</td>
<td></td>
</tr>
</tbody>
</table>
Well-trained staff.  
Continuous need to replace and improve on fleet of vehicles and equipment.  
Long waits (average 36 minutes) at Queens A&E a constraint on LAS Havering Services.

| More flexible in its approach to responding to need – emergency care practitioners, community responder volunteers, motorbike and cycle teams and clinical telephone advice. |
| Achieved 79% Cat A Calls within 8 minutes (Target 75%) |
| 98% Cat A within 19 mins (Target 95%) |
| 84% Cat B within 19 mins (Target 95%) |

### 3.4.4 Market development

In the absence of a developed Market Management Strategy, the following represents the current state with regards to the Provider Landscape and strengths, weaknesses and capacity constraints set out above, and in line with World Class Commissioning competencies.

The Provider Landscape shows that the majority of the health services commissioned by NHS Havering or in some cases, on our behalf, for Havering people, has been from NHS Providers based locally. Whilst the challenge at the core of recent health and social care reform is about the development and offer of choice to patients, this must be balanced by the need to retain good, high quality local services with good local access for all of Havering’s population.

We intend to develop a greater knowledge of the choices preferred by local people and to respond to these in our marketing and procurement strategies.

Practice Based Commissioners are already indicating intentions to seek out more opportunities for locally based Primary Care and Community Services.
Some issues for developing the market include the following:

- Developing capacity and value for money in Primary Care provision.
- Establishing more robust commissioning relationships and influence with the existing providers.
- Developing the potential for commissioning more services from the Voluntary Sector and Independent Sector.
- Developing clinical and non-clinical care pathways, which will offer opportunities to commission differently for whole pathways or parts of pathways.
- Testing the market through the use of NHS Portal, tendering as required by the governance rules of Standing Financial Instructions (SFIs), and learning from experience of present and past procurement and performance management of Providers' contracts.
- Ensuring that the key initiatives in this CSP are aligned with knowledge of the market in order to achieve best value for money (VFM), high quality, and the outcomes specified.

3.4.5 Provider arm (Autonomous Provider Organisations) strategy

Shortly after the publication of Commissioning a Patient-Led NHS, NHS Havering made a conscious decision to move towards separation of the Provider Arm, which was approved in May 2008.

Havering APO has its own finance team with link to the NHS Havering director of Finance. The APO has authority to implement changes to structures, staffing and delivery of services. Through its Commissioning Strategy we will develop business infrastructures to enable collaborative working with all Contractors thereby ensuring fairness and transparency.

Ultimately, patients receiving services must experience an improvement in quality, responsiveness and outcome whilst commissioners receive better value for money. In accepting APO status, NHS Havering and Havering APO have agreed to move towards separation by April 2010.

The APO is a lead pilot for the development of the new national NHS Commissioning Services Contract and a template for Service Specifications.

3.5 Financial situation

NHS Havering has produced a Medium Term Financial Strategy which is the financial representation of the CSP and has been included as a separate document in the submission.

3.5.1 Historical Financial Position

3.5.1.1 NHS Havering financial position has been under a range of pressures since 2004/5, when, after achieving a balanced position in its first 3 years, it ended the year with a deficit of £3m. A small surplus was achieved in 2005/6 but a deficit of £6.3m was incurred in 2006/7 mainly as a result of a top slice of £9m to support the overall national and NHS London Financial position. During 2006/7 NHS Havering delivered a savings programme of £16m.

3.5.1.2 Last year (2007/8) NHS Havering returned to recurrent balance and achieved a small surplus of £285k and also paid off all of its historic deficit. It delivered savings of £9m achieving 95% of the total programme. Top Slice monies of £6m are still held by NHS London.
3.5.1.3 The key influences putting pressure on the PCTs finances in recent years have included:

- Havering is very close to its weighted capitation target position and so has received relatively low levels of growth compared to many PCT.

- The current NHS funding formula provides significant extra growth monies to those PCTs with high deprivation factors within its population. Havering does have pockets of high deprivation but overall has lower deprivation than most other North East London Boroughs and therefore has received lower growth. What Havering does have is a very elderly population (highest percentage of over 65’s in London) and this factor is not given a particularly high weighting in the current formula. NHS Havering has therefore had difficulty in funding increased costs in areas such as continuing care, long term conditions and associated high levels of emergency admissions and the impact of increased numbers of nursing homes.

- Increasing pressure from the payment by results system. Our local NHS acute provider Barking, Havering & Redbridge NHS Trust (BHRT) is part of the financially challenged Trust programme and has a substantial historic and a further planned deficit of £16m in 2008/9 to 2009/10. A key element of their recovery strategy has been to improve systems for capturing and coding of activity. Also BHRT has made little progress in improving below national average performance on key productivity measures such as new to follow-up ratios, emergency admission thresholds, length of stay etc. which limits our opportunity to release costs to invest in its key strategic objectives.

- We have had some but limited success in managing demand and reducing referrals into secondary care. A range of initiatives have been put in place such as an Urgent Care Centre at Queen’s Hospital commissioned from our Autonomous Provider Unit and community based Musculoskeletal and Heart Failure Clinics.

- In common with other local PCT there has been significant difficulties in achieving full utilisation of the Independent Sector Treatment Centre contract at King George’s Hospital. This was a centrally negotiated contract which has a “minimum take” contract requirement of £10m per annum and requires around 80% of that activity to be transferred by BHRT. In spite of negotiated case mix changes the under utilisation in 2008/9 is likely to be around £2m.

3.5.1.4 These issues have limited our ability to fund key developments and pump prime initiatives to shift spend in line with its strategic objectives.
3.5.2 Forecast Position 2008/09

3.5.2.1 The planned position for 2008/9 is for a surplus of £475k (excludes £220k for our Autonomous Provider Unit).

3.5.2.2 The current forecast is that this will be achieved but this is under significant pressure as a result of:

- A review of the Non-PbR element of the SLA with BHRT across the 3 main commissioning PCTs. BHRT maintain that the current block SLA arrangement has resulted in a significant under-recovery of actual costs and wishes to move all such services to a cost and volume basis at local cost. An additional non-recurrent fixed sum of £1.4m has been paid to BHRT in 08/9 whilst further work is completed and the position is reviewed for 09/10 in light of the position on this issue across London.

- Over-performance on the PbR element of the SLA with BHRT currently estimated at £4m. This is a result of a range of factors including coding and recording improvements within BHRT, a shortfall on referrals to the ISTC, plus difficulties in reducing referrals and achieving performance improvements within BHRT. The main over performance is on elective day case and outpatient activity caused also by higher than anticipated levels of activity needed to optimise performance on the 18 week admitted and non-admitted targets.

- The need to outsource significant levels of day case activity to the private sector to maximise performance against the 18 week target. The current estimated cost of this is £3m.

- Central re-negotiation of the Pharmacy Contract in year costing NHS Havering an additional £1m (full year £2m).

3.5.2.3 NHS Havering has again been successful in delivering a significant savings programme across prescribing, primary care and non-acute commissioning but to maintain its forecast position NHS Havering has had to hold back on some non-mandatory local service developments that were not national key targets.

3.5.3 Medium Term Financial Strategy For The Future

3.5.3.1 NHS Havering’s Medium Term Financial Strategy is a financial translation of the organisations Commissioning Strategic Plan (CSP).

3.5.3.2 The key elements of the Financial Strategy for the next 4 years are as follows:

- Ensure sufficient funding is identified to meet all key national and Healthcare for London Targets.

- Invest in the six key initiatives and four CCI initiatives identified in NHS Havering’s Commissioning Strategic Plan.

- Commit investment into key public health initiatives to improve the long term health of the population based on a clear needs assessment and to achieve a split of the total spend which is aligned to the Strategic Direction of NHS Havering.
• Effectively manage demand into secondary care through Practice Based Commissioning and transfer funding to wherever improvements in quality, access and value for money can be achieved into primary and community services

• Ensure investments keep pace with expected population growth including that resulting from the Thames Gateway development

• Invest in increasing the capacity and capabilities of NHS Havering to meet World Class Commissioning requirements as laid out in its Organisational Development Plan

• Identify and achieve savings/disinvestment programmes where value for money can be improved to maximise the resources available for investment

• Ensure achievement of all statutory financial targets and effectively manage financial risk

3.5.3.3 The ability to afford the delivery of the strategy over the period of the CSP will be heavily dependent on the financial impact of any financial support required to clear historic deficits across London plus the outcome of discussions regarding support for our local financially challenged Acute Trust’s financial liability with specific regard to Non PbR uplifts.

3.5.4 Key Assumptions – 2009/10 to 2012/13

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uplift to Revenue Resource Limit</td>
<td>5.8%</td>
<td>5.8%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Pan London Investment Fund</td>
<td>(1.0)%</td>
<td>(1.0)%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Efficiency Savings</td>
<td>(3.0)%</td>
<td>(3.0)%</td>
<td>(3.0)%</td>
<td>(3.0)%</td>
</tr>
<tr>
<td>Tariff Uplift (net of efficiency)</td>
<td>2.8%</td>
<td>2.8%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Other assumptions required are: -

• Maximum 0.5% contingency
• No new topslices

3.5.5 Key Initiatives commencing in 2009/10

The key initiatives are outlined in section 4.2 of the CSP.

The estimated costs of these initiatives over the next 4 years are as follows:

<table>
<thead>
<tr>
<th>Initiative Title</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/2</th>
<th>2012/3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>828</td>
<td>1,000</td>
<td>2,000</td>
<td>2,000</td>
<td>5,828</td>
</tr>
<tr>
<td>Maternity</td>
<td>500</td>
<td>392</td>
<td>380</td>
<td>500</td>
<td>1,772</td>
</tr>
<tr>
<td>Children Services</td>
<td>260</td>
<td>400</td>
<td>780</td>
<td>700</td>
<td>2,160</td>
</tr>
<tr>
<td>Older People Services</td>
<td>300</td>
<td>500</td>
<td>780</td>
<td>1,000</td>
<td>2,550</td>
</tr>
<tr>
<td>Care Outside Hospital</td>
<td>300</td>
<td>500</td>
<td>780</td>
<td>1,000</td>
<td>2,550</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>1,062</td>
<td>1,045</td>
<td>763</td>
<td>643</td>
<td>3,513</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>155</td>
<td>75</td>
<td>110</td>
<td>0</td>
<td>340</td>
</tr>
<tr>
<td>Stroke</td>
<td>100</td>
<td>500</td>
<td>500</td>
<td>300</td>
<td>1400</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>10</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>25</td>
</tr>
</tbody>
</table>
### 3.6 Activity commissioned

#### 3.6.1 Current situation

Summary of acute activity commissioning of acute activity commissioned

<table>
<thead>
<tr>
<th>Admission</th>
<th>Baseline 2007/08</th>
<th>Year 1 2008/09 forecast*</th>
<th>Increase/Decrease (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective day case (spells)</td>
<td>18,399</td>
<td>19,031</td>
<td>3%</td>
</tr>
<tr>
<td>Elective ordinary (spells)</td>
<td>9,671</td>
<td>10,378</td>
<td>7%</td>
</tr>
<tr>
<td>Non-elective (spells)</td>
<td>24,266</td>
<td>23,710</td>
<td>-2%</td>
</tr>
<tr>
<td>Outpatient (new) (attendances)</td>
<td>73,465</td>
<td>79,554</td>
<td>8%</td>
</tr>
<tr>
<td>Outpatient (follow up) (attendances)</td>
<td>195,016</td>
<td>205,867</td>
<td>6%</td>
</tr>
<tr>
<td>Regular attendee</td>
<td>4,811</td>
<td>5,779</td>
<td>20%</td>
</tr>
<tr>
<td>Bed days (Paediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU), Intensive Care Unit (ITU), High Dependency Unit (HDU) Critical Care)</td>
<td>6,447</td>
<td>5,796</td>
<td>-10%</td>
</tr>
<tr>
<td>A&amp;E Major (attendances)</td>
<td>19,497</td>
<td>22,723</td>
<td>17%</td>
</tr>
<tr>
<td>A&amp;E Standard (attendances)</td>
<td>6,986</td>
<td>11,105</td>
<td>59%</td>
</tr>
<tr>
<td>A&amp;E Minor (attendances)</td>
<td>31,528</td>
<td>24,253</td>
<td>-23%</td>
</tr>
</tbody>
</table>

The Non-Acute Commissioned Activity is summarised in section 3.7.1.1 below.

#### 3.6.2 Key assumptions

**HfL Activity Assumptions**

The baseline activity for 2007-08, as detailed in the Finance and Activity spreadsheets, has been constructed utilising the HfL model. This has been implemented by importing Summary of Managerial Finance (SUS) and other data into the HfL model the output of which has then been converted into the required format for the CSP. It has been built using Health Resource Groups (HRGs) converted to the most appropriate specialty description.

This baseline has then been extrapolated forward using the Healthcare for London planning assumptions to derive annual outputs across the five years of the CSP. Therefore the underlying activity baseline for the full duration of the CSP is entirely consistent with the Healthcare for London model.

A further set of local planning assumptions has then been incorporated into the Finance and Activity worksheets. These include, for example, the impact of the initiatives, demand management and Referral to Treatment (RTT).

Through our emerging polysystem strategy, one of the aims is to move work out of acute care settings and into polyclinics for example, outpatient activity, diagnostics, minor day case procedures.
3.7           Primary and Community Care Strategy

3.7.1        Current position and commissioning activities

NHS Havering is in the process of developing a Primary and Community Care Strategy. The strategy will set out an investment plan for the next five years and will address a number of key strategic priorities. We have completed a number of primary care developments using the LIFT initiative in South Hornchurch, Cranham and Harold Hill. We will develop our existing service strategy including the feasibility of developing a network of larger Primary Care Resource Centres/Polyclinics supporting the localities of Romford, Hornchurch and Upminster. The aim is that these centres will offer patients access not only to health but also social care. (See the Proposed Polysystem diagram at 3.7.3).

These are: -

- Improving accessibility to primary and community care services including the development and expansion of primary care resources and new ways of working.
- Agreeing a future configuration of primary and community care services including the potential benefit of fewer, but a larger network of practices operating from modernised or new premises.
- Developing access to an enhanced range of higher quality primary and community care based services with increased availability and the potential for new diagnostic and treatment services.
- Improving the overall level and quality of core primary and community care services ensuring there is a more convenient and more consistent level of high quality access across NHS Havering.

Early work that is already being taken forward includes: -

- Actions to improve access in all primary care practices, focussing on areas where current performance is below average.
- The implementation of “GP Practice Extended Opening Hours” starting on a pilot basis and increasing to over 50% practices providing extended opening hours in 2008/09. 77% of practices now offer extended opening hours with several other practices intending to provide this extended service in the near future.
- Procurement for establishing a new Healthcare Centre and GP practice in the Harold Wood area.
- Improving access to NHS dental services (includes a new dental practice commissioned in 2008-09).
### 3.7.1.1 Non Acute Commissioned Activity

<table>
<thead>
<tr>
<th></th>
<th>Baseline 2007/08</th>
<th>Year 1 2008/09 forecast*</th>
<th>Increase/Decrease (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Practice in-hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultations¹ WTE GPs</td>
<td>793,410</td>
<td>796,530</td>
<td>0.4%</td>
</tr>
<tr>
<td>WTE GPs</td>
<td>122.91 WTE</td>
<td>124.35</td>
<td>1.2%</td>
</tr>
<tr>
<td>Amount £’000</td>
<td>£28,666</td>
<td>£29,540</td>
<td></td>
</tr>
<tr>
<td>GP practice out-of-hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultations¹ Amount £’000</td>
<td>£1,450</td>
<td>£27,250</td>
<td>0.8%</td>
</tr>
<tr>
<td>Amount £’000</td>
<td>£27,015</td>
<td>£1,471</td>
<td></td>
</tr>
<tr>
<td>Prescriptions</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Number Amount £’000</td>
<td>3,376,311</td>
<td>3,381,907</td>
<td>1.5%</td>
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<tr>
<td>Amount £’000</td>
<td>£33,177</td>
<td>£33,232</td>
<td></td>
</tr>
<tr>
<td>Optometry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number Amount £’000</td>
<td>55,320</td>
<td>51,776</td>
<td>6.4%</td>
</tr>
<tr>
<td>Amount £’000</td>
<td>£1,933</td>
<td>£1,768</td>
<td></td>
</tr>
<tr>
<td>Dentistry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendances¹ – UDA;s UOA’s</td>
<td>312,588</td>
<td>316,926</td>
<td>1.4%</td>
</tr>
<tr>
<td>UDA;s</td>
<td>38,141</td>
<td>38,152</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other Pharmacy Contract</td>
<td>Amount £’000</td>
<td>£1,195</td>
<td>-1.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£1,178</td>
<td></td>
</tr>
<tr>
<td><strong>Community Services:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds (SGH)</td>
<td>60</td>
<td>120</td>
<td>100%</td>
</tr>
<tr>
<td>Bed days (SGH)</td>
<td>21,900</td>
<td>41,280</td>
<td>88%</td>
</tr>
<tr>
<td>Community Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact: District Nurses</td>
<td>142,000</td>
<td>142,000</td>
<td>0%</td>
</tr>
<tr>
<td>Contacts: Health Visitors</td>
<td>55,645</td>
<td>55,645</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access and crisis services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home treatment team</td>
<td></td>
<td></td>
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<tr>
<td>Attendances¹</td>
<td>421</td>
<td>416</td>
<td>-1%</td>
</tr>
<tr>
<td>Episodes of care</td>
<td>7,160</td>
<td>10,276</td>
<td>44%</td>
</tr>
<tr>
<td>Face to face contacts</td>
<td></td>
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</tr>
<tr>
<td>Assertive outreach team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face to face contacts</td>
<td>7,087</td>
<td>5,152</td>
<td>-27%</td>
</tr>
<tr>
<td>Early intervention team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face to face contacts</td>
<td>3,482</td>
<td>4,152</td>
<td>19%</td>
</tr>
<tr>
<td>Clinical Services</td>
<td>No. of referrals</td>
<td>Attendances(^1)</td>
<td>Outpatients</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>------------------</td>
<td>-------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>A&amp;E Liaison</td>
<td>1,138</td>
<td>5,893</td>
<td>11,378</td>
</tr>
<tr>
<td>Mental Health Initial Assessment Team</td>
<td>996</td>
<td>6,616</td>
<td>13,924</td>
</tr>
<tr>
<td>No. of referrals</td>
<td>-12%</td>
<td>12%</td>
<td>22%</td>
</tr>
</tbody>
</table>

**Ambulance**

| Ambulance Services | Cases Seen\(^1\) | 18,222 | 19,118 | 5% |

**Notes**

Where there is no activity measure the contract value is provided.

### 3.7.2 Case for change

NHS Havering has a high proportion of single-handed GP’s who are nearing retirement age. In order to recruit and retain new GP’s into the area, a different service model is required that also meets the needs of the population. The system will be particularly aiming at developing sound training and governance arrangements within primary care and encouraging general practice to embrace a wider and more comprehensive service model.

Access to Primary Care Services in Havering is good when benchmarked with London and National survey results. There are however pockets where access is poor.

As with deficiencies in Primary and Community services across London, Havering too is faced with poor infrastructure and configuration of GP premises.
3.7.3 Future vision for primary and community services commissioning

Our future direction for primary and community care commissioning is consistent with recent publications including NHS Next Stage Review – “Our Vision for Healthcare in the community”.

NHS Havering held its first stakeholder consultation in June 2008.

The primary care and community services model currently being designed for Havering will operate on a Polysystems approach (see diagram on the following page), which represents a potential configuration of services and facilities.

The aim of this strategy is to offer high quality primary care services seven days a week, with extended opening times and a range of support services. These services are designed to meet the local needs of patients and their carers, offering improved access to primary care services and wherever possible the co-location of Borough services. A key feature of these services will be to encourage a positive approach to health and well-being and dedicated support to encourage self-care for patients with long-term conditions. The aim is to significantly reduce the number of patients using Accident and Emergency Services inappropriately, allowing the secondary care service to use its highly skilled workforce in more effective ways.

The strategy for the poly system is to develop a hub and spoke model with a polyclinic at the centre (or hub) based at St Georges Hospital and five polycentres based across the Borough. To the North of the Borough there will be three poly centres, with two in the south of the Borough. There will be some GP Surgeries that choose and others maybe encouraged to locate these premises once these centres are developed. For surgeries that are no longer fit for purpose, this will provide patients and staff with an improved environment that meet modern standards, including meeting disability access requirements.

The polyclinic will offer a range of services including core GP services, a full range of diagnostics (including x-rays), outreach services – consultant appointments, Pharmacy, mental health, minor injuries, GP assessment, rehabilitation and respite beds, urgent care, a full range of therapies, co-located Borough services, Social Care and Voluntary Sector and a café. NHS Havering is seeking to look at innovative models of delivery including encouraging social enterprise models, for services such as café and transport.

All the polycentres will offer extended hours and weekend working. Each Polycentre has a core service and a slightly different range of specialised services i.e. podiatry, dental, substance abuse and sexual health that is tailored to meet the specific needs of its local population.

A key plank of the polysystem is the alliance that has been created with the London South Bank University (LSBU), as this offers the potential to create and sustain a learning environment for our staff. The first poly centre is to be located alongside the LSBU. This offers a primary care campus that is able to offer leading edge primary and community services within a research and learning environment.

Error!
PROPOSED POLYSYSTEM

- Opening Hours: Extended Hours & Weekends
- Core GP Services (and Enhanced)
- Special Interest
- Minor Surgery / Minor Injuries
- Well-Being

POLY CENTRE: Harold Hill

- Opening Hours: Extended Hours & Weekends
- Core GP Services (and Enhanced)
- Special Interest
- Minor Surgery / Minor Injuries
- Well-Being
- Diagnostics – Inc X-Ray

POLY CENTRE: Havering Park

- Opening Hours: 12hrs x 365 days
- Core GP Services (and Enhanced)
- Long Term Conditions
- Older Persons Service
- Disability
- Joint Provision with Social Care
- Range of Supporting Diagnostics
- Well-being
- Pharmacy
- Café
- Mental Health & Social Care / Voluntary Sector

POLY CENTRE: Harold Wood

- Opening Hours: 12hrs x 365 days
- Core GP Services (and Enhanced)
- Well-Being
- Minor Injuries / Minor Ailments
- Long Term Conditions & Older Peoples Services (Joint with Borough)
- Substance Abuse / Sexual Health
- Urgent Care
- Podiatry
- Dental

POLYCENTRE: Mardyke

- Opening hours: 12 a day minimum / 365 days
- Core GP Services (and Enhanced)
- Well-Being
- Minor Injuries / Minor Ailments
- Long Term Conditions & Older Peoples Services (Joint with Borough)
- Substance Abuse / Sexual Health
- Urgent Care
- Podiatry
- Dental

BHRT: SECONDARY CARE

- Opening Hours: Extended Hours & Weekends
- Core GP Services (and Enhanced)
- Special Interest
- Minor Surgery / Minor Injuries
- Well-Being

POLYCLINIC St. George’s Hornchurch

- Opening Hours 7am-10pm
- Full range of diagnostics (Inc X-Ray)
- Outreach Services – Consultants
- Pharmacy
- Mental Health
- Minor Injuries
- DPS Assessment / Rehab / Respite Beds
- Urgent Care
- Full Range of Therapies
- Co-located Borough Services
- Core GP Services (and Enhanced) Social Care & voluntary Sector
- Well-Being
- Café

POLY CENTRE: Rainham Village

- Opening Hours: Extended Hours & Weekends
- Core GP Services (and Enhanced)
- Special Interest
- Minor Surgery / Minor Injuries
- Well-Being
- Diagnostics – Inc X-Ray

POLY CENTRE: Rainham Village

- Opening Hours: Extended Hours & Weekends
- Core GP Services (and Enhanced)
- Special Interest
- Minor Surgery / Minor Injuries
- Well-Being
- Diagnostics – Inc X-Ray

POLY CENTRE: Mardyke
3.7.4 Implementation

Through a fully inclusive dialogue and consultation with the Havering population and key stakeholders, the aim is to implement these changes on a phased basis between now and 2014. The implementation of each project is based on ‘Needs’ priorities i.e. where it is evidenced that one area of the population has more pressing issues to be resolved than others.

Phase 1 of this process is already well advanced with plans for the development of services on the old Harold Wood Hospital site, the expectation being that services will become available in the Spring of 2009.

The vision is clear but the final service configuration for each locality will be subject to detailed further analysis and consultation.

4. Strategy

4.1 Goals

4.1.1 Goal 1 - *To improve the health and well-being of the people of Havering so that life expectancy and quality of life compares with the best in Europe and health inequalities are reduced.*

Prioritisation

There are variations in life expectancy of six years between the most and least advantaged wards in the Borough.

This Goal, along with others, has been the subject of discussion with key stakeholders who have prioritised it as an important area, alongside initiatives to reduce health inequalities.

Description of goal including timeline

This Goal is about improving overall health and well-being whilst reducing health inequalities over the next five years. In order to tackle this and reduce the gap, we are focusing on addressing risk factors for the major causes of morbidity and mortality such as cardiovascular disease (Initiative 6), by targeting resources within our more deprived areas using a ‘Healthy Communities’ approach.

Our ‘Healthy Communities’ Strategy (2007-14) will ensure local communities are engaged in the improvement of their own health and will include a focus on education, training and improvement of life skills.

We have strengthened partnership working through the Local Area Agreements (LAA 1 2007-10, LAA2 2008-11), which include a focus on the major risk factors for poor health as well as the wider determinants of health. In this way, we will improve quality of life for local people, particularly those with Long Term Conditions (LTC). These plans are well developed, with specific actions and timelines that are agreed by the local Havering Strategic Partnership (HSP).
Link to vision and health needs

This Goal directly links to the Vision because both have a focus on life expectancy, quality of life and health inequalities.

We have a large proportion of older people living in Havering and quality of life is important to them as it impacts on their everyday life experience and their ability to remain active in society and retain their independence. In recognition of this, we have also developed an initiative aimed at older people focusing on improving quality of life by developing services that are effective and appropriate.

Fit with Healthcare for London key themes and specific projects

This Goal fits with the Healthcare for London project of ‘health improvement and well-being’ and ‘long term condition’ both of which are also ‘Next stage review’ priorities.

Success Measures

By 2014 we want to:

- Reduce gaps in life expectancy between wards with highest and lowest levels of deprivation from the current 4 years to 3.7 years.
- Increase life expectancy for women from 81.9 years to 84 years.
- Increase life expectancy for men from 78.2 years to 80.5 years.
- Improve the quality of life and well-being of Havering residents, as measured by Euroqol EQ 5D utility (the most common generic tool to measure quality of life) by 5% i.e. against the 2007 baseline.
- Halt the year on year increase in obesity, prevalence, and reduce average blood pressure in the population by 2mm/1mm, from current baseline.

4.1.2 Goal 2 - To change the pattern of healthcare to reflect the needs of the local people and requirements of Health Care for London, so that, wherever appropriate, care is provided outside hospital, and to ensure the quality of care is of the highest standard wherever it is provided.

Prioritisation

Patients want care closer to home. Our health and residents quality of life, our care, our say and the Local Listening Exercise confirm this need. This is also a key priority for the implementation of Health Care for London. This will lead to improving access, and which in turn will contribute to resident qualities of life.

Description of goal including timeline

This Goal focuses on our individual and collaborative plans with our Partner PCTs in ONEL and LBH to develop proposals and a supporting infrastructure to ensure the implementation of improved Out of Hospital Care over the next five years.

Link to vision and health needs

This Goal links to our Vision and Local Health Needs in contributing to higher standards of care in the Community and reducing health inequalities. The development of a proposed Havering Polysystem will provide enhanced infrastructure and capacity in the community particularly in ‘under doctored’ areas.
Fit with Healthcare for London key themes and specific projects

This fits in with Healthcare for London priorities for improving care in Primary and Community settings including Polyclinics and Care Outside of Hospital.

Success Measures

By 2014 we want to:

- Be fully integrated health and social care outside hospital for adults and children and young people.
- Have primary care and modern facilities providing general and specialised services.
- Reduce emergency hospital admission for Long Term Conditions by 7%.
- Reduce A&E attendance by 10%.
- Ensure all service specification include quality and outcome metrics.
- Reduce hospital outpatient attendance by 20%.

4.1.3 Goal 3 - To make the most cost effective use of the resources available to the Trust, and in doing so, shift a proportion of spend from treatment to prevention.

Prioritisation

This is a priority area for NHS Havering, as we are committed to the optimum use of resources for improving health and well-being, focusing on a shift from treatment to prevention.

We have developed a priorities framework for achieving the maximum/best health gain for the local population with the available resources. We are developing the use of Programme Budgeting and Marginal Analysis (PBMA) and other economic evaluation and analysis techniques for priority setting.

Description of Goal including Timeline

In order to take the priority setting forward, a PBMA Group advises the Priorities Forum and PCT Board on the basis of cost and health outcomes effectiveness. The evidence on the economic evaluation of health care interventions and strategies are then used to drive the commissioning agenda forward.

Link to vision and health needs

In order to meet our overall Vision of improving the health of the population, we need to ensure we make appropriate investments that will deliver the evidence-based, effective, easily accessible health care and prevention of ill-health initiatives as identified in the JSNA.

Fit with Healthcare for London key themes and specific projects

Investment in the healthcare for London key themes and specific projects is dependent on adequate resources that can be appropriately directed towards delivery of effective outcomes. The use of our Priorities Framework will ensure investment and disinvestment is considered in a systematic way.
Success measures

By 2014 we want to:
- Evidence the shift of focus from treatment to prevention.
- Evidence shift of resources to prevention (Wanless Report).
- Identified in shifting resources to prevention over the next five years (Wanless Report).
- Commission on the basis of Value for Money (VFM) using Programme Budgeting and other techniques.
- Use the market to assure efficiency and economies of scale.
- Avoid any duplication of services.
- Evidence a year on year development and delivery of prevention strategies.

4.1.4 Goal 4 - To establish partnerships or strengthen existing partnerships to respond to the Joint Strategic Needs Assessment and work towards joint commissioning of services to achieve these aims.

Prioritisation

NHS Havering is committed to working in partnership to achieve its goals. This has been prioritised because we recognise that partnership working is key to achieving outcomes that will improve the quality of life both in health and well-being for the overall population including specific targeted groups in areas of disadvantage.

We have prioritised a number of important work areas with partners – these include a shared vision for the Sustainable Communities Strategy, joint strategies for physical activity, obesity and alcohol harm reduction and joint targets with the Local Authority and other agencies for LAA1 and LAA2.

Description of goal including timeline

Our goal is to strengthen key partnerships over the next 5 years. This includes a commitment to:
- Havering Strategic Partnership – Sustainable Communities Strategy
- Havering Community Safety Partnership
- Health and Well-being Group
- Drug and Alcohol Treatment Board
- Children’s Trust Board and Executive
- Havering Children and Young Mental Health Partnership Board
- Mental Health Partnership Board
- Learning Disabilities Partnership Board
- Older People’s Partnership Board
- Physical and sensory Disabilities Partnership Board

By working effectively with the above groups, we will oversee the implementation of LAA1 and LAA2 and subsequent refresh over the next few years. We will jointly commission more services with the London Borough of Havering over the next five years, building on the success of the joint learning disabilities, joint mental health teams and the Drug and Alcohol Treatment Board.
Link to vision and health needs

This partnership will ensure that key targets for health and well-being, including morbidity and mortality can be effectively delivered between 2009-14, leading to achievement of the Trust’s vision and attainment of the agreed health outcomes.

The JSNA will inform the development of commissioning plans of partners from 2009 onwards. We aim to narrow the gap in life expectancy and improve quality of life for local people by responding to identified need and linking this to the further development of local area agreements, which fit within the overall structure of Havering Sustainable Communities Strategy.

Fit with Healthcare for London key themes and specific projects

Partnership working is not explicitly mentioned in Healthcare for London or the Next Stage Review, but it is key to the achievement of local priorities which will, in turn, help us to achieve our goals and see the vision realised for Havering.

Success measures

By 2014 we want to be:
- Evidence shared aims, budgets, posts, including within the Children’s Trust.
- Have joint Health and Well-being strategy agreed, resourced and implemented.
- Have joint Literacy Strategy agreed and implemented.
- Meet local Area Agreement 1 and 2 targets.

4.1.5 Goal 5 - To ensure that the Trust is fit for purpose in terms of World Class Commissioning (WCC) and is compliant with all requirements of Governance and national standards for better health.

Prioritisation

World Class Commissioning (WCC) is an integral component of ensuring that both commissioners and providers of health promotion (Staying Healthy) and health care provision comprehensively deliver “maximum improvements in health and well-being outcomes”. This goal is therefore a priority across the NHS and is consistent with the World Class Commissioning Assurance Framework, and the delivery of services by all providers in compliance to the national standards for better health including patient safety.

Description of goal including timeline

World Class Commissioning has been structured around a framework that will continually drive improvements, year after year, and comprises objectives that will necessitate significant organisational change management processes focusing on outcomes, competencies and governance. The assurance process commenced in the summer of 2008 with the baseline assessments and will continue throughout the life of the CSP and beyond.
Link to vision and health needs

World Class Commissioning is designed to improve the commissioning and provision of healthcare, ensuring that the needs of the population are appropriately identified and addressed through the development of stakeholder engagement, effective partnerships and collaborative commissioning.

Fit with Healthcare for London key themes and specific projects

The development of World Class Commissioning will support and enhance the design and delivery of Healthcare for London, Local Health and Social Services.

Success measures

By 2014 we want to: -

• Have an agreed Organisational Development plan that will enable us towards becoming a World Class Commissioning (WCC) organisation.
• Be assessed as ‘excellent’ for Healthcare Commission Standards (including developmental standards) and other inspections.
• Be compliant with Civil Contingencies Act 2005.

The PCT has identified the following ten outcome measures, from the WCC list including the two compulsory ones and are mapped to the six initiatives to measure progress: -

1. All age, all cause mortality – Staying Healthy
2. Index of multiple deprivation – Staying Healthy
3. Low birth weight – births under 2500 grammes – Staying Healthy and Maternity
4. Cancer mortality rates (under 75 years) – Staying Healthy
5. Self reported experience of patients and users – All initiatives
6. Mortality rate from causes considered amenable to healthcare – Care Outside Hospital and Older People
7. Stroke deaths within 30 days – Cardiovascular, Stroke
8. Rate of hospital admissions for alcohol related harm – Staying Healthy
9. Cardiovascular mortality rates (under 75 years) – Cardiovascular
10. Percentage of deaths that occur at home – Care Outside Hospital, End of Life Care
4.2 Initiatives

The process for selecting the following six initiatives has been informed by JSNA. Our Local priorities and by the Collaborative Commissioning Group where opportunities to improve healthcare services can most effectively be delivered over the next five years: -

- Staying Healthy
- Maternity Services
- Children and Young People Services
- Older People Services
- Care Outside Hospital – Urgent Care, Interface Discharge and Co-ordination Service, Telehealth and Polyclinic
- Cardiovascular Disease – Incorporating stroke, Diabetes and Cardiovascular Risk

We committed to working with key partners within the LBH, NEL and ONEL to ensure the structure and process of healthcare and delivery, continue to be actively developed, locally and across the sector. This should result in accessible, high quality and efficient services being commissioned to address the current and future need of our growing population.

Collaborative Commissioning Priorities across the North East London Sector

The initiatives presented here represent what we will commission in collaboration with our sector partners to meet local needs: -

- End of Life Care
- Stroke
- Tuberculosis
- Redesign of the Acute Provider Landscape

Local Priorities

Each Initiative developed for this Commissioning Strategy Plan is relevant to the health needs of Havering’s local population and contribute most to our overall vision and strategic goals.

Stakeholder and Clinical Engagement

Patient, public and clinicians have been involved in the selection of the Initiatives through a series of Stakeholder events organised by NHS Havering to assist in the overall decision as to which Initiatives should be put forward in this plan. Our Priorities Forum decided upon the criteria and scoring methods to rank the Initiatives from a larger number of suggestions.
4.2.1 Initiative 1 - Staying Healthy

Prioritisation

Improving the health of the population is one of the core functions of PCTs. Our *Staying Healthy in Havering* initiative fits well with the priorities of NHS Havering. As well as a strategic fit with 3 of our goals (improving health and well-being, shifting spend to prevention and strengthening partnership), our local Priorities Forum ranked ‘prevention’ as a top priority during 2007. In addition, *Staying Healthy* encompasses the joint prevention programmes with key partners, as outlined in LAA1 and LAA2 and in our joint health improvement strategies, and also mirrors the Health Care for London priority area of Staying Healthy. Furthermore, Havering has the highest proportion of older people in London. Older people tend to be high users of health services. It is therefore essential that we work with our partner organisations to prioritise the health of the older population now and in the future to promote health and well-being and independence.

Many of the projects outlined in this initiative also serve to underpin other initiatives, particularly Initiative 6 (Cardiovascular reduction), for which unhealthy lifestyles are a major risk factor. We have chosen to have a separate initiative for prevention to signal the Trust’s intention to prioritise this area over the next five years and to assure the level of investment. This avoids the possibility of it being subsumed within other priority areas.

**Initiative Description including timeline**

Our *Staying Healthy in Havering* initiative has several strands, including:

1. Health improvement
2. Health protection
3. Research and development:

**1. Health Improvement**

The health of people in Havering is generally about the same as the England average, but there are marked inequalities within our Borough. A baby boy born in one of our most advantaged areas can expect to live 6 years longer than a baby boy born in one of our least advantaged areas. To tackle this inequality, our health improvement initiatives are both population based and targeted at specific groups in the community and use a ‘healthy communities’ approach to engage and empower local people.

Over the next five years, we will use the findings of the JSNA and social marketing approaches to segment the population and identify appropriate approaches to work with ‘hard to reach’ groups and reduce the gap in health inequality.

Over the last year we have gained significant additional information on the well-being of the local population, through the Joint Strategic Needs Assessment (JSNA), which includes a local health and well-being survey. We have used this information to inform our health improvement programmes. We intend to use a social marketing approach to engage with communities in a meaningful way in relation to identified areas of need.

The JSNA is an on-going process and we have commissioned additional work to provide more detail on population trends and care groups. We have used this information to inform our health improvement programmes.
• **Local Area Agreements**

Local Area Agreements are one area where NHS Havering has played an active partnership role since 2007 in engaging with other agencies to address the determinants of ill health and disadvantage. We are committed to implementing a range of initiatives up until 2011.

We have agreed action on several health improvement targets, including childhood obesity, physical activity for adults and cardiovascular disease. These support, and complement the initiative for Cardiovascular (initiative 6).

<table>
<thead>
<tr>
<th>Topic</th>
<th>Stretch target</th>
<th>Timeline</th>
<th>PCT contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>Reduce the increase in prevalence of obesity amongst ten to eleven year olds by 0.8% from baseline by 2010</td>
<td>2008-10 (We will analyse 2009 data to set more exacting targets for 2010-14)</td>
<td>Junior weight management programmes. Healthy Schools workshops/Training</td>
</tr>
<tr>
<td>Physical activity (adults)</td>
<td>Increase the level of physical activity in the population by 1.33% a year (as measured by Sport England survey)</td>
<td>Annual increments amounting to 4% increase from 2007 baseline by 2010</td>
<td>Website – Havering Active. Expansion of Exercise Referral Scheme</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>Additional 440 people from highest deprivation quintiles on hypertension registers with BP controlled and additional 710 people Borough-wide having their BP controlled.</td>
<td>Diabetes Self Management (DSM) for Cardiovascular under 75’s 67 per 100,000 in 2009 and 63 per 100,000 in 2010</td>
<td>Part funding Age Concern Coordinator to target BP testing in areas of inequality</td>
</tr>
</tbody>
</table>
Concurrently with action on LAA1, the PCT has agreed to lead on the achievement of four targets for LAA2, supported by other key partners. We are also supporting a number of targets led by other agencies. All these targets have been identified through a lengthy process of local engagement and negotiation with Government Office for London (GOL) and reflect local priorities. The baselines and trajectories reflect the position agreed for Vital Signs.

The indicators shown in italics are where the PCT is supporting, rather than leading.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Timeline</th>
<th>PCT contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI39</td>
<td>Reduce the alcohol harm related hospital admission rates</td>
<td>Baseline 1,333 per 100,000 in 2007/8 reducing to 1,200 per 100,000 in 2010/11</td>
<td><strong>Commission brief intervention training for 300 people by the end of 2008/9.</strong></td>
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<td>Funding for a co-ordinator to implement above and assist in delivery of alcohol treatment services and preventative plans.</td>
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<td>Participate in working groups for Alcohol Harm Reduction Strategy 2008-11</td>
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<tr>
<td>NI55</td>
<td>Obesity among primary school age children in reception year</td>
<td>Baseline of 11.2% in 2007/8, 12% in 2010/11</td>
<td>Funding for three Mini-MEND (preventative obesity programme) for pre-school children and their families 08/9, rising to six per year (subject to evaluation).</td>
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<td></td>
<td>Refresh current obesity strategy for 2009-14 (Healthy Weight Healthy Lives)</td>
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<td></td>
<td>Commission National Child Measurement Programme (NCMP) programme and analyse data to target areas of inequality (through Healthy Communities programme*)</td>
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<td></td>
<td>Fund four local cookery projects 2008-9, targeting priority neighbourhoods (Based on NCMP data). Increase to six per year from 2009-14 (subject to evaluation)</td>
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<td></td>
<td>Research French EPODE model (Nov 2008) and if appropriate, implement roll-out from 2009-14.</td>
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<tr>
<td>NI119</td>
<td>Self-reported measure of people's overall health and well-being</td>
<td>Baseline to be agreed. It will be based on q29 in 'My Place Survey' – How is your health in general?</td>
<td>No specific programmes to be developed. It is anticipated that the six initiatives will lead to an overall improvement in people’s health and well-being.</td>
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<td>Repeat Health and Lifestyle Survey (HALS) during 2010-11 to measure changes in EQ5D since last survey (2007)</td>
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<td><strong>Proxy measures to include:</strong></td>
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<tr>
<td>Increase in physical activity levels (as measured by Sport England survey)</td>
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<tr>
<td>Decrease in adult obesity levels (as measured by QoF local enhanced service and local survey (to be repeated in 2010))</td>
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<tr>
<td>Overall decline in smoking prevalence (as measured by local survey), but with particular reference to manual working groups.</td>
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<tr>
<th><strong>NI124</strong></th>
<th><strong>Increase the number of people with a long term condition supported to be independent and in control of their condition</strong></th>
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<tbody>
<tr>
<td><strong>Baseline:</strong> HCC Patient Survey question on patients with an LTC who had received enough help in the last 12 months. 2007/8 – HPCT 36% (compared to 44% in all Trusts).</td>
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<td><strong>Trajectory (Tbc)</strong></td>
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<td>2008/9 - 38%</td>
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<tr>
<td>2009/10 - 41%</td>
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<tr>
<td>2010/11 - 44%</td>
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<td>2011/12 - 46%</td>
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<td>2012/13 - 48%</td>
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</table>

| **Commission 'My Action' – nurse-led integrated community-based multidisciplinary vascular prevention programme for individuals at high risk of Cardiovascular, and their families.** |  |
| **Scope:** 3080 patients in year one plus 300 partners, rising in subsequent years (subject to evaluation) |  |

| **Health Literacy course being developed with local college Pilot course Dec 08 (eight participants). Expand programme (exact details to be developed). Joint Literacy Strategy currently being developed with Local Authority during 2008/9, for roll-out 2009 onwards.** |  |

| **Support local authority outreach programme for physical activity. Commission two condition specific classes by ward in three identified areas. Evaluate and expand during 2009-14, if appropriate.** |  |

| **Physical Activity Referral programme – increase from 600 places a year in 2008/9 to 2000 a year in 2013/14, to support the Cardiovascular initiative and target areas of health inequality** |  |

| **Commission Expert Patient programme – six courses to run by March 2009. Evaluate and review for expansion from April 2009 onwards eight courses a year.** |  |

<p>| <strong>Diabetes booklet funded and produced. 15,000 copies distributed by March 2009. Review and refresh for on-going implementation.</strong> |  |
| <strong>Also see Integrated Case Management NI 139</strong> |  |</p>
<table>
<thead>
<tr>
<th>NI 149</th>
<th>Adults in secondary mental health services who are in settled accommodation</th>
<th>Establish baseline position through data submitted within Q3 Mental Health MDS by Dec 2008</th>
<th>Led by us: Establish baseline by Dec 2008 Update system – on-going</th>
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<tr>
<td></td>
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<td>Detailed analysis of circumstances of people in unsettled accommodation by April 09</td>
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<td></td>
<td>Review role and remit of Mental Health (MH) Accommodation panel by Feb 09</td>
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<td></td>
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<td>Review needs and circumstances of all people placed in local residential/nursing care provision to explore potential for ‘move on’ (by March 09)</td>
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<td>Investigated potential arrangements for shared tenancies (by March 09)</td>
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<td></td>
<td>Flag housing needs of this group via Family Mosaic from Feb 2009</td>
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</tr>
<tr>
<td>NI 4</td>
<td>The % of people who feel they can influence decisions in their locality</td>
<td>Under negotiation</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>NI110</td>
<td>Increase young people’s participation in positive activities</td>
<td>Under negotiation</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>NI131</td>
<td>Decrease delayed transfers of care from hospitals</td>
<td>By 2011</td>
<td>Member of Whole Economy Group set up to progress this area PCT Provider single point of access set up – to be rolled out across services</td>
</tr>
<tr>
<td>NI139</td>
<td>People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently</td>
<td>Under negotiation</td>
<td>To be confirmed Integrated Case Management pilot programme to be commissioned in 09/10. A mapping exercise will ascertain extent of existing services and feedback to key stakeholders will develop the final model to be piloted. Steering group consists of PCT representation, LBH Health and Social Care and local Primary Care providers. NB this target integrates with, and supports NI 124.</td>
</tr>
<tr>
<td>NI152</td>
<td>Working age people on out of work benefits</td>
<td>Under negotiation</td>
<td>To be confirmed</td>
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</table>
• Health Improvement Strategies

Over the next five years we are planning to implement the action plans arising from the various health improvement strategies we have in place. These are strategies that have been agreed with our board and local Strategic Partnership. These include:

• Refresh of 2005-8 Obesity Strategy

NHS Havering achieved the goals and aims within the 2005-8 Obesity Strategy. This is now due for refresh and will focus on promoting Havering as a ‘healthy weight healthy lives’ location. Our aim is to develop a strategy which engages the local community and local stakeholders and to this end, we are holding a conference in December 2008 to plan the actions for the new strategy. We need to ensure ownership across a range of partners and discussion and prioritisation is key to this process.

However, the strategy is likely to include a continuing focus on children and young people (thus meeting the objectives of LAA1 & LAA2), but also broaden this to target adults above their ideal weight. We know from our local Health and Lifestyle Survey (HALS) that approximately 55% of Havering residents are either overweight or obese – this is particularly a problem for ‘middle aged’ people. However, we also know that focusing on lifestyle only is a limited approach. We will research the French EPODE (Ensemble prévenons l'obésité des enfants (Translation – Together Prevent Childhood Obesity)) model and assess whether elements of it can be transported to Havering and implemented.

Key areas for inclusion:

• Increasing uptake and sustainability of breast feeding*.
• Improving workplace initiatives for healthy eating (NHS and Local Council led).
• Roll out of Counterweight programme across Havering (subject to satisfactory evaluation).
• Increase number of Mini-MEND and MEND (junior weight management programmes) from three to six a year.
• Data analysis of 2007/8 NCMP and targeted initiatives in areas of high obesity prevalence using Children’s Centre and Extended Schools networks. Focus on two areas of high prevalence in 2009-10 and 2010-11.

These areas of focus will contribute to a reduction in risk factors, for children and adults alike. The strategy will contribute to the overall reduction in prevalence of obesity amongst adults from 23% to 20% (i.e. by 6,000).

*See section 4.2.2 maternity initiative

• Joint physical activity strategy

The joint strategy with the Borough supports the LAA1 target of increasing the percentage of physically active adults, as measured by the Sport England Survey. The implementation of the strategy has been strengthened by local promotional campaigns including a website with all local activities listed.

The 2012 Olympics, whilst not hosted in Havering, provide an ideal opportunity to build on the enthusiasm and momentum that will be generated by the games in North East London. The PCT will work closely with Local Authority colleagues to ensure a coherent marketing and communications plan is in place to promote the newly emerging
opportunities for physical activity in the Borough. We will review the literature relating to the legacy of Olympic Games elsewhere to identify actions that could be relevant to increasing the level of physical activity amongst local people.

We have strengthened the resource for this area, which traditionally has had low levels of investment. This resource will see the continued expansion of the Physical Activity Referral Scheme (600 places in 2008-9, with extended choice of venues for patients from 2009-2014). In conjunction with London Borough of Havering (LBH) we have successfully secured funding from Sport England to expand the Physical Activity team and will focus on provision for people with long term conditions over the next 5 years (LAA2 target, NI 124). These programmes will also underpin the secondary prevention element of the cardiovascular initiative.

In addition, we know from local data (HALS 2007) that older people and those living in less advantaged areas are less likely to be active. Over the next five years, we will focus on increasing the numbers of people from these groups and localities who are physically active, by facilitating opportunities and removing traditional barriers.

The physical activity strategy will get about 10,000 adults more active, which will also reduce life expectancy inequalities by 10% by 2013 (see section 4.3, goal 1 impact calculations)

Key areas: -

- Expand Exercise Referral scheme from 600 places in 2008-9 to 2,000 places in 2012-13 to support patients on Cardiovascular programme (initiative 6) in need of health promotion activity.
- Maintain and develop Havering Active Website, thus providing information and guidance to local residents on opportunities to get more active.
- Support the free swimming for under 16s initiative, by providing funding to enable a focus on children from areas of inequality to become more active.
- Expand the Physical Activity team and focus on older people with LTC’s (NI 124). We will work with the Borough to monitor uptake by this cohort, starting initially with those identified at risk through the Cardiovascular programme.
- Marketing and communications plan for physical activity to capitalise on the momentum generated by the 2012 games.

- Alcohol harm reduction strategy

We have been an active partner in the development of the above strategy, which is jointly owned by the Community Safety Partnership and the Health and Well-being Group, both of which report to the Local Strategic Partnership. Key working groups are being set up for specific target groups, such as children and young people, and action plans for the next few years will be developed. In the meantime, the PCT is Commissioning Brief Interventions training to support the achievement of the LAA2 target NI39.
• Strategy for smoking cessation and tobacco control

In order to create more synergy between enforcement and education, the PCT's Stop Smoking Team has relocated to the Local Authority and sits with the Environmental Health Department. This co-location is part of a three year plan to achieve the revised stop smoking target, with an increased focus on routine and manual workers and children and young people. This programme links with the Developing Healthy Communities (DHC) approach and initiative 6 for Cardiovascular.

Specific programmes include: -

Routine and manual workers: smoking rates vary by ward, ranging from 24% in less advantaged areas where they are more likely to reside to 7% in more advantaged areas. This inequality will be tackled by:

• Liaison with local businesses to encourage managers/nominated staff to attend level two smoking cessation training, to run in-house courses for staff.
• Developing intelligence and using social marketing techniques to target this group.

Children and young people: Local survey data (HALS 2007) showed 40% of respondents in the 16-24 age category were current smokers, yet only 1% of Havering's successful quitters are under eighteen years old.

The focus for 2009-14 will be: -

• Continue expansion of Havering Smoke Free School Award (2010 target already achieved).
• Workshops in all schools on smoking prevention/cessation by 2014.
• Develop and maintain in-house smoking cessation programmes in 50% of all Havering Schools.
• Increase under 18s accessing the Stop Smoking Service by 50% by 2014.

There is an active Tobacco Control Alliance in the Borough, which is well supported and is planning a range of initiatives to strengthen this area of working over the next few years.

• Developing Healthy Communities (DHC)

The DHC strategy was approved by the Havering Strategic Partnership and PCT Board in 2007. Its focus is the reduction of inequalities in areas of deprivation within Havering and action to date has been on three wards where people are less advantaged. We intend to expand and develop this work over the next few years to include: -

• Three super output areas in Romford Town ward.
• Three super output areas in Rainham and Wennington ward.
• Work with a community of interest, options to be discussed and agreed.
• Refocus on the Harold Hill estate (to fit with the regeneration programme of the local authority) with greater emphasis on the Briar Road estate, and Waterloo estate.
• React to the high interest in cookery by identifying possible community settings to refit a community kitchen to support cookery sessions (2010 onwards).
The DHC strategy was approved by Havering Strategic Partnership and our Board in 2007. The strategy aims to tackle health inequalities in Havering using community development methods to engage communities. During 2008, the focus has been on two wards and two super output areas where there is disadvantage. The focus of work will be reviewed annually, with a view to either (a) intensifying/developing existing activity, (b) expanding current work or (c) refocusing activity. A three year evaluation of the effectiveness of the work overall will be commissioned during 2008/09. An in-depth evaluation programme will be commissioned from an academic institution to monitor the effectiveness of these community programmes over a three year period.

Complementary to the DHC strategy is the social marketing approach we will use to work with hard-to-reach community groups to ensure health improvement messages are appropriately tailored in terms of language and community needs.

**Partnership Working**

*Staying Healthy Havering* encompasses the key prevention strands of NHS Havering’s plans for the next five years. However, these cannot be delivered by the NHS alone, and partnership working is crucial to the achievement of these plans. Indeed, the plans have been conceived and developed together with other key stakeholders and should not be seen as the sole responsibility of the NHS. We are an active member of the Local Strategic Partnership and its relevant sub groups.

Discussions with local partners have resulted in the aim of developing a further two strategies to address inequalities in Havering (which address our strategic goal 1). These include a Health Literacy Strategy, which is planned for 2009-14, and a Health and Well-being Strategy, also for 2009-14.

### 2. Health Protection

**i) Screening programmes**

- Roll out of Chlamydia screening programme

This programme will target 15% of the 15-24 year old population during 2008-9. A web-based service has been developed which uses an innovative approach to targeting young people. Currently three pharmacies are contracted to provide treatment services for those young people identified as a ‘positive’ screen. During 2009-10, this number will be increased to offer a more accessible service. Our plans for April 2009 are being developed to take account of a potential need to screen up to 3% of the target population.

- Implement bowel cancer.
- Implement Abdominal Aortic Aneurysm (AAA) screening as part of the vascular risk reduction programme if it is proven to be cost-effective.
- Retinal screening – This programme is commissioned from Optometrists and the local Ophthalmology Department. The current predicted uptake rate for 2008/9 is 80%. The trajectory for next year is to achieve 85% uptake by quarter four, with further improvement year on year thereafter.
- Ensure uptake of cervical and breast screening services are >80% within the eligible population: actions plans are in place to achieve these rates. These actions include list cleaning of GP registers and a training programme for primary care staff on their role in increasing uptake.
- Through the joint commissioning process assure a two week turn-around for reporting cervical cytology tests.
ii) Immunisation programmes

We have commissioned a service to ensure a failsafe approach to achieving high uptake rates of childhood immunisations, the delivery of HPV vaccine programme in line with national guidance, and BCG vaccination for high risk individuals. The local immunisation service as specified will provide coordination of the operational elements of the programmes, managing the implementation of local or national policy. The service will complement the existing arrangements and take responsibility for identifying, tracing and offering immunisations to the non-immunised and hard-to-reach groups. There will be special attention to addressing inequalities in uptake in different communities within the Borough.

The provider will provide quarterly progress reports to the Health Protection Committee via the Governance & Health Protection team in the Directorate of Public Health. The reports shall include performance against the agreed quality indicators in the SLA.

The minimum dataset required will include:

- Submission of quarterly data for the Health Protection Agency (HPA) and for DoH (HPV immunization returns).
- Submission of quarterly performance data to Health Protection Committee.

This data will be provided from a reconciliation between GP held information and that of the Child health System. The PCT anticipates the implementation of RiO version in 2009, which will contribute to substantial improvement in data quality.

3. Research and development

In collaboration with London South Bank University (LSBU), the PCT will seek to commission, using direct funding and/or grant funding, the following research and evaluation projects:

- Developing healthy communities.
- Health literacy.
- Developing a generic tool for evaluation of public health initiatives.

Healthcare for London key themes and specific projects

_Staying Healthy in Havering_ fits with the Healthcare for London theme of _Staying Healthy_ as well as the local priorities outlined in the LAA 1 & 2.

Collaborative working requirements

_Staying Healthy in Havering_ has numerous strands of work, the majority of which require collaborative working arrangements with a number of partners, but particularly with LBH. Some areas of work are being commissioned from a range of providers.

Consultation plans

_Staying Healthy in Havering_ reflects the priority of ‘prevention’ as agreed with local stakeholders at our Priorities Forum, which is held quarterly. _Staying Healthy_ fits with three of our five strategic goals, and these goals have been subject to consultation with a range of stakeholders. These include the Local Authority and numerous partnership boards.
Market management and procurement summary

A range of providers are in the marketplace to supply health improvement initiatives, including leisure services (LBH), Voluntary Sector (Age Concern), the APO and Independent Primary Care Contractors (Optometrist, Pharmacists and GPs). Some of the larger projects within this initiative will be tendered for in line with EU procurement rules.

Impact on health outcomes and inequalities

The Staying Healthy initiative will tackle the LAA1 & LAA2 priority areas. Health outcomes have been negotiated for these areas, many of which are major risk factors for the major killers, such as Cardiovascular and cancer, and include the following:

LAA1:
- A reduction in the childhood obesity rate for year six children.
- An increase in the level of physical activity across the population*.
- An increase in the number of people on primary care hypertension registers, with a particular focus on areas of inequality*.

LAA2: action plans are still under discussion, but will include.
- Reduce the alcohol harm related hospital admission rates.
- Reduce obesity among primary school age children in reception year.
- Self-reported measure of people’s overall health and well-being.
- Increase the number of people with a long term condition supported to be independent and in control of their condition.

*these include a particular focus on our less advantaged areas

Our DHC strategy has a particular focus on areas of disadvantage, but focuses on the wider determinants of health, with the aim of providing training, life skill development and empowering the local community. As, it is not currently possible to give specific numerical measures appropriate to use quantitative tools to evaluate the impact, therefore we are employing an action research model which means we react to, and act upon, issues emerging from the community. Please see the section on Research and Development, which includes an explanation of the evaluation of the DHC strategy.

Impact on activity and finance

Staying Healthy Havering will not have an immediate impact on activity and finance. It will focus on reducing inequalities and promoting health over a longer term, particularly the projects aimed at children and young people. Some of the actions directed at detecting high blood pressure will have a more medium term impact on reducing Cardiovascular events and consequential use of community and hospital resources

Investment or disinvestment requirements

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Year on Year Investment (£’000)</th>
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<tr>
<td></td>
<td>2009/10</td>
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<tr>
<td>Staying Healthy</td>
<td>828</td>
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Stakeholder engagement

Partnership working is crucial to delivery of this initiative and fits within our strategic goal 4 aim. The joint strategic needs assessment has been developed with stakeholders and overseen by the Health and Well-being Group, which reports to the HSP. The Health Improvement strategies for obesity, physical activity, alcohol harm reduction and developing healthy communities have all been developed through a process of stakeholder engagement.

PCT capabilities required

A skilled public health workforce with a full range of public health competencies is required to deliver the above programmes. Currently we have a range of public health skills in place but this is stretched to capacity against current deliverables. It is also recognised that WCC competencies for partnership working, procurement and performance management will be required.

Success measures

Success measures include the specific outputs as outlined in each of the key strategies referred to as part of the Staying Healthy Havering initiative.
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<td>1. LAA1</td>
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<tr>
<td>3. Health Improvement Strategies</td>
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<tr>
<td>3.1 Obesity Strategy</td>
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<tr>
<td>Stakeholder event</td>
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<tr>
<td>Strategy launched</td>
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<tr>
<td>Roll-out AWMP</td>
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<tr>
<td>NCMP data analysis</td>
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<td>3.2 Physical Activity Strategy</td>
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<tr>
<td>Increase PARS capacity</td>
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<tr>
<td>LTC classes</td>
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<tr>
<td>Focus on inequality</td>
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<tr>
<td>Marketing plan</td>
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<tr>
<td>3.3 Alcohol Harm Reduction Strategy</td>
<td></td>
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<tr>
<td>NI39 – LAA2</td>
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<tr>
<td>Smoking Cessation</td>
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<td>Routine/manual</td>
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<td>CYP</td>
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<td>Tobacco Control</td>
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<td>3.4 Healthy Communities</td>
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<tr>
<td>Review/refocus activities</td>
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<tr>
<td>Commission 3 yr evaluation</td>
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<tr>
<td>Commence/Carry out research</td>
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<thead>
<tr>
<th>4. Partnership Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Literacy strategy</td>
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<tr>
<td>Health and well-being strategy</td>
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</tbody>
</table>

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<tr>
<th>5. Health Protection</th>
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<tbody>
<tr>
<td>Chlamydia Screening</td>
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<tr>
<td>Bowel Cancer Screening</td>
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<tr>
<td>AAA Screening</td>
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<tr>
<td>Cervical Screening</td>
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<tr>
<td>Breast Screening</td>
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<td>Immunisation</td>
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<thead>
<tr>
<th>6. Research &amp; Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commission 3 yr evaluation</td>
</tr>
<tr>
<td>Commence/carry out research</td>
</tr>
</tbody>
</table>

**Key:** ![Milestone](image) Milestone
<table>
<thead>
<tr>
<th>Risk</th>
<th>Description of impact</th>
<th>Likelihood (%)</th>
<th>Severity (Low 1, Medium 2, High 3)</th>
<th>Risk Score (Likelihood* Severity)</th>
<th>Mitigating action</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAA1 targets may not be achieved</td>
<td>Obesity rates (year 6) rise.</td>
<td>50%</td>
<td>2 (medium)</td>
<td>1.0</td>
<td>Sign up from key partners in Havering (including resource allocation).</td>
</tr>
<tr>
<td>LAA2 targets may not be achieved</td>
<td>Obesity rates (reception year) continue to rise.</td>
<td>50%</td>
<td>2 (medium)</td>
<td>1.0</td>
<td>Sign up key partners in Havering (including resource allocation).</td>
</tr>
<tr>
<td>Obesity strategy refresh may be compromised in terms of resource, lack of interest and organisational structural changes</td>
<td>Obesity rates across general population continue to rise leading to increase in major risk factor for Cardiovascular.</td>
<td>50%</td>
<td>2 (medium)</td>
<td>1.0</td>
<td>Commitment to action plan for obesity strategy by key organisations, committing resources to ensure progress. Develop procurement expertise to ensure timely implementation of contracts.</td>
</tr>
<tr>
<td>Chlamydia screening programme – unable to deliver anticipated increased target for 09/10</td>
<td>No reduction in prevalence or rate of new infections.</td>
<td>80%</td>
<td>2 (medium)</td>
<td>1.6</td>
<td>Adequate resourcing and marketing plan to reach target group. Wider network of distribution and screening sites. Commission out to effective provider.</td>
</tr>
<tr>
<td>Breast screening Failure to reduce the round length</td>
<td>Increase in interval cancers.</td>
<td>50%</td>
<td>3</td>
<td>1.5</td>
<td>Commissioners’ action plan.</td>
</tr>
</tbody>
</table>
Key Metrics

- **Health Improvement**

  LAA1 metrics: see table above

  Additional LAA2 targets:

  Metrics to be agreed for indicators NI39, 119, 124, 149

  *Physical activity metrics:*
  1) LAA1 measure: 22.9% of adult residents (sixteen years or more) taking part in physical activity as measured by Sport England’s Active People Survey (from a baseline of 18.9% in 2005/6).
  2) Physical activity referral scheme: Increase capacity to 2,000 by 2014 from a baseline of 600 in 2008/9.

  *Obesity metrics:*
  1) NCMP 85% coverage of reception year and year six.
  2) LAA1 measure: reduce the increase in prevalence of obesity amongst 10-11 year olds by 0.80% from baseline (11.2% in 2007/8) by 2010.
  3) LAA2 measure: (to be agreed with GOL).

  *Alcohol harm reduction:*
  1) Reduce the alcohol harm related hospital admissions to 1,200 per 100,000 by 2010/11(from a baseline of 1,333 per 100,000 in 2007/8).

  *Healthy Communities metrics:*
  1) Results from Health and Lifestyle Survey relating to community engagement.
  2) Evaluation of strategy (period of evaluation 2009-12).

- **Health Protection**

  *Chlamydia screening metrics:*
  1) 15% of 15-24 year olds screened for Chlamydia.

- **Research and evaluation**

  Evaluation report detailing outputs and outcomes from Healthy Communities intervention – exact outcomes to be detailed in forthcoming specification.
Initiative 2 - Maternity Services

Prioritisation

Improving Maternity care is a priority for the NHS. This is especially so within London where Maternity services are noted as headline areas for development. Maternity services have undergone extensive reviews since 2006. This has included a review by the Health Care Commission during 2007. The Health Care Commission reported upon findings, mostly from service users, by each maternity provider. Maternity providers were rated on a scorecard assessment. Our local provider, Barking, Havering, Redbridge Trust (BHRT) were rated as least well performing. Havering have focused upon the basket of indicator areas that demonstrated the lowest scores and are focused upon women centred care. These are:

- Women attending NHS antenatal classes.
- Supporting infant feeding (links with childhood obesity and other areas of prevention).
- Quality of support in caring for baby after discharge.
- Stakeholder involvement.

Maternity Matters has given a focus and a direction of travel for maternity services with key issues and milestones for improvements such as improving access to maternity care, choice of type of antenatal care, choice of place of birth and choice of postnatal care. Local, access to maternity services by twelve completed weeks of pregnancy is being addressed. However shifting the access to be closer to the woman’s home would be the next stage.

An area of immediate action is addressing the midwife ratio. This currently stands at 1:37. Progress towards a 1:33 establishment has the commitment of the PCTs. This area is being followed up through ongoing a Quality Framework Schedule and a Clinical Quality Indicators Audit and the formation of Joint Partnership Maternity and Neonatal Board.

Maternity care is also a priority supported by the Next Stage Review and Health Care for London. The North East Sector of London has also prioritised maternity services within its strengthening commissioning proposal.

As can be seen from the table below there has been very little change in the birth rate for Havering. This is in contrast to that of our adjoining Boroughs. Havering also has a proportionally lower birth rate to our adjoining Boroughs and as a consequence has a lesser need upon a provider who has the highest delivery rate in London. However with the expected development of the Thames Gateway an increase in the birth rate of around 4% is to be expected.

Table 1.0: Number of live births and percentage change for Havering, 2001-2006:

<table>
<thead>
<tr>
<th>Year</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births</td>
<td>2,319</td>
<td>2,257</td>
<td>2,366</td>
<td>2,559</td>
<td>2,492</td>
<td>2,442</td>
</tr>
<tr>
<td>Annual % Change</td>
<td>-2.7</td>
<td>+4.8</td>
<td>+8.2</td>
<td>-2.6</td>
<td>-2.0</td>
<td></td>
</tr>
</tbody>
</table>
Table 1.1: Number of live births by place of birth, and PCT (North East London), 2006:

<table>
<thead>
<tr>
<th>Live Births</th>
<th>2006</th>
<th>North East London PCTs</th>
<th>NHS</th>
<th>Non NHS</th>
<th>Home</th>
<th>Total</th>
<th>% Home delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Havering</td>
<td>2,426</td>
<td>4</td>
<td>77</td>
<td>2,507</td>
<td>3.1</td>
<td></td>
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</tr>
<tr>
<td>B&amp;D</td>
<td>3,208</td>
<td>4</td>
<td>96</td>
<td>3,308</td>
<td>2.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>3,977</td>
<td>14</td>
<td>71</td>
<td>4,062</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City and Hackney</td>
<td>4,539</td>
<td>42</td>
<td>65</td>
<td>4,646</td>
<td>1.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newham</td>
<td>5,523</td>
<td>2</td>
<td>44</td>
<td>5,569</td>
<td>0.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>4,152</td>
<td>43</td>
<td>81</td>
<td>4,276</td>
<td>1.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>4,185</td>
<td>5</td>
<td>59</td>
<td>4,249</td>
<td>1.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>28,010</td>
<td>114</td>
<td>493</td>
<td>28,617</td>
<td>1.7</td>
<td></td>
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</tr>
</tbody>
</table>

Source: National Centre for Health Outcomes Development (NCHOD)

Initiative Description including time line

As indicated above, Havering are focusing upon improving women centred care and linking to other prevention work streams. This will work hand in hand with moving access to maternity services closer to the woman’s home. Developing the use of children’s centres and providing a cohort of linked maternity services will support women both during and post birth. It is vital for NHS Havering to commission services that are linked to other areas of Staying Healthy in an established community environment. Additional support for this will necessitate a secure IT link to ensure client confidentiality.

Key Programmes to be Implemented/Commissioned

1. Investment to allow community midwifery access to IT systems closer to a woman’s home is a priority. This will need to be a joint initiative across the adjoining PCTS and local authorities to ensure a safe and secure service.

2. Extending the current provision of our antenatal/breastfeeding initiative, to allow access to all pregnant women especially first time mums and to those from areas of deprivation. Impact will be as set out as within impact of health outcomes (see below). The programmes are aimed at encouraging women who have initiated breastfeeding to continue with the required additional support. We will revise the current specification for 09/10 provision.

3. Keeping in line with prevention, Healthy Birth is a project to investigate the needs of obese women and improve maternal outcomes. The recent Confidential Enquiry into Maternal and Child Health (CEMACH) report highlighted a lack of research that could inform clinical pathways with a view to reducing maternal death of obese women. A small pilot study will be undertaken based upon the needs of the women informed by social marketing.

4. NHS Havering formed a Maternity Services Liaison Committee (MSLC) that has been in place since November 2007. This has been supported by investment in training for all members of the MSLC. There is representation from the four key PCTS that BHRT provide maternity services for. The MSLC are developing a project “Walking the Patch” based upon a model developed by Westminster. This will strengthen stakeholder involvement on an ongoing basis. Resource for this project from April 09 will be necessary.
5. To further support women and extending their choice of where to give birth, NHS Havering are developing links with an out of London maternity provider. The aim is to reduce some of the pressure on an already stretched service and realise the choice agenda supported by primary care.

6. We are a partner in developing a Maternity Network. This will support the strategic planning and commissioning of maternity services for both local need, the London North East Sector and in line with Heath care for London. The network will be responsible for setting standards and provide services improvements to meet agreed standards. The network will also take a lead to provide clinically based advise, develop clinical pathways, advise on redesign of services and inform workforce planning. This would be a joint resource across all North East London PCT’s. Funding for 09/10 will be necessary

Fit with Healthcare for London key themes and specific projects

Improving maternity care fits with Healthcare for London and prioritises maternity care in terms of choice, quality and having the women at the centre of care. Our local provider has the largest delivery rate within London and delivers a third of the babies born in North East London (table 1.1). The service users originate from an array of cultures with varying needs. There is an expected increase in birth rate that will vary across the sector and all of these issues need equal consideration. Getting it right at the start of the pregnancy with continued care of the best quality will ensure the best start for the woman, child and family.

Collaborative working requirements

Collaborative working arrangements will be needed to collectively fund the additional resources for the antenatal screening programme for an equitable service. This will need to extend the provision for the MSLC.

Consultation plans

Ongoing consultation is provided through the MSLC. Improving maternity care will include a number of stakeholders including the local acute provider, the local authority and the adjoining PCT’s. Some of the consultation has already begun in identifying the needs. Women have also been consulted and their continued feedback is being sought.

Market management and procurement summary

Some market management has been undertaken for the antenatal/breastfeeding initiative. Providers have responded to the needs of NHS Havering and developed their internal strategies. Evaluation will be undertaken.

Procurement of IT will be via BHRT procurement system. Antenatal Screening will be a development of the maternity provider.
Impact on health outcomes and inequalities

Improving maternity care will reduce inequalities based upon a prevention model and supported networking. Anticipated outcomes will be:

- Increased initiation of breastfeeding in line with LAA1 targets.
- Sustained breastfeeding at 6-8 weeks in line with vital signs.
- Reductions in A&E attendances for young children (due to reduced vascular infection).
- Reduced levels of postnatal depression (ongoing support).
- Increased uptake of training opportunities (children’s centre network).
- Reduced levels of Obesity (breastfeeding).
- Reduction in Caesarean Section delivery (information and quality of care).
- Increased % women booking by twelve completed weeks of pregnancy (IT support within the community).

Impact on activity and finance

Improving access to maternity care, choice of type of antenatal care, choice of place of birth and choice of post-natal care, and shifting access to be closer to the woman’s home will lead to increases in community based activity.

Investment or disinvestment requirements

It may be necessary to consider investment in alternative maternity providers juxtapose with disinvestments with our local provider. This will need to be supported with an agreed tariff for community midwifery in the antenatal period.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Year on Year Investment (£’000)</th>
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<tbody>
<tr>
<td></td>
<td>2009/10</td>
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<tr>
<td>Maternity Services</td>
<td>500</td>
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</tbody>
</table>

Stakeholder engagement

As per consultation. Stakeholders will be Acute Provider, LBH and adjoining PCT’s, women and families.

PCT capabilities required

Robust monitoring of quality indicators. Robust monitoring of tariff to support effective commissioning of high quality and innovative services.

Success measures

- Increased uptake of breastfeeding.
- Women using children’s centres for bookings.
- Increased home delivery rate.
- Referral to and uptake of additional services such as Health Literacy.
- Increased data from maternity provider.
### Initiative 2: Maternity

<table>
<thead>
<tr>
<th>Milestone</th>
<th>2008/9</th>
<th>2009/10</th>
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<tbody>
<tr>
<td>Complete Overall Project plan</td>
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<tr>
<td>Develop PCTs</td>
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<tr>
<td>Maternity initiative</td>
<td></td>
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<tr>
<td>Service Provision</td>
<td></td>
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<tr>
<td>Models inline with Modernising Maternity Board</td>
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<tr>
<td>Develop an agreed future organisational model for maternity provision in</td>
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<tr>
<td>collaboration with clinicians, service users</td>
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<tr>
<td>Develop Investment map</td>
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<td></td>
</tr>
<tr>
<td>Market Management</td>
<td></td>
<td></td>
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<tr>
<td>PID and funding bids / agreed</td>
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<tr>
<td>Consult on / refine / finalise</td>
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<tr>
<td>Approvals</td>
<td></td>
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<tr>
<td>Agree clinical pathways</td>
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<tr>
<td>Roll out plan ready</td>
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<tr>
<td>Engage in procurement process</td>
<td></td>
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<tr>
<td>Roll out implementation</td>
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<tr>
<td>PCT Project Review</td>
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</table>

**Key:** ♦ Milestone
<table>
<thead>
<tr>
<th>Risk</th>
<th>Description of Impact</th>
<th>Likelihood (%age)</th>
<th>Severity (Low 1, Medium 2, High 3)</th>
<th>Risk Score ( Likelihood * Severity)</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of interest in families to breastfeed</td>
<td>Existing inequalities maintained and opportunity for healthier start to life lost</td>
<td>20%</td>
<td>Medium - 2</td>
<td>0.4</td>
<td>Continued positive messages given to mother and family at every antenatal engagement. Follow up during postnatal period.</td>
</tr>
<tr>
<td>Lack of interest from service users to undertake project</td>
<td>Service user input from a wider audience not achieved</td>
<td>15%</td>
<td>Low – 1</td>
<td>0.15</td>
<td>Continued support for MSLC service users to include further training. Continued advertising for MSLC members.</td>
</tr>
<tr>
<td>Lack of financial resource for a midwife led unit</td>
<td>Lack of choice for local women</td>
<td>50%</td>
<td>High – 3</td>
<td>1.5</td>
<td>Strong business case to DOH. Evidence of consultation and support for project.</td>
</tr>
<tr>
<td>Lack of support for a maternity network co-ordinator</td>
<td>Lack of strategic vision for maternity service both, locally, outer North East sector and across North East London</td>
<td>40%</td>
<td>Medium - 2</td>
<td>0.8</td>
<td>Evidence of support from Maternity Improvement Board. Suggest one network coordinator across North East London.</td>
</tr>
</tbody>
</table>

**Key Metric**

- % of bookings undertaken in the community with direct access to BHRT's IT system.
- Breastfeeding initiation rates.
- Breastfeeding at 6-8 weeks.
- Uptake of antenatal/breastfeeding service.
- Delivery of “Walk the Patch” project.
- Delivered actions as a consequence of user input.
- Formation of Maternity Network.
4.2.3 Initiative 3 – Children and Young People Services

Prioritisation

The early findings of the JSNA have identified improvement in child development in early years as a key priority for Havering. The findings are being developed in the Children and Young People Plan 2009-2012. The Children Trust Board have endorsed key improvement for services for Children and Young People within the LAA2. This fits with three of the PCT strategic goals - improving health and well-being, shifting spend to prevention and strengthening partnership.

Initiative Description including time line

The initiative is to deliver an integrated set of programmes in line with the National Child Health Promotion Programme (DH March 2008), which is relevant to meeting the needs of children and young people in Havering maximising the use of early year settings. Early years settings are opportune “spaces” for practitioners to come together and the opportunity is created to use their collective skills to support a shared vision of optimising child health and well-being informed by a holistic child public health framework.

1) The key LAA targets for Children and Young People that we is the Lead agency are: -
   - NI 55  – Obesity among primary school age children in Reception year.
   - NI 110 – Young People’s participation in positive activities.
   - NI 39  – Alcohol harm hospital admission rates.

2) Children and Young People’s health promotion programme (CYPP)

   The PCT will commission the published national Child Health Promotion Programme (CHPP) from April 2009 revising the current service specifications accordingly. All children, young people and their families in Havering will have access to the CHPP in pregnancy and the early years of life through expert early intervention and prevention teams led by a Health Visitor and specialist therapy staff. The CHPP feeds directly into The Children’s Plan (Department for Children, School and Families 2007). The local implementation of our CHPP will feed directly into the Havering Children’s Plan and the CYPP 2009/2012, which includes strengthened support for all families during the formative years of children’s lives and helps parents to ensure that children in Havering are ready for early years education, school and later life.

   In order to deliver this key health initiative, the PCT will commission a whole range of early years and prevention services as set out below:

2.1 Family nurse partnership programme

   This is being piloted by the DoH in ten sites. The programme is based on the successful programmes in the United States of America (USA). The Family Nurse Partnership programme is being extensively piloted in England as an example of an enhanced health visitor programme for especially vulnerable families. If the evaluation confirms the approach has impact in UK communities, the programme will be adopted locally from April 2010.
2.2 Environmental improvement

This initiative will audit the local community and home environments and work with organisations such as Learning through Landscapes to develop a strategy for better play areas, safe travel etc. This will be informed by the national strategy for Environmental Health for Children proposed by the HPA. The proposals will be developed consulted and agreed by June 2009, with three year plan for implementation.

2.3 Injury prevention

This will give new impetus to the multiagency efforts to implement a strategy on injury prevention, in line with recommendations in national strategies such as the Children’s Environment and Health Action Plan for Europe (CEHAPE). The aim of the CEHAPE is to protect the health of Children and Young People from environmental hazards.

Practitioners currently provide advice, information and training in Early Years setting on First Aid, Healthy and Safety, Food and Hygiene. However, NHS Havering intends to build further capacity to strengthen injury prevention in local community settings such as Sure Start Children’s Centres.

2.4 Child Development

Developmental delays and disorders: impaired speech and language development, learning impairments affect approximately 20% of the child population. Most impairments are delays in normal developmental trajectories, which may be linked with poor nurturing and result in sub optimal brain development. In other cases there are more obvious insults to the developing brain such as infection, poor nutrition or injury. Proposed interventions include: -

- Early Talk programmes in early years settings - there is good evidence that speech and language development can be enhanced by these programmes.
- Introduce other programmes such as the Reach out and Read, Bookstart, baby massage, toy libraries, and play activities, for which there is some evidence of effectiveness.
- Supporting the groups at highest risk – e.g. teenage parents and parents with learning difficulties, children with disabilities and complex needs.
- Provision of mobile libraries and reduction of excessive television viewing.
- Establish effective methods of early identification: promising work from Canada, USA, Australia and the UK, using the Parental Evaluation of Developmental Status (PEDS) has demonstrated the value of raising carer awareness about child development and using this to enhance diagnostic assessment.
- Ensure good nutrition, especially iron intake, reducing excess milk intake.
- Reducing the use of bottles and teats after first year of life and promote breast feeding.
- Early identification of high risk infants who were premature, in special care or requiring prolonged respiratory support.
- Identify those with hearing loss due to glue ear or in need of hearing aids.
- Optimise visual acuity by early identification of impairment.
- Early intervention and preventive work with parents where there may be concerns around Safeguarding or poor parenting capacity.
- Structured parenting programmes to develop parenting skills and capacity.
- Family support and outreach projects to reach and support the ‘hard to reach’ families including fathers and women facing domestic violence issues.
- Healthy food and nutrition programmes in schools and early years settings.
2.5 Parenting Strategy / Family Support

We have a comprehensive parenting strategy 2008/11. This outlines the support needs of parents/carers in Havering. It provides a framework for our plans to enable us to meet the diverse needs of parents and children in Havering. The strategy focuses on structured recognised parenting programmes specifically aimed at helping parents to parent their children more effectively. These programmes are delivered in early years settings and children centres by a multi agency team.

2.6 Family Support and Outreach

Research indication early intervention supports young children and their families build positive relationships and develop strong bonds. Every Child Matters and National Service Framework Children and Maternity Services both place heavy emphasis on prevention and early intervention using targeted working models like – family support and outreach. For many isolated parents/carers with children with complex needs, disabilities, mothers facing domestic violence issues and parents with twins or triplets family support is a crucial lifeline. Many of Havering Children Centre services support parents/carers in the community as well as offering support in the home through home visiting. Home visiting has been successful in engaging with many of the disadvantaged communities who may not readily access mainstream services.

Children Centres and early years settings offer this model of intervention to monitor the progress of children who may have additional needs or parents who need support developing their parenting skills in the home setting like boundary setting and establishing routines for young children. NHS Havering has commissioned Home-Start Havering to offer family support and outreach work to families who may be referred by professionals or self referred.

Family support and outreach have also been targeted towards children where there may be developmental or safeguarding concerns. This intervention enables professionals to monitor and target appropriate level of support to assess any significant risks to the children.

2.7 Speech and Language Therapy (SALT) provision for Children with Disabilities

NHS Havering's intention for the SALT Service is to commission a comprehensive need assessment and benchmark the analysis against one of our comparative statistical neighbours in Health and Education. This needs assessment will be completed within our partnership with the Havering Children’s Trust and joint commissioning of SALT will enable us to develop improved services for Children and Young People.

The Bercow Report (2008) recommends, “that PCT’s and Local Authorities work together to undertake surveillance and monitoring of children and young people to identify potential speech, language and communication needs across the age ranges and particularly at key transition stages”.

Early intervention means making prompt intervention to support the child and the family. In addressing speech, language and communication needs there is strong clinical opinion about the value of early intervention and the danger of its absence. If a child receives the right help early on he or she has a better chance of tackling problems communicating well and making progress. If the child does not benefit from early intervention there are multiple risks – low education attainment, behaviour issues, emotional and psychological difficulties.
2.8 Child and Adolescent Mental Health Services (CAMHS) towards a comprehensive service by 2014.

Through a partnership model we have commissioned a comprehensive needs assessment to enable us to review our current CAMHS provisions and identify any gaps in the service. This process will also support us to reconfigure services to meet the needs of Children and Young People who may have mental health disorder or Learning Disability.

Concurrently we have also approved investment in our Operating Plan to commission CAMHS in three specific areas to develop service capacity and meet current needs. These services include: -

- Tier 4 Community Outreach Project.
- Learning Disability Specialist Post.
- Child and Adolescent Psychology Service.

2.9 Immunisation

This service has been commissioned through the APO and monitoring the success of the interventions will be a priority. More investment will be required in 2009 onwards to ensure full capacity. This work can be delivered through a multi-agency model and by skill mixed teams in early years settings, playgroups and outreach programmes.

2.10 Young People’s Substance Misuse – Drug and Alcohol Services

The PCT in collaboration with the London Borough of Havering are required by the National Treatment Agency (NTA) to conduct an annual assessment of young people with substance misuse needs. We are part of a local expert group with other key stakeholders in the Children’s Trust to identify a shared responsibility for Commissioning Drug and Alcohol Services to inform the treatment planning and resource allocation for 2009/10.

2.11 Early Development Instrument

Early Development Instrument (EDI) system is a method of measuring the status and changes to that status over time, and was developed in Canada. The EDI is a community measure of young children’s development, based on the scores from a teacher-completed checklist (EDI Checklist).

The PCT intend to commission an evaluation of the early years development programme. The EDI Checklist consists of over 100 questions and measures five areas of child development: -

- Language and cognitive skills
- Emotional maturity
- Physical health and well-being
- Communication skills and general knowledge and
- Social Competence

Results from Canada indicate that where appropriate and accessible early child development and parenting programs have been implemented, community efforts appear to reduce socio-economic risks. The EDI acts as a surrogate measure of how well a community is performing in raising their children and has shown to act as a catalyst for community mobilisation and inter-agency collaboration.
Fit with Healthcare for London key themes and specific projects

This fits with key themes of Health and well-being and project and priorities of children services.

Collaborative working requirements

The commissioning of services and interventions by partner organisations is influenced by the strategies and decisions of the Havering Children’s Trust.

Consultation plans

Consultation with Children and Young People and their carers has informed the Children and Young People’s Plan. Regular service reviews, service user forums and evaluations will enable us to consult with service user regularly. Further regular consultation will be carried out through the Children’s Trust.

Market management and procurement summary

The procurement of these programmes will be subject to a clear market strategy towards achieving high quality provision, particularly in areas of recruitment difficulties. This will include Current Providers such as NELFT, the APO and the Voluntary Sector.

Impact on health outcomes and inequalities

The programmes will improve the overall measurement of child health, education and social development and readiness for school. Targeted investment in key skills in the localities with high measures of socioeconomic deprivation is expected to lead to reduction in the gaps in the above measures.

Impact on activity and finance

The overall programme will require increased specialist activity in early year settings, and be expected to reduce the referrals to hospital or specialist services including CAMHS.

Investment or disinvestment requirements

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Year on Year Investment (£’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Services</td>
<td>2009/10 2010/11 2011/12 2012/13</td>
</tr>
<tr>
<td>TOTAL</td>
<td>260 400 750 750</td>
</tr>
</tbody>
</table>

Stakeholder engagement

Stakeholder engagement will be managed through the Children’s Trust. In addition to parents/carers, Early Years providers and primary schools are the main stakeholders. Participation and engagement with the Voluntary Sector is crucial to target hard to reach families or families who will not engage with mainstream services.

PCT capabilities required

Key WCC competencies for, joint commissioning, partnerships, procurement, market management, and performance management.
Success measures

- Established services for vulnerable families by Health Visitors.
- Reduction in A&E attendance for childhood injuries.
- Established intervention for childhood development.
- Improved Speech and Language Therapy services.
- Evidence of increased activity in Parenting Programmes.
- Increase activity in Family support and outreach.
- Increase uptake in Childhood immunisation.
- Improved health outcome for children in disadvantaged areas.

Milestone

<table>
<thead>
<tr>
<th>Initiative 3</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
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<tbody>
<tr>
<td>Children &amp; Young Peoples Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1- Child and health promotion</td>
<td>✜</td>
<td></td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>2- Family Nurse partnership</td>
<td></td>
<td>✜</td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>3- Injury Prevention</td>
<td>✜</td>
<td>✜</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4- Environmental Improvement</td>
<td></td>
<td>✜</td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>5- Child development</td>
<td></td>
<td>✜</td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>6- Parenting strategy and Outreach</td>
<td></td>
<td>✜</td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>7- SALT</td>
<td>✜</td>
<td></td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>8- CAMHS</td>
<td></td>
<td></td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>9- Immunisation</td>
<td>✜</td>
<td></td>
<td>✜</td>
<td></td>
</tr>
<tr>
<td>10- Substance Misuse</td>
<td></td>
<td>✜</td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>11- Early development Instrument</td>
<td></td>
<td></td>
<td></td>
<td>✜</td>
</tr>
<tr>
<td>12- Child Health Promotion programme</td>
<td></td>
<td></td>
<td></td>
<td>✜</td>
</tr>
</tbody>
</table>

Key: ✜ Milestone
<table>
<thead>
<tr>
<th>Risk</th>
<th>Method/Source of risk identification</th>
<th>Likelihood (%age)</th>
<th>Severity (Low 1, Medium 2, High 3)</th>
<th>Risk Score (Likelihood * Severity)</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not reaching the hard to reach and vulnerable communities</td>
<td>Children placed on the Child Protection Register or Looked After by Local Authority, Lack of resources and services for children with special needs and disabilities</td>
<td>50%</td>
<td>Medium 2</td>
<td>1.0</td>
<td>Working towards the five outcomes specified by Every Child Matters, Monitoring impact of services and provisions provided to children on the Child Protection Register, Disability and Looked After Children</td>
</tr>
<tr>
<td>Staff delivering services do not have required core competencies</td>
<td>Performance management issue arise, Staff do not have the appropriate skills and expertise to provide an effective and high quality service</td>
<td>50%</td>
<td>Medium 2</td>
<td>1.0</td>
<td>Recruitment and retention of experienced professional staff, Children’s workforce strategy and the Children’s Trust have specified all the core competencies which are included in the job descriptions</td>
</tr>
<tr>
<td>Poor consultation and engagement with parents and carers.</td>
<td>Poor turnouts on parenting courses, Poor service evaluations</td>
<td>50%</td>
<td>Medium 2</td>
<td>1.0</td>
<td>Using incentives and family support &amp; outreach approaches to engage with parents, Out of hours/weekend consultation events.</td>
</tr>
<tr>
<td>Schemes not delivered to time and within budget</td>
<td>Lack of Project Management</td>
<td>50%</td>
<td>Medium 2</td>
<td>1.0</td>
<td>Ensure project management support is obtained</td>
</tr>
<tr>
<td>Poor quality data collection</td>
<td>Poor monitoring information and data. Inadequate data collection systems</td>
<td>50%</td>
<td>Medium 2</td>
<td>1.0</td>
<td>Integrated monitoring systems Clear multi-agency information sharing protocols and agreements</td>
</tr>
</tbody>
</table>

### Key Metric

- Number of vulnerable families supported by Health visitors.
- Number of A&E attendances involving injuries.
- Number of Children with disabilities receiving Speech and Language services.
- Number of parents/cares receiving structured parenting programme.
- Number of families receiving support where children may have developmental or safeguarding concerns.
- Number of parents/cares with children with disabilities receiving counselling support.
- Number of children who may have mental health disorder or learning disability receiving Mental Health services.
- Number of childhood immunisation take up.
- Number of Children reported for substance misuse.
- Analysis of Early Development Instrument measurement.
4.2.4 Initiative 4 - Older Peoples Services

Prioritisation

Whilst identifying and addressing population needs NHS Havering have established that the Borough has the highest population of older people in London with 18% of the population being sixty-five and above as compared to 12% for the rest of London. The Life expectancy for Havering males and females on average is 78.2 and 81.9 years respectively. Therefore it is vital we deliver a Health and Social Care provision where Older People needs have been identified and planned for. In doing this NHS Havering ensured that throughout the majority of the initiatives described in this CSP Older Peoples needs are considered, planned for and commissioned. This can be further evidenced in initiatives such as Cardiovascular Disease and Staying Healthy.

Older People tend to have higher health needs than average populations and therefore create additional demands on health and social care services. By helping older people to maintain optimum health and thereby delaying the onset of symptoms of disease, we can maximise investment and support key targets i.e. increasing numbers of older people helped in Havering to live at home, preferred place of care at End of Life, reducing readmission rates to hospital, reducing delayed transfers of care, etc.

There is a need to have a positive view of Older People in society, ensure that opportunities exist for Older People to contribute as active citizens, ensure information exists to enable Older People to remain as independent as possible and support vulnerable Older People to retain as good a quality of life as possible through appropriate use of primary and community services.

NHS Havering and LBH are working jointly to improve the experience of older people who use Health and Social Care Facilities, in particular there is a focus on improving Intermediate Care provision and this work will be done as part of the Care Outside Hospital Initiative.

These initiatives will contribute toward achieving three of the PCT strategic goals- Improve health and well-being, changing the pattern of health care, and strengthening partnership.

Older people in Havering should experience services which will help them to live independently, safely, and in good health, in their homes.

Initiative Description including timeline

Given the early findings of the JSNA and the population projections for people aged sixty-five and above in Havering, the HSP has endorsed key improvement targets for services for older people through the Local Area Agreement (LAA2) for 2009-2012 as follows:

- **NI 119** – Self-reported measure of people’s overall health and well-being.
- **NI 124** – People with a long-term condition supported to be independent and in control of their condition.
- **NI 131** – Delayed transfers of care from hospitals.
- **NI 139** – People over sixty-five who say that they receive the information, assistance and support needed to exercise choice and control of live independently.
The following projects have also been identified to support this initiative:

- Care Outside Hospital
- Integrated Case Management Pilot
- Dementia

(i) **Care Outside Hospital**

This project will be commissioning collaboratively with Outer North East London (ONEL) PCTs as described in our Care Outside Hospital Initiative 5 in section 4.2.5.

(ii) **Integrated Case Management**

Some thirty-nine thousand persons in Havering have one or more LTC, including up to one thousand two hundred older persons with complex health and social care needs. About nine hundred of these persons account for about 38% of all emergency bed days. During 2006/07 there were four thousand six hundred and thirteen emergency admissions for older people with LTC at a cost of £13.8 million. The evidence from around the world suggests that when patients with LTC receive effective treatment within an integrated system, with self-management support and regular follow-up, they have better clinical and functional outcomes.

We will be commissioning an integrated case management service to bring together a multi-agency and multi-disciplinary approach to care planning and delivery for these persons with complex needs to enable them greater independence and their care to be managed outside of hospitals. The goal of this initiative is to ensure patients with complex long-term conditions are managed effectively within the community/primary care setting through integrated pathways of health improvement and treatment that generate the best health outcome. This initiative will ensure an integrated personalised care and health improvement, develop links and referral pathways to services, and leverage prevention services developed through the LAA’s.

Some of the components of the integrated case management programme are:

- Prevention, community awareness, behaviour change, with links to the Staying Healthy initiative.
- Risk stratification, to identify the high risk persons with complex health and social care needs.
- Supporting self care.
- Effective intensive case management of the highest risk group that joins up health and social care information assessments and management.

A mapping exercise and gap analysis will be carried out that will inform the further development of our model. An integrated case management pilot will be carried out during 2009/10, focusing on our most deprived communities. This will be mainstreamed in 2010/11.

This programme will be expected to reduce emergency admissions for LTCs by 7% within three years, and improve the health related quality of life for older people.
(iii) Dementia

A mental health needs assessment undertaken in 2004 estimated that there are two thousand eight hundred and thirty-three people with dementia in Havering. The impact of dementia is strongly associated with expected demographic changes, with a projected increase of 61% from 2007 to 2026 (Paying the Price – The cost of Mental Healthcare in England to 2026 Kings Fund 2008).

Around a third of people with dementia are severely affected, with 50% living at home with a carer, 13% living alone, and 37% living in residential or nursing homes. A national Dementia Strategy is expected in Winter 2008 and the PCT will work closely with the London Borough of Havering (LBH) and other key stakeholders to agree the key actions for Havering.

This will include:

- Undertaking up to date detailed needs assessment
- Mapping existing services
- Identifying gaps in provision
- Developing a comprehensive integrated pathway of care to cover the full range of generic and specialist services
- Defining specifications for each element of the pathway against which services would be procured and performance managed.

Fit with Healthcare for London key themes and specific projects

This initiative will contribute to the Healthcare for London key themes, projects and priorities of reducing health inequalities, achieving greater health improvement and well-being in addition to supporting the development of integration and connected services.

Collaborative working requirements

The consultation and engagement process is established to ensure collaborative working is achieved through a range of Joint Partnership Boards and the HSP Board where representatives from the Statutory and Voluntary Sectors are able to input to all new developments within the community. Each of the above projects involve collaborative working with the HSP, NHS Havering commissioners in ONEL, the London Borough of Havering, the Voluntary Sector and other key stakeholders including service users and carers.

Consultation plans

Wide consultations have been held to support the ONEL Initiatives and the development and agreement of the LAA2 targets. The membership of local partnership boards with representation from a number of stakeholder groups have been involved in the development of each project within this Initiative. In addition, the PCTs Priority Forum has been involved in the prioritisation of the Initiatives.
**Market management and procurement summary**

The procurement of these programmes will be part of the development of services by our APO and the London Borough of Havering as the two main providers of Older People Services. The Integrated Case Management Pilot will be subject to the normal procurement rules and tendered accordingly.

**Impact on health outcomes and inequalities**

It is anticipated that the projects will contribute towards:

- Better self-care through health promotion and support to maintain care at home.
- Reductions in inappropriate hospital admissions for this care group.
- Reductions in inappropriate A&E attendance.
- Reducing demand for long term care.
- Supporting people at End of Life to choose Preferred place of Care.
- National priorities as set out in the National Service Framework is addressed.
- Improving access by vulnerable people to key services.
- An improvement in the self reported measure of people’s overall health and well-being.

**Impact on activity and finance**

- It is expected that there will be a reduction in inappropriate hospital admissions and A&E attendances by this care group.
- Early discharge will also contribute to reduction in bed days activities.
- The collaborative working approach in each of these projects will produce greater value for money by ensuring more economic, efficient and effective use of resources.

**Investment or disinvestments requirements**

Investment in these projects will result in opportunities to disinvest in secondary care.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Year on Year Investment (£’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009/10</td>
</tr>
<tr>
<td>Older People Services</td>
<td>300</td>
</tr>
</tbody>
</table>

**Stakeholder engagement**

As indicated in the section on Collaborative Working we have engaged with key stakeholders in our commissioning activities.

**PCT capabilities required**

NHS Havering subsequent to self assessment of the World Class Commissioning competencies has identified needs for the development of better marketing and procurement capabilities, partnership working, joint commissioning and performance management.

**Success measures**

- Reduction in hospital, Lengths of Stay.
- Reduction in readmission rates.
- Delay in entering long term care.
- Increased numbers of older people helped to live at home.
## Milestone

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Phase 1 – Mapping Exercise</td>
<td>Oct</td>
<td></td>
</tr>
<tr>
<td>Phase 2 – commission provider to develop the pilot</td>
<td>Nov-Dec</td>
<td>Mar</td>
</tr>
<tr>
<td>Phase 3 – employment of/commission project coordination team</td>
<td>May-Jul</td>
<td>Jul-Sep</td>
</tr>
<tr>
<td>Phase 4 – implement pilot</td>
<td>Sep-Jan</td>
<td>Oct-Mar</td>
</tr>
</tbody>
</table>

**Key:** ✷ Milestone

### Key Metrics

- Number of delayed discharges.
- Number of readmission.
- Number of people with a diagnosed LTC.
- Number of people with LTC receiving support to live at home.
- Number of people living with dementia receiving services.
4.2.5 Commissioning Care Outside Hospital (Outer Cluster Only)

i) Prioritisation

The four primary care trusts in outer NEL have a shared vision for how healthcare will be delivered in the future and have developed collaborative commissioning plans, which focus on the major improvements to care outside hospital which they believe will deliver significant improvements in health outcomes and patient experience. This was summarised ‘The strategic vision for care outside hospital in Outer North East London’ report which was submitted to the Strategic Health Authority in February 2008.

There is substantial evidence that current services are no longer able to provide the services that the public should expect and that action is needed to secure a better range and quality of services for the future. Some of the findings of the analysis completed by the PCTs in 2008 summarised that: -

- There is significant under-provision of GPs in most parts of outer North East London (ONEL) and significant improvement in the quality of primary care across ONEL is required
- There is scope for reducing reliance on hospital care, especially emergency admissions
- There is significant scope for improvement in use of resources within acute hospitals in ONEL and that patients are being kept in hospital inappropriately
- There is an urgent need to drive improvement in access and quality of clinical care
- The public in ONEL are more dissatisfied with local health services than elsewhere in London

The PCTs concluded that improvements were needed in both primary and secondary care health provision and success in delivering these improvements required progress in terms of models of care and working with the local community to ensure that they appreciated the options that were available to them to most appropriately meet their health care need.

The PCTs were and remain committed to supporting their local acute hospitals by allowing them to focus their expertise on the specialist and life-saving services for which they have the staff, equipment and facilities. Primary Care will be the foundation for healthcare with a comprehensive local infrastructure which allows more services to be provided closer to home, delivered to high clinical standards, without undue delay. In developing the vision for health care the key objectives of the PCTs were: -

- To reduce health inequalities
- To improve the health and well-being of the local population
- To improve the quality of healthcare offered to local people
- To ensure that the health needs of the growing population in ONEL can be met
- To develop services that are affordable and value for money for the tax payer

It is envisage that investment in improving access to high quality care outside hospital will not only alter the balance of delivery of care between primary and secondary care, but also provide a more integrated approach which will ensure that services are redesigned to address the needs of the patient rather than the providers of service. Whilst each PCT has developed a local investment plan for care outside of hospital, which is delivered through their CSP, three initiatives were prioritised for collaborative commissioning and they now form the CCI going forward in 2008/9.
ii) Description of initiative

As part of our agreed Care Outside Hospital Strategy agreed by the four outer NE London PCTs, 6 shared service specifications have been developed aimed at enhancing the range and diversity of community services to enable health care to be provided closer to home and where appropriate, reducing need for hospital admission and where possible, reducing length of stay. These were:

- Urgent Care Centres
- Rapid Response Service
- Community beds
- Interface Discharge Co-ordination Service
- Intermediate Care
- Assisted technology

Having agreed the outline service specifications it was recognised that a mixed procurement model was needed:

a) Individual PCTs could locally procure services against an agreed specification so to ensure the necessary integration with other services (e.g. links between Telecare and Telehealth needed to be managed with each LA but using a single core specification);

b) Central procurement by one PCT on behalf of the cluster would only be only sought where PCTs believed that they could achieve greater benefit by joint procurement. This was particularly significant where a service was linked to an acute provider or where the PCTs may be able to negotiate a better service from an external provider.

This prioritisation resulted in 3 services being agreed for on-going development where the PCTs felt collaborative procurement offered both clinical and financial benefit:

<table>
<thead>
<tr>
<th>Collaborative Commissioning</th>
<th>Individual PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>(procured by one PCT on behalf of partners)</td>
<td>(Using the Core Specification)</td>
</tr>
<tr>
<td>Urgent Care/Rapid Response Service (BHR only)</td>
<td>Intermediate Care</td>
</tr>
<tr>
<td>Interface Discharge Co-ordination Service</td>
<td>Community beds</td>
</tr>
<tr>
<td>Assisted technology - Telehealth</td>
<td>Assisted technology – Telecare</td>
</tr>
</tbody>
</table>

It was agreed that the PCTs would therefore proceed to independently procure 3 services – intermediate care, community beds and by working with their Local Authority, seek closer partnerships between Telecare and Telehealth.
The 3 services currently being procured are:

1) **Urgent Care/Rapid Response Service**

The provision of an integrated Urgent Care/Rapid Response Service in outer North NE London is required to respond to the unscheduled and unpredicted needs of patients that can be effectively resolved without the necessity to refer or admit to secondary care. The range of services provided within Urgent Care Centres (UCC) is currently being considered within a Healthcare for London (HfL) work stream looking at unscheduled care.

It is intended to co-locate an UCC at the front of each of the Accident and Emergency (A&E) departments in outer NE London. There may in future be further UCCs located in Polyclinics, which may have the same range of core services but will require a number of on-ward referral routes to be defined for those patients needing acute assessment.

The Rapid Response Service (RRS) will provide services both within the UCC and local community, aimed at preventing an unnecessary admission by responding to the immediate care needs of a patient, providing clinical advice, assessment and/or direct care as appropriate to the situation. The RRS will also work in the community to support the London Ambulance Service Emergency Care Practitioners (ECP) by providing ongoing assessment and care to patients who might otherwise have attended A&E in order to fully address their care needs.

It is the aim of the integrated UCC and RRS to provide patients and carers with a real time response to their unpredicted healthcare needs, working in partnership with the local community and Primary Care Services so that patients benefit from the continuity of care provided by their General Practitioner (GP) and do not require attendance in A&E to address a healthcare need that can effectively be met in the community or UCC. These services will work closely together and in collaboration with other multi-agency health care providers to offer a seamless transition of care from the acute setting into the primary care setting in order to prevent avoidable hospital admissions.

The market readiness analysis and procurement strategy have been completed for this work stream. However the outer NE London Steering Group have decided to defer the tender by 5 months to allow the PCTs to undertake a review of their Out of Hours (OoH) services to ensure an improved strategic fit that will simplify services for patients, better address the need for continuity of care and deliver high quality primary care out of hours, avoiding unnecessary duplication of service.

The contract with the current provider of OoH services expires at the end of March 2009, which is an extension to the previous contract, which expired in March 2008. In keeping with the Department of Health (DH) guidance on co-operation, contestability and competition, this service should be tendered to ensure best value and considered fit with existing local and national strategies. The PCTs have therefore jointly given notice to the current provider (extending their contract to cover the procurement period) and intend to procure OoH services alongside the UCC/RRS procurement. A service specification is currently being drafted that takes account of the new models of care provided by the UCC/RRS, GP led centers and polyclinics and the existing specification for the UCC/RRS will be modified to take account of this decision.
2) Interface Discharge Co-ordination Service

The core function of the Interface Discharge Co-ordination Service (IDCS) is to provide a single point of contact to access community health and social care services in the 4 outer NE London Boroughs (together with services provided by South West and West Essex PCTs), in line with the strategy developed for Care Outside Hospital which was described in *A Framework for shaping out of hospital services in Outer North East London*. The aim of the IDCS is to enable the smooth and timely flow of patients between care settings, ensuring services are provided to address the health care needs of patients either immediately after an acute admission to hospital, and in some instances, supporting Primary and Community Service Providers to care for patients in the community, avoiding an unnecessary hospital attendance.

To ensure integrated health and social care planning, it was envisaged that the IDCS would incorporate personnel from both health and social care working in an integrated manner using a common framework for assessment. The reconfiguration of services within BHRT as part of their turn-around programme has altered the interface arrangements and strengthened their discharge planning arrangements. To ensure that the PCTs do not commission a service that will not add value to the health system, the Steering Group initiated a review of all the services engaged in the discharge process and the impact of JONAH on the system; The initial assessment is that a new service might not be required but that the desired outcomes identified in the service specification may be achieved through better commissioning and management of the services currently in place.

The review is expected to conclude by the end of November will enable the Steering Group to decide a course of action, the anticipated options being:

- Tender for the service as planned and outlined in the service specification
- Re-write the service specification to reflect recent changes
- Put resources into current services to support achievement of our stated outcomes

3) Assisted technology - Telehealth

There are a range of possible technological synergies between Telehealth and Telecare which will be explored within this procurement to ensure the best outcomes at the most competitive rates are achieved; it is recognised that Telehealth will closely integrate with Telecare systems as provided by the Local Authorities. Telecare is a service that enables people, especially older and vulnerable people, to live safely and independently in their own home by providing a community alarm service that is able to respond to an emergency and provide regular contact by telephone. Telecare Monitoring Centres such as that provided by Redbridge Lifeline operates 24 hours a day, 7 days a week, 364 days a year and provides reassurance, advice and support to users.

The Telehealth initiative will compliment the use of Telecare for a limited group of patients. The deployment of assisted technology in this instance seeks to serve a more diverse group, particularly those living with a long term condition (LTC) where an individual with the continued support and remote monitoring from a specialist LTC team (e.g. Diabetes, Chronic Obstructive Airways Disease, Heart Failure), can achieve effective self-care where better health outcomes are made possible by informed and personalised care planning which promotes general concordance between the patient and care giver/s as to health goals and the required interventions.
The Telehealth specification has now been updated, a market readiness analysis completed and the PQQ prepared for this tender which has been now been advertised. We expect a market management event will take place in mid November, which will bring together potential providers to discuss our requirements and help shape the type of service provided.

iii) **Fit with Healthcare for London**

This CCI will enable the commissioners to provide services that are consistent with the goals of HfL in that there will be enhanced access to health care provided closer to home with an extended range of services being provided in the home setting (including care homes), GP practices, Polyclinics and Urgent Care Centres.

This CCI will dovetail with the Care Outside Hospital services to be provided as part of the E11 Independent Sector Procurement so that patients are afforded a choice of provider of acute home care and the enhance support afforded to GPs, who with extended access to community services (including diagnostics) and home nursing services, can effectively provide a higher level of intermediate care in the home setting, hence avoiding unnecessary hospital attendances and promoting greater continuity of care.

iv) **Collaborative working**

The Outer NE London Steering Group currently oversees this CCI. It is proposed that the newly convened Joint Committee of Primary Care Trusts in outer NE London will assume oversight of this project. A joint PCT Steering Group has been established to oversee the operational functions of the procurement and to manage the establishment of multi PCT evaluation panels.

v) **Consultation plans**

The Telehealth procurement is underway and will require consultation with staff as part of the implementation of the services.

The recently issued DH guidance with regard to consulting on UCC will be followed in relation to the UCC/RRS and out of hours procurement.

vi) **Market Management and Procurement summary**

The attached details the current high level plan for the procurements. The UCC/RRS procurement will be strongly linked to the out of hours procurement and we anticipate that the procurement will be delayed in the short term whilst the specification for out of hours is drafted and consulted upon with both current providers, potential providers and other key stakeholders.

vii) **Impact on health outcomes and inequalities**

Collectively, the PCTs want to see services provided which deliver a positive health outcome, demonstrate Value for Money and which respond to the changing needs of the communities they serve, improving the patient experience so as to build confidence in new models of care as we go forward with the implementation of HfL.
Collaborative commissioning of these services will promote equality of access facilitated by joint working both between health and social care and among the PCTs, made possible by:

- Evidence based clinical models
- Drift of resources towards community-based care closer to home
- Improved continuity and personalisation of care

This CCI should enable better health outcomes to be delivered across the economy by assisting PCTs to address some of the historic inequalities in access to core primary care services; The Care Outside Hospital programme will improving the scope and quality of primary, community and social care so as to provide viable alternatives to hospital admission and facilitate timely hospital discharge following an acute intervention. By investing in Primary and Community care services and the CCI, residents of outer NE London will be able to more easily access their GPs and receive increased local care and support from skilled multidisciplinary teams, who in turn, will be supported to provide greater continuity of care through the provision of by a single point of contact to improve integration between GPs and a range of service providers.

viii) Impact on activity and commissioning costs

The three procurements will have varying impacts on activity and commissioning costs.

An urgent Care Centre is already in place at all three sites across ONEL and the procurement will embed a new model of care together with the additional services provided by a Rapid Response Service. It is planned that current expenditure of Urgent Care Centres will be released from the current provider and transferred to the providers appointed via the procurement process.

At this stage it is envisaged that the IDCS will serve to make the transition from hospital to community services more fluid and that an increase in the speed of services ability to discharge rather than an increase in activity will be the outcome.

ix) Investment or disinvestment required

Disinvestment from current UCC and OoH service providers is required. This will be managed through the formal tender process and notification to current providers of termination of contracts. Current providers of services will be involved in market management activities.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Year on Year Investment (£'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009/10</td>
</tr>
<tr>
<td>Care Outside Hospital</td>
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</tbody>
</table>

x) Possible impact upon the provider landscape

We hope to see an increase in the range of providers within our landscape through the successful procurement of these services. Should the current providers not be successful in the tender process or choose not to participate in the process then they shall use their current income in relation to these services.
xi) Stakeholder engagement

Stakeholder engagement has been achieved through a range of activities:

- Involvement in service specification design and finalisation.
- Involvement in specification reviews.
- Involvement in a review of the Telehealth project and the agreement to pilot services.
- Stakeholders will be invited to be part of market event days for potential providers both current and new.
- Stakeholders without a conflict of interest shall be invited to be part of the evaluation panels to award the tenders.

xii) Capabilities required

Prior to the implementation of the Strengthening Commissioning arrangement in outer NE London, the PCTs recognised the capability and the capacity gap to undertake this level of procurement and have therefore commissioned Tribal Avail to support the procurement process. Part of the contract with Tribal Avail is to ensure knowledge and skills transfer to the PCT to ensure that our capabilities in this area significantly increase in the short term.

Success measures

The success measures for the PCTs are:

- The successful implementation of the services to the agreed timescales.
- The successful introduction of new providers' to the ONEL's landscape.
- Positive engagement of key stakeholders, patient's and carers.
### Milestone

<table>
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<tr>
<th></th>
<th>2008</th>
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<tbody>
<tr>
<td></td>
<td>June</td>
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</tr>
<tr>
<td><strong>Urgent Care/Rapid Response</strong></td>
<td>Aug</td>
<td>Sep</td>
</tr>
<tr>
<td>Specification Review</td>
<td></td>
<td>✩</td>
</tr>
<tr>
<td>Market Readiness</td>
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<td>✩</td>
</tr>
<tr>
<td>Procurement Approach</td>
<td></td>
<td>✩</td>
</tr>
<tr>
<td>PQQ</td>
<td>✩</td>
<td></td>
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</table>

**Key:** ✩ Milestone

For a more detailed chart please refer to CCI document, which accompanies this CSP.
Risk

The current identified risks are summarised in the table below together with mitigation actions.

<table>
<thead>
<tr>
<th>Description</th>
<th>Impact (3=High, 1=Low)</th>
<th>Probability (3=High, 1=Low)</th>
<th>Overall Risk Score</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delays in ONEL stakeholder engagement impact on project timescales/deliverables</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>29/10 – ONEL board now established and have taken on accountability for the projects. Steering groups being established.</td>
</tr>
<tr>
<td>Potential negative impact on the existing IDCS project following the discovery of the BHRT/Paul Sinden piece of work, also taking place in parallel.</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>Discuss with Jane Mehta and Paul Sinden to understand what existing work has been undertaken and what is in progress. The aim should be to align the projects with a common objective.</td>
</tr>
<tr>
<td>PCT(s) pull out of the collaborative approach part way through the process, rendering the procurement void.</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>Ensure stakeholder communication and relevant decision makers are kept up to speed with progress. Stakeholder mapping exercise to take place mid-November across 4 PCTs and Tribal.</td>
</tr>
<tr>
<td>UCC at Queens has issues with staff (TUPE). This could apply to other sites and impact on any procurement.</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>Cover off in the communication exercise mid-November. Recognise effected groups of staff.</td>
</tr>
<tr>
<td>Political impact on the programme by not involving councillors/MP/Local Press</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>Cover off in the communication exercise mid-November. Recognise effected groups of staff. Involve NHS Redbridge Comms</td>
</tr>
</tbody>
</table>

Key Metrics

As per service specifications.
4.2.5.1 Polyclinic

Priorities

Polyclinic developments are a new way for GPs and other health and Social Care Professionals to work together to provide improved local care. Polyclinics will make it easier for people to see a GP during the evening and at the weekends and get an urgent appointment.

There is no set target, however, it is intended that every Londoner will be in easy reach of a neighbourhood polyclinic within the next ten years.

All thirty-one London PCTs are developing plans for Polyclinics in their local areas but each is at a different stage. Five PCTs not including Havering will be involved in the first phase and will be fully operational by Spring/Summer 2009.

The Polyclinic initiative is very important to NHS Havering as it is an under-doctored area and not all local patients are able to access a GP within 48 hours. People will require fewer hospital visits, as a wide range of services including diagnostic outpatient care and minor surgery will be provided locally.

Initiative Description including time line

NHS Havering has developed a service model, which envisages the Polyclinic as a key outreach partner to the secondary care provider. The polyclinic has been developed according to local needs with strong local support and clinical input and will be based at St Georges hospital, Hornchurch. The polyclinic will have a complete range of services tailored to support equal and easy access, plus some inpatient beds. These beds will support stroke rehabilitation, early discharge, respite and diagnosis.

The Polyclinic will, subject to affordability, eventually have five poly centres, based across the Borough, which provide core GP services, extended hours, weekend services and a range of diagnostic and community services. There will be some GP surgeries that choose and others maybe encouraged to locate to these premises once these centres are developed. For surgeries that are no longer fit for purpose, this will provide patients and staff with an improved environment that meet modern standards, including disability access requirements.

The Polyclinic and the poly centres have been designed and located to match the local need and access. The Polyclinic urgent care services will operate from 7am to 10pm and the five supporting poly centres will operate as a minimum twelve hours a day, seven days per week. GP practices not working from either the Polyclinic or a Polycentre will be able to rely on the six sites to provide them with a range of support that enables them to offer the best possible primary care.

All patients will be actively encouraged to use these six centres as their first choice for out of hours services, minor injuries and minor ailments rather than use A&E services. The northwest of the Borough is fairly well served for primary care services and the aim is to work with GP’s to introduce a Polycentre which would include GP-led services operating twelve hours a day and for 365 days. To the northeast of the Borough there will be two polycentres. Each centre will have a full range of core and extended GP services, in addition one of these centres will concentrate on minor surgery, podiatry, radiology, and ultrasound. The other will concentrate on older people and disabled people services including mental health, long-term conditions, self-care, health, well-being and rehabilitation. This latter centre will also be an APMS service model and will
include GP-led services. In the south of the Borough two polycentres will be developed, one to the west and one to the east. The south west centre will be a new GP led service for an estate community that includes a transient immigrant population, emergency housing and drug and substance abusers. This Polycentre will offer services for registered and unregistered patients, 365 days operating a minimum of twelve hours a day in order to meet this community needs. The southeast centre will be developed in partnership with the local Borough as part of the redevelopment of the village primary school. This Polycentre will offer a full range of GP services and community services, which will allow joint working and co-location of services.

**Fit with Healthcare for London key themes and specific projects**

NHS London requires all London PCT to develop at least one “polyclinic” as London has the worst GP access figures in the country (Healthcare Commission survey figures 2008). In London A&E attendances are predicted to increase by 60% in the next ten years unless we improve access to more appropriate services. Polyclinics are a vital solution in making GP services more user friendly and as a solution to some of these challenges.

**Collaborative working requirements**

The success of this initiative relies on collaborative working with all key stakeholders – GP’s, public engagement, Acute trust, and local authority. The work commenced in order to work up the scheme will continue to ensure that the benefits are realised with stakeholder engagement.

**Consultation plans (if applicable)**

A consultation timetable had been submitted to NHSL.

**Market management and procurement summary**

The PCT will be working to the WCC guidelines and SFI’s, seeking to work in an open and transparent manner, mindful of the importance of co-operation and conflict of interest.

**Impact on health outcomes and inequalities**

Thirty thousand people with an extended range of up to seventy thousand people will benefit from this service model. This will give patients great accessibility to Primary Care Services and the longer opening hours will meet the needs of patients who may seek early interventions.

**Impact on activity and finance**

This is detailed in the Activities and Finance template.

**Investment or disinvestment requirements**

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<thead>
<tr>
<th>Initiative</th>
<th>Year on Year Investment (£’000)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2009/10</td>
</tr>
<tr>
<td>Polysystem</td>
<td>1,515</td>
</tr>
</tbody>
</table>
Stakeholder engagement

At present the key focus on stakeholder engagement is around the new GP-led service and the new ‘under-doctored’ practice. All stakeholders have been actively engaged in understanding these early phases of the overall Primary Care Strategy. Further engagement is planned on polyclinics once this initial phase of developments are under way.

PCT capabilities required

Service modelling, financial modelling, commissioning specifications, IT, procurement. Legal advice. All of these areas will be developed to support the proposal. Service modelling is a key need. Additional support is likely to be needed in working with the secondary care provider, for reprovision, outreach and care pathways.

Success measures

This initiative is strongly advocated by Healthcare for London with a Commitment to achieve the infrastructure development and procurement of the new services.

Milestone

<table>
<thead>
<tr>
<th>Milestones commentary</th>
<th>Procurement of polyclinics</th>
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</thead>
<tbody>
<tr>
<td>Procurement of GP-led and GP practice</td>
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<tr>
<td>Discussion with London Borough of Havering on Rainham School</td>
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<tr>
<td>New equitable access service opens</td>
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<tr>
<td>Planning for Polyclinic at St Georges and procurement commencement for Rainham and Mardyke</td>
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<tr>
<td>Mardyke service commences</td>
<td></td>
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<tr>
<td>Rainham Village project opens, Romford procurement commencement</td>
<td></td>
</tr>
<tr>
<td>Polyclinic St Georges opens</td>
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</tr>
</tbody>
</table>

Key Metrics

- Delivering GP core and enhanced services
- Opening from 7 am to 10 pm 7 days per week, 365 days per year
- Providing urgent care and diagnostics
- Delivering outpatient appointments as an outreach from BHRT offering evening and weekend appointments
- Minor procedure and endoscopy offered at evening and weekends
- Community services – health and well-being, leg ulcer, podiatry, stroke, Diabetes, LTCs, continence, sexual health, etc.
4.2.6 Initiative 6 - Cardiovascular Disease incorporating Stroke, Diabetes and Vascular Risk

Prioritisation

Cardiovascular disease (comprising coronary heart disease or CHD, stroke, Diabetes, chronic kidney disease and peripheral arterial disease) accounts for 36% of all deaths and one fifth of all hospital admissions in Havering. It is the most common cause of death and disability (with CHD leading and stroke as the third). Cardiovascular is also the second leading cause of premature death in Havering, second only to cancer. Yet, it is largely preventable; for example, up to two-thirds of Diabetes can be prevented. Cardiovascular also has a large social gradient, contributing significantly to health inequalities in Havering.

This initiative will contribute to the delivery of evidence based, patient centred and cost effective care for persons living with or at high risk of Cardiovascular, and to improving their health and well-being. It will also add to effective care closer to home and the safe reduction of the use of hospital resources. This initiative therefore contributes to all five strategic goals of NHS Havering, especially goal 1 (to increase life expectancy), goal 2 (local need, care outside of hospital, quality) and goal 3. It also links into the Staying Healthy and Care Outside of Hospital initiatives.

Initiative Description including time line

Havering’s Vascular Programme is designed to deliver a combination of both ‘at-risk’ and population strategies for the prevention and reduction of Cardiovascular risk.

It aims to:

- Reduce avoidable death and disability from vascular diseases
- Improve the patient experience
- Release healthcare resources
- Narrow inequalities

This initiative is organised under four sub-programmes: In addition to these, population activities to reduce modifiable Cardiovascular risk factors (smoking, obesity, physical inactivity, high blood pressure, lipids) are delivered as part of the LAA’s and the Staying Healthy initiative.

1. Cardiovascular risk assessment and management

Implementing an at-risk strategy, to identify persons aged forty to seventy-five years who are at high risk (>= 20% 10 year risk of Cardiovascular). This will use a combination of record-based and opportunistic strategies, and develop a call and five-yearly recall programme. The programme will initially concentrate on deprived communities in Havering and link with similar ongoing work commissioned under LAA1. Record based assessments will be facilitated by a primary care data and information system (PCDIMS), while opportunistic assessments will be provided under a Locally Enhanced Services (LES).

When fully implemented, the programme can potentially prevent 45 heart attacks or strokes (10 of which would be fatal), 20 incident cases of Diabetes, and lead to earlier detection of 120 persons with kidney disease or Diabetes.
2. Stroke care pathway

This sub-programme aims to accelerate improvements in stroke outcomes, in terms of death and disability, the patient experience, healthcare utilisation, and inequalities. The main strands are as follows:

a. Public awareness, through working with the local Stroke Association on blood pressure campaigns and FAST training (Facial Weakness, Arm and Leg Weakness, Speech Problems, Time to Call 999);

b. Prevention: case finding and management for hypertension and atrial fibrillation, lipid management, smoking cessation advice, together with commissioning a fit-for-purpose one-stop TIA service. This can reduce strokes by 106 annually (and save 30 lives).

c. Acute stroke management: working with partners to commission hyper-acute and acute services and deliver the Healthcare for London stroke pathway. Work has already started with the acute trust provider to improve the quality of acute stroke services. This strand can reduce stroke mortality from around 30% to less than 15% (and save another 60 – 75 lives).

d. Rehabilitation: Early Supported Discharge Teams (ESDT) commissioned for 70% of acute stroke survivors; and improve access to community based rehabilitation. A service review of community stroke rehabilitation to enable appropriate provision and access to quality rehabilitation for all stroke survivors will to be undertaken early in the process. This strand of work can reduce disability from strokes and contribute significantly to improved quality of life.

3. Diabetes improvement plan

Diabetes is a risk factor equivalent for Cardiovascular. This sub-programme is designed to improve the experience and outcomes for the ten thousand persons living with Diabetes in Havering, and to deliver appropriate preventative interventions for those at risk of developing the condition. This is urgent, following the 2007 Healthcare Commission review of Diabetes services. All stakeholders, including patients and carers, have agreed a strategy to ensure the commissioning and delivery of the highest quality of comprehensive care for people with Diabetes in Havering. The programme will include the development of a local Diabetes managed clinical network that includes all healthcare professionals involved in the delivery of Diabetes care, together with a quality assurance framework, and the implementation of the agreed care pathway for the delivery of seamless care across primary secondary and community care sectors. Appropriate investment in Diabetes self-management education (DSME) is planned as a clinically appropriate and cost-effective measure.

4. Cardiac rehabilitation

Providing cardiac rehabilitation (CR) is an important part of the secondary prevention of CHD. A business case for CR is already agreed. Over the next three years at least 85% of persons with CHD will be able access CR, a requirement of the CHD NSF. This is to be through a mix of programmes, to include four My Action programmes (providing six hundred places), and other multi-fit out-of-hospital programmes (another six hundred places), to enable patient choice. CR provision will be expected to reduce the overall cost of managing CHD by 38%.
Fit with Healthcare for London key themes and specific projects

This initiative is a local implementation of three Healthcare for London projects: the stroke care pathway and the Diabetes project. It fits with the Staying Healthy, Acute care and Long Term Conditions key themes.

Collaborative working requirements (if applicable)

The services offered by the NHS to both prevent and manage Cardiovascular span both primary and secondary care. Whilst the majority of primary care services are within Borough, secondary care provision requires collaborative commissioning. Hyper-acute and acute stroke services are specified within the HfL work streams and involve collaborative working at the sector and outer North East London structures.

Consultation plans (if applicable)

The initiative has been agreed by the Cardiovascular Commissioning Group, which has patient representation. A stakeholder workshop is planned for late November 2008 to further develop the initiative.

Market management and procurement summary

This initiative requires a range of community; primary care and secondary care providers to deliver the programmes. Effective commissioning from these providers will ensure the successful bidder meets quality standards and value for money. Collaborative commissioning will be required for some specialist services. The Public Health Directorate’s role includes supporting the development of potential providers, particularly community and voluntary organisations who may be commissioned to deliver patient-centred community-based programmes. This type of work is essential to encourage self-awareness and self-management of Cardiovascular risk.

Impact on health outcomes and inequalities

Investing in this initiative can save more than 100 lives annually and also prevent one hundred and fifty-one heart attacks and strokes and twenty incident cases of Diabetes (from the CVRA stroke and Diabetes improvement sub-programmes). This is over and above the health gains accruing from controlling risk factors from the Staying Healthy initiative. We estimate that this has the effect of adding two thousand three hundred and twenty-eight Quality-Adjusted Life Years (QALYs) to Havering annually. Moreover, considering that Cardiovascular contributes a large share of life expectancy inequalities, this initiative can help narrow health inequalities especially as it plans to target the most deprived communities.

Impact on activity and finance

Implementation of this initiative will require significant investment in the short term. However, there are significant savings to be made. For example, prescribing statins for Cardiovascular prevention (primary and secondary) would cost an additional £300K while savings from reduced events would come to £270K, a difference of just £30K.
Investment or disinvestment requirements

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<th>Initiative</th>
<th>2009/10</th>
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<th>2012/13</th>
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<td>1,045</td>
<td>763</td>
<td>643</td>
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</tbody>
</table>

This will eventually lead to a shift in investment towards primary care and community based programmes. Ongoing implementation of programme budgeting and marginal analysis (PB/MA) will facilitate effective decision-making for the investment required to deliver this initiative or disinvestments that flow from it.

Stakeholder engagement

Governance of Cardiovascular initiatives is led by the Cardiovascular Commissioning Group, which reports to the Commissioning Forum. Various stakeholders are represented on the Commissioning Group: patients, LBH, independent contractors, commissioners, and public health. In addition, the consultations on Cardiovascular initiatives involve the wider public. We will develop a communication strategy whose function will include keeping various stakeholders engaged in the development and implementation of this initiative.

PCT capabilities required

Procurement expertise is required to commission the programmes outlined in this initiative. In addition, further work is required across the Trust to develop to World Class Commissioning standards.

Success measures

- Cardiovascular Risk Assessment (CVRA) call and recall protocols in place.
- Local managed clinical network commissioned, in place.
- Quality Outcome Framework (QOF) indicators analyse for trend.
- Average blood pressure.
- Hypertension prevalence.
- Stroke deaths within thirty days.
- % Stroke admissions given a brain scan within three hours.
- % Stroke admissions given a physiotherapist assessment within seventy-two hours.
- Cardiovascular mortality.
- Diabetes controlled blood sugar: HbA1c < 7.5%.
- Diabetes complications: lower leg amputations.
### Milestone

<table>
<thead>
<tr>
<th>Initiatives:</th>
<th>2008/9</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct Nov Dec Jan Feb Mar Apr May Jun July Aug Sept Oct Nov Dec Jan Feb Mar</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 1. Cardiovascular Disease

- Procure PCDIMS
- Develop Records-based risk assessment strategy
- Develop GP LES
- Implement GP LES
- Develop Pharmacy Hypertension LES
- Commission and implement Pharmacy Hypertension LES
- Deliver Know Your Numbers Self Assessment Campaign
- Commission MyAction Programme
- Deliver MyAction Programme

#### 2. Stroke

- Develop Stroke and TIA service specification/programme

#### 3. Diabetes

- Implement Diabetic Improvement Plan

**Key:** ✷ Key Milestone
<table>
<thead>
<tr>
<th>Programme Component</th>
<th>Risk</th>
<th>Likelihood (%age)</th>
<th>Severity (Low 1, Medium 2, High 3)</th>
<th>Risk Score (Likelihood * Severity)</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Records Based Risk Assessment</td>
<td>1.1 Assessment identifies significantly more people who require prescriptions for appropriate prophylactic therapies (statins, ACE inhibitors etc.) and more people who require acute interventional procedures. This will have a significant impact on the Trust’s prescribing costs and acute commissioning budget.</td>
<td>80</td>
<td>3</td>
<td>2.4</td>
<td>Planning ahead for such an event will allow appropriate allocation of resources according to the needs of the population. Initiation of the Programme Budgeting and Marginal Analysis Group is intended to mitigate this risk by focusing attention on cost-effective allocation of the PCT’s entire budget according to these identified needs.</td>
</tr>
<tr>
<td>1.2 PCDIMS programme not procured in timely manner for commencement of programme</td>
<td>60</td>
<td>2</td>
<td>1.2</td>
<td>PEC, GP and Senior Management of NHS Havering are advised to discuss and agree alternative systems for appropriate sharing of anonymised primary care data and information</td>
<td></td>
</tr>
<tr>
<td>2. Population based risk assessment</td>
<td>2.1 Patients do not attend follow-up appointments after their initial assessment (i.e. potential for high loss to follow up)</td>
<td>50</td>
<td>2</td>
<td>1.0</td>
<td>The LES for primary care targeted risk assessment should include social marketing techniques and tie in with national and local social marketing campaigns</td>
</tr>
</tbody>
</table>
### 3. Self-assessment for Cardiovascular risk

<table>
<thead>
<tr>
<th>3.1 Patients using the self-assessment tools do not interpret the results correctly, which may lead to misdiagnosis and inappropriate lifestyle changes</th>
<th>75</th>
<th>2</th>
<th>1.5</th>
<th>Awareness raising of self-assessment tools should be accompanied by appropriate training and education programmes to enable people to utilise these tools, along with clear explanations of where to get appropriate advice if people are concerned.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2 People rely on pharmacological therapies to reduce their risks rather than taking an active role in changing their lifestyle and behaviours</td>
<td>50</td>
<td>1</td>
<td>0.5</td>
<td>There is an identified protocol for first and second-line advice for low, medium and high-risk individuals, which should be followed by all professionals.</td>
</tr>
</tbody>
</table>

### 4. Cardiovascular Prevention

| 4.1 MyAction programme increases prescribing costs | 80 | 2 | 1.6 | Effective programme budgeting, based on effective assessment of the needs of the population will allow for appropriate planning of prescribing budget |

#### Key Metrics

- Cardiovascular Premature mortality rate (<75 years) for men and women.
- Stroke Mortality Rate.
- Ratio number of patients with stroke who are thrombolysed.
- Number of patients who spend >90% of their stay in an acute stroke unit.
- Number of patients who access TIA services who are scanned and assessed within twenty-four hours.
- The percentage of patients with Diabetes in whom the last HbA1C is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.
- Number of people on Hypertension register below 140/90 mmHg (below 130/85 mmHg in people with Diabetes).
- Number of people who have been risk assessed for Cardiovascular.
- Numbers of patients whose total cholesterol is below 4.0 mmol/l and LDL below 2.0 mmol/l.
4.2.7 Collaborative Commissioning initiatives are:

- End of Life Care (EoL)
- Stroke
- Tuberculosis
- Redesign of the Acute Provider Landscape

4.2.7.1 End of Life Care

Prioritisation

Following the PCTs baseline assessment of EoL Care provision in 2007, and the publication of the DoH national EoL Care Strategy in July 2008, it was agreed that EoL Services should be commissioned for the North East London sector populations in order to achieve a common approach to care delivery, outcomes, reduction in inequalities, and improvement in the patient and carer experience. NHS Havering has increased its investment in 2008/09 in local provision of Palliative and EoL Care Pathway, as a priority of the 2008/09 Operating Plan.

Description of Initiative

The EoL Strategy and gaps identified in the Baseline Reviews have informed the focus of the NEL initiative on the following fine areas:

- Sector wide Education and Training to develop competencies and skills to deliver EoL Care.
- An EoL Care Register to provide a central resource to monitor and potentially case manage patients with individual care plans designed to achieve their choices.
- Cluster – Specific Quality Assurance of the services to be commissioned across EoL Care Pathways which should meet best practice standards, improve local access to services and ensure specified outcomes are achieved.
- Bereavement Care compliant with NICE Supportive and Palliative Care Guidance.
- A Rapid Response Service providing intensive nursing interventions with appropriately trained staff up to twenty-four hours at home for a defined time until death occurs or a crisis is resolved.

Timeline

The CCI is a five year implementation plan with the first three years implementing the initiatives and the final two years for consolidation of the developments. This is reflected in the CSP.

Fit with Healthcare for London key themes and specific projects

HfL identifies proposals to improve EoL Care as follows:

- EoL Care providers should be Commissioned to coordinate care.
- People should have an EoL Care Plan, including preferences on place of death and this should be registered electronically.
- All organisations should meet best practice guidelines.
- There should be greater investment to support people to die at home.
Collaborative working requirements

PCTs in the Inner and Outer North East London Clusters will set up a governance structure to support the commissioning of EoL Care. Implementation of this CCI will be managed through a Project Board chaired by the CCI Programme Director. The Programme Director will be responsible for the delivery of the CCI and act as the strategic lead for EoL Care to ensure that aspects of Palliative and EoL Care outside the scope of the CCI are appropriately addressed in NEL.

Consultation

All PCTs in NEL have agreed to this Collaboration to achieve the goals and outcomes set out above for EoL Care. Locally in Havering, two conferences have been held including Providers of the NHS, Voluntary Sector and independent sector (Nursing and Residential Homes), and carers confirming the need to address the gaps in the baseline assessment and national strategy expectations. These events were also supported by the Cancer Network.

Market management and procurement summary

The Collaborative Commissioning Group will be working with the local PCT to assess the current and potential new provider market for Palliative and EoL Care services. In Havering, the St Francis Hospice has played a significant role in re-shaping service provision for EoL Care in the community in people’s homes thus working to reduce the high proportion of deaths occurring in hospitals. Likewise, Marie Curie Services are now covering cancer and non-cancer Palliative and EoL Care and has increased capacity for the new demand. Nursing and Residential Homes are working with the Cancer Network Lead, PCT Commissioners and the Borough, towards adopting the Liverpool Care Pathway. The APO has appointed a Specialist Nurse to help promote excellent Palliative and EoL Care in the community hospital and community setting. Macmillan Nurses and District Nurses have a long tradition of providing excellent advice and services for Palliative and EoL Care.

GP Practices and Community Pharmacists have also provided care in this area. Commissioners plan to develop this market further through procurement based on better Outcome Specifications.

Impact on health outcomes and inequalities

The CCI working with the PCT and Local Partners in Havering, is seeking to significantly reduce inequalities in EoL Care and improve health outcomes so that:

- The EoL Care workforce will be able to access appropriate education resources to meet the competency requirements with 50% having received appropriate training by the end of the first three years of the plan.
- Patients in the last year of life will benefit from care that meets best practice standards with 50% of expected deaths benefiting from the Liverpool Care Pathway (LCP), 80% benefiting from the Gold Standards Framework (GSF) and 100% having a recorded EoL Care Plan.
- 80% of patients identified as being in the last year of life will be added to an electronic EoL Care register.
• All bereaved people will be sign posted to appropriate bereavement support services.
• An ongoing reduction in the number of hospital deaths reducing by 2% per year to 58% in year 5, for the sector.

Impact on Activity and Finance

The National EoL Care Strategy was launched with additional funding for PCTs which will be distributed in baselines; £88 million for 2009/10 increasing to £198 million in 2010/11. PCTs are required to ensure that existing EoL Care resources that are outside the scope of CCI, such as sufficient levels of community nursing staff are appropriately funded.

Anticipated changes in CCI Commissioned activity will include a reduction in hospital admissions, increase in inpatient hospice activity, increase in Care Homes and Community Hospital activity.

It is uncertain whether PCTs will see cost savings as the improved commissioning will be initially cost neutral. However, over time costs are likely to increase due to an increase in unmet demand from people who would not receive a good service normally, and the influence of the ageing population, particularly in Havering.

The government’s infection of additional funding recognises this scenario.

Investment or disinvestment requirements

In the absence of the formal allocation announcement for the EoL Strategy, the assumed investment for Havering in 2009/10 against the proposed projects is as follows:

<table>
<thead>
<tr>
<th>CCI Initiative</th>
<th>Year on Year Investment (£’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009/10</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>155</td>
</tr>
</tbody>
</table>
4.2.7.2 Stroke – Collaborative Commissioning Initiative

Prioritisation

Stroke is a major cause of death and disability contributing to the gap in Cardiovascular Disease mortality between the spearhead areas and the country as a whole. The overall death rates for stroke between 1993 – 2007 has shown a general declining trend for stroke mortality, with London having a lower mortality than that seen nationally. In NE London, mortality from stroke was similar to the rest of London until 2001 when it rose above the London rate and has since then, more reflected the national rate.

The greatest number of deaths from stroke occurring to residents of Havering and Redbridge who together accounted for 40% of the deaths from Stroke in NEL; Waltham Forest and Barking & Dagenham again lying towards the middle of the range for London, with the inner PCTs showing much smaller totals.

A Recent study completed by the Public Health Action Support Team, on behalf of the NE London Stroke Network, highlighted areas of concern regarding the provision of services and the performance of providers – the oldest population living in outer NE London and as a result the greatest number of admissions each year are for residents of Redbridge and Havering, are admitted to their local acute provider which is currently less well performing than others in NE London. Surviving stroke patients have less well developed support from specialist community rehabilitation services and patients often experience an extended hospital length of stay. Despite the high death numbers but average death rates, hospital admissions from both Redbridge and particularly Havering are noted to be significantly lower than the London or national rates, suggesting that many people in outer NE London having had a stroke never get to hospital but remain in the community and die there. In contrast, admission rates in Tower Hamlets are the highest for London as a whole, followed closely by Waltham Forest and Newham.

North East London has consistently higher death rates from stroke than London as a whole. If the London rate were applied to the sector, seventy-four deaths a year may be avoided. To achieve the London pattern, two thirds of these prevented deaths would need to be primarily in men over seventy-five years. Work to prevent strokes should therefore not be targeted just at young people who are at risk of death from stroke sometime in the future, but also the older population – those over seventy-five years. Given our elderly population, this collaborative initiative is highly important for Havering.


Initiative Description including time line

The CCI to address Stroke Services in NE London was launched in 2007/8. In year two (2008/09), the NE London Stroke Network aims to undertake the following pieces of work to support commissioners and service providers to raise standards of care: -

- Continued roll-out of Hyper Acute Care including Thrombolysis.
- Further development of TIA service provision.
- Routine monitoring against specifications and standards for TIA, Hyper Acute, Acute in line with those developed by the HfL designation process and Rehabilitation by the Network.
- Further development of community rehabilitation and a Early Stroke Discharge services.
- Work collaboratively with independent sector providers for community rehabilitation services.
- Development of vascular prevention and screening services.
- Development and piloting of local tariffs (where applicable).
- Independent peer review of services.
- Define and identify the needs of stroke survivors of working age.
- A sector wide training needs assessment in relation to the continued development of specialist stroke skills.
- Review of vascular surgical input to TIA service to improve pathway for carotid intervention.

A detailed project plan is developed each year by the Network Board in agreement with the Collaborative Commissioning Group (CCG) who receive quarterly update reports from the local SRO for Stroke (Sally Gorham, Chief Executive Waltham Forest PCT).

Goals to achieve over the coming three to five years: -

- Increased recognition of signs and symptoms of stroke and TIA.
- Improved access to TIA services meeting best practice guidance.
- Improved ‘Hyper Acute’ and acute care.
- Improved rehabilitation pathways reducing morbidity.
- Enhancement of the workforce to meet guidelines laid down in best practice and to ensure delivery of the overarching goals.
Fit with Healthcare for London key themes and specific projects

The overarching goal of Healthcare for London (HfL) is improved quality of services for stroke patients in the capital and an on-going system of continuous improvements in the quality of care and equality of access.

A designation process is being conducted by the HfL Stroke project Team on behalf of the London Commissioning Group, the process seeks to verify those providers able to deliver stroke services to an acceptable level, ensuring that there is optimum coverage in terms of stroke incidence and travel times to HASUs.

This initiative will continue to support collaborative commissioning of all aspects of stroke and TIA services to enable PCTs across NE London to meet the NHS London standards for Stroke care. This would be in line with the prioritisation of Stroke and TIA in across London for 2009/10. NEL will maintain compliance with the Department of Health’s National Stroke Strategy and the CCI will be further underpinned by the vision for World Class Commissioning in NEL, which will aim to improve health and well-being, achieve better outcomes and deliver value.

Collaborative working requirements (if applicable)

The CCI is delivered by a sector-wide Stroke Network established in 2007 to improve stroke services across NE London by supporting commissioners to develop services, which meet the needs of the population.

Working with providers, the Stroke Network will continue strive to deliver a range of service improvements that ensure good practice and learning is spread across NE London, actively promoting and supporting service innovation.

The NE London Stroke Network has maintained effective engagement with the HfL stroke team, local clinicians, patients, carers, Local Authorities and the Voluntary Sector and has consulted (where appropriate) and will continue to support the HfL consultation on designation of stroke centres.

Consultation plans (if applicable)

The NE London Stroke Network will support the designation process currently underway, working closely with the local health economy and in partnership with the HfL team who will formally lead this process.

The consultation process on the NEL pilot was undertaken across health care, patients and carers through stroke clubs and representation on the Network Board, training events and the designation process itself. In addition all of the seven local authority and the City’s health scrutiny committees were contacted and presentations or written information was provided.

HfL will be undertaking the public consultation for the London designation process in the early 2009.
Market management and procurement summary

This initiative requires the commissioning of a range of services, primarily in secondary care settings, but also in community and primary care, particularly for preventative work and rehabilitation. In order to ensure the successful bidder meets quality standards and value for money EU guidelines for competitive tendering will need to be followed. The contract value of each of the programmes covered in this initiative is likely to exceed the limits for non-competitive tendering under EU Procurement Law, and thus will require rigorous competitive procurement. The scale and complexity of the services required means there are a number of both acute and non-acute established statutory and independent providers from whom these services may be commissioned across the NE London sector. This may include the large acute Hospital Trusts, Voluntary Organisations such as the Stroke Association and Independent Sector Providers such as Clinicenta. Collaborative commissioning will be required for specialist services and delivered for a sector or across the whole of London.

Impact on health outcomes and inequalities

Effectively reducing health inequalities is a continuing challenge for the NE London CCGs; the communities between and within the seven Boroughs in NE London differ markedly from each other in terms of demographic, ethnicity, access to services and relative poverty/affluence. Many of these differences will continue to be the main determinants of stroke risk and hospital demand in future years.

The continuation of this CCI will ensure ongoing impact on quality, health outcomes and inequalities. This will be achieved by reducing mortality and morbidity, more effective prevention and enhanced access to specialist stroke services that meet the key indicators and quality markers. In the period 2004/05 – June 2008, there has been a significant reduction in hospital mortality in NE London, most markedly within inner NE London.

Impact on activity and finance

Over the coming years as improving Stroke and TIA services together with the enhanced public awareness and clinical knowledge, activity will inevitably be increased across all pathways from identification, treatment and admission. The continuation of this CCI will make better use of resources and investments; stroke services currently have high levels of investment but often fail to achieve the needed health outcomes. There will be impacts on current activity flows and costs following the HfL Designation process.

Investment or disinvestment requirements

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Funding Required £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009/10</td>
</tr>
<tr>
<td>Stroke CCI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Stakeholder engagement

The Stroke Network has achieved effective engagement with the HfL stroke team, local clinicians, patients, carers, Local Authorities and the Voluntary Sector and has consulted (where appropriate) and will continue to support the HfL consultation on designation of stroke centres.
PCT capabilities required

The World Class Commissioning capabilities required to deliver this initiative are:-

- Lead the local NHS - through signalling future priorities and areas of need
- Collaboration with clinicians through the Stroke Network as a tool for delivering effective clinical engagement and the initiative as a way of delivering best practice
- Manage knowledge and assess needs - this initiative will support a strategy for on-going investment and improving the care of those affected by TIA and Stroke
- Prioritise investments according to local needs - identifying needs appropriate to NE London residents and ensuring that the correct initiatives are identified
- Stimulate the market - analysing the market and developing a robust quality assurance framework
- Manage the local health system - developing a robust scorecard and monitoring system

These capabilities together with the necessary Project Management skills will be provided through the Stroke Network Board, working in close partnership with the Joint Committee of Primary Care Trusts (JCPCTs), CCGs and the wider community of health & social care colleagues spanning across NE London.

Success measures

Stroke Services will be evaluated using exiting national data sources (e.g. Sentile Audit, Vital signs etc) but as these are often periodic and retrospective; the stroke network board will monitor success in-year using locally developed audit tools and in some instances, repeated snapshots/sampling. NE London Stroke Network will look to further develop the existing scorecard to include: -

- Increased identification of stroke and TIA symptoms and resultant referral.
- PCTs have access to TIA services seven days week.
- PCTs have access to Thrombolysis for those eligible patients.
- PCTs have access to acute care that meets the quality markers and audit criteria.
- PCTs have access to rehabilitation that meets the quality markers and audit criteria for stroke specific in-patients, community and ESD.
- Increase in the specialist stroke workforce, particularly Stroke Consultants and specialist therapists.
- Quarterly cluster and sector summary of Length of Stay (LoS) and Mortality.
<table>
<thead>
<tr>
<th>Initiatives:</th>
<th>2008/9</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Collaborative Stroke Initiative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued roll-out of Hyper Acute Care including Thrombolysis</td>
<td></td>
<td></td>
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<tr>
<td>Further development of TIA service provision</td>
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<td>Work collaboratively with independent sector providers for community rehabilitation services</td>
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<tr>
<td>Development of vascular prevention and screening services intervention</td>
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<tr>
<td>Development and piloting of local tariffs (where applicable)</td>
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<td>Independent peer review of services</td>
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<td>Define and identify the needs of stroke survivors of working age</td>
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<td>A sector wide training needs assessment in relation to the continued development of specialist stroke skills</td>
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</tr>
<tr>
<td>Review of vascular surgical input to TIA service to improve pathway for carotid</td>
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</tbody>
</table>
Key Metrics

- Life expectancy at birth for men and women according to IMD.
- Reduction in gap in life expectancy between men and women and between those in the most and least deprived neighbourhoods of Havering.
- All age, all cause mortality rate.
- Cardiovascular Premature mortality rate (<75 years) for men and women.
- CHD Mortality Rate – including acute MI and IHD.
- Stroke Mortality Rate.
- Number of acute coronary events.
- Number of patients with stroke who are thrombolysed.
- Number of patients who spend >90% of their stay in an acute stroke unit.
- Number of patients who access TIA services who are scanned and assessed within 24 hours.
- Prevalence rate for Diabetes, AF, CKD, CHD, Hypertension.
- Numbers of patients on Diabetes, CKD, AF CHD, and Hypertension register.
- Each GP practice can produce a register for CHD, Hypertension, Diabetes, Chronic Kidney Disease, and Atrial Fibrillation.
- The percentage of patients with Diabetes in whom the last HbA1C is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.
- Number of people on Hypertension register below 140/90 mmHg (below 130/85 mmHg in people with Diabetes).
- Number of people who have been risk assessed for Cardiovascular.
4.2.7.3 Tuberculosis

Prioritisation
Tuberculosis (TB) remains a significant problem in NE London with some of the highest rates of disease seen within the Boroughs of North East London. This initiative would build upon the existing TB CCI and continue to support collaborative commissioning of TB services enabling PCTs to meet the NHS London standards for TB control. Overall more equitable services would be commissioned and health outcomes would improve.

This initiative is in line with the prioritisation of TB in London for 2009/10. North East London will maintain compliance with the Department of Health’s toolkit - ‘Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high-quality services in England’ (June 2007) which sets out a framework for assessing local needs, and identifying how services can be best provided to meet those needs.

Description of initiative
The NE London TB Commissioning Unit (TBCU) was developed in October 2007 to advise on issues relating to commissioning TB services and to actively commission services in combination with NE London PCTs. This model can be used to successfully commission world class TB services. In 2007/08 the TBCU focused upon the development of a commissioning framework for TB, introducing Interferon Gamma Release Assay (IGRA) testing, the introduction of Pharmacy DOT (Directly Observed Treatment), achieving expected staffing levels and achieving the NHS London TB standards. Going forward in 2009/10, this CCI will initiative three further streams of work in addition to the continued investment in TB control programmes and evaluation of existing programmes.

PCTs should commission TB services to the agreed specification to ensure high quality equitable services. The contract specification for 2009/10 will be revised to ensure that providers are aware of the standards of care required and the national standards for service delivery. This work will ensure that the on-going investment in TB services in NE London delivers better health outcomes.

From 2010/11 onwards the TBCU will continue to operate but its focus will be on sustaining the progress achieved in 2008/09, assessing the impact of the initiate and working towards the development of London wide TB commissioning.

Fit with Healthcare for London

The historic absence of actively commissioned TB services means that services have developed in an ad-hoc manner; the consequence of this is variability in terms of health outcome, service provision and quality. Through the effective collaborative commissioning of TB services, these inequalities can be reduced. The initiative will support the identification of areas of care where regionalisation, localisation and personalisation can occur. An equality impact assessment has been carried out on this initiative and it will impact people on grounds of race, homelessness, poverty and immigration, though this will not be in an adverse way. TB disproportionately affects those not born in the UK and particularly those whose ethnicity is Indian, Black African, Pakistani and Bangladeshi. This initiative will aim to improve services for these groups to reduce the effects of TB upon their communities.
Collaborative working

This initiative will support this development, identifying the needs of NE London, ensuring that there is a local focus to TB commissioning in addition to attempts to deliver London wide value.

Consultation plans

It is not envisaged that the plans will require consultation.

Procurement summary

The initiatives will be based on an agreed specification and although there will be no need for the NHS to procure new services; the demand for each of the initiatives has been assessed.

Impact on health outcomes and inequalities

Since the introduction of formally commissioned TB services in NE London, the quality of care provided has improved. It is envisaged that by the end of 2008/09 PCTs will have commissioned TB services capable of achieving the NHS London metrics for TB care, with the headline figure of achieving 85% treatment completion for TB cases. This performance will be maintained in 2009/10 and additional stretch targets for PCTs have been developed to measure the effectiveness of TB services in controlling TB. The clinical forum has identified the following additional stretch targets for PCTs in North East London. The effectiveness of all of the initiatives will be evaluated as part of a Health Impact Assessment.

Impact on activity and commissioning costs

Effective commissioning of resources will have the potential of reducing unnecessary activity and shifting activity from secondary care.

Investment required

It is anticipated that commissioning costs will increase in 2009/10 by £240,000 with subsequent anticipated reductions in year due to savings in tariff and in future years as the effects of better control are realised, as these reductions are realised they will be reported to the CCG. PCTs are expected to continue to fund recurrent funding streams from the 2008/09 investments, including IGRA testing, Pharmacy – Directly Observed Treatment (P-Dot) and enhanced case management services.

<table>
<thead>
<tr>
<th>CCI - Initiative</th>
<th>Year on Year Investment (£’000)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2009/10</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>10</td>
</tr>
</tbody>
</table>

Stakeholder engagement

This initiative has been discussed at the TB commissioning board, is well supported and looks to build on the success of TB CCI from 2008/09.
Capabilities required

The World class commissioning capabilities are required to deliver this initiative. These capabilities together with the necessary Project management skills will be provided through the TBCU.

Risks to delivery

Since commencing the CCI the TBCU has experienced a number of problems with achieving the agreed initiatives. Achievement of the Year 2 work plan has a number of potential risks to effective delivery

<table>
<thead>
<tr>
<th>Potential Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome of HfL review may lead to changes in service provision or configuration</td>
<td>Planning in June 07 and developing and agreeing TB SLAs in April and new specification for 09-10</td>
</tr>
<tr>
<td>Identifying priorities for 09-10</td>
<td>Mitigated by September commissioning intentions planning event with clinical forum</td>
</tr>
<tr>
<td>Developing NE London priorities that are better delivered London wide-</td>
<td>Mitigated by dialogue with London TB group and NHS London TB lead</td>
</tr>
<tr>
<td>Ensuring effective input to Cusps</td>
<td>Mitigated by development of TB CCI for 09-10</td>
</tr>
<tr>
<td>Data quality to identify resources for accommodation for socially hospitalised patients in 09-10</td>
<td>Mitigated by literature and data review</td>
</tr>
<tr>
<td>Local PCT initiatives not linking in to CCI</td>
<td>Mitigated by attendance of TBCU at DsCF meeting and circulating CCI to PCT CSP leads</td>
</tr>
<tr>
<td>LA not collaborative with accommodation plans</td>
<td>Mitigated by dialogue with local authority as stakeholder in project management process</td>
</tr>
<tr>
<td>HIV network unable to deliver coordinated testing programme</td>
<td>Mitigated by collaboration between TBCU and HIV network to develop effective care pathways</td>
</tr>
</tbody>
</table>

Success measures

The success of this initiative will be measured over the next three to five years by specified indicators.
4.2.7.4 Redesign of the Acute Provider Landscape

A significant new CCI will be planned for the future redesign of the acute provider landscape, one which is both clinically and financially sustainable so as to support PCTs to deliver the vision for 2016 as set out in ‘Healthcare For London – a framework for action’. This CCI will review the clinical configuration of acute services across NE London and make recommendations as to the redesign of clinical care across the sector-wide health care system in order to:

- Reduce health inequalities.
- Achieve tangible health improvement and well-being.
- Increase clinical quality by investing in best clinical practice care pathways.
- Improve the productivity and performance of providers.
- Build public confidence in the NHS by meeting the expectations of our service users.
- Invest in knowledge management and the continued development of clinical practice.
- Consistently provide timely access to the right care from a skilled professional at the most appropriate location.
- Commission sustainable health and social care services, which meet the diverse needs of the population living in NE London.

This CCI will encompass a number of work streams, amongst them initiatives to address each of the Healthcare for London Service lines, looking at detail at Emergency Medicine and Surgery to support the redesign of A&E, Urgent Care Centres and unscheduled care models; Elective Medicine and planned surgery to profile the impact of Polyclinics upon the provider landscape and to redesign Maternity and Newborn Services to address existing clinical quality, performance and capacity issues; The role of the Trauma and Stroke Networks in service redesign will be encapsulated within this CCI which will require continued close partnership working between the NEL CCGs and the associated HfL work streams.

The current scoping exercise and phase 2 of the project will require the two NEL CCGs to work together in 2009/10 in order to develop an agreed map of services for NEL and identify whether formal public consultation may be required; It is currently our intention that the relevant JCPCT will be the body that leads any consultation affecting its service configuration and will assume responsibility for the implementation of any service changes to the local acute provider landscape post consultation.

The more detailed planning of this CCI is still to be completed and the order in which priorities are to be addressed will emerge over the coming weeks as the detailed case for change is agreed (target mid December). The investment needed by JCPCTs in this process will be considerable and it is currently the view that a partnership approach between the two NE London JCPCTs will be the most effective way forward in phase 2, where a Joint Programme Board is established, accountable to both JCPCTs for the successful delivery of phase 2.
4.3 Overall Impact for each Goal

4.3.1 Goal 1

To improve the health and well-being of the people of Havering so that life expectancy and quality of life compares with the best in Europe and health inequalities are reduced.

Five initiatives contribute to this goal. The Staying Healthy and Cardiovascular initiatives will mostly deliver the life expectancy component. The others will deliver the improved well-being and reduction of inequalities.

Quality, outcomes, inequalities

Specifically: the Staying Healthy and Cardiovascular initiatives are expected to prevent more than 200 deaths per annum by 2014; improve life expectancy; and add more than 5300 quality adjusted life years (QALYs) annually: more than 2300 from the Cardiovascular initiative, and in excess of 3000 from Staying Healthy. The initiatives target the most deprived communities in the Borough and are expected to reduce life expectancy inequalities by 10% by 2013.

These two initiatives are expected to reduce the prevalence of obese adults from 23% to 20% (i.e., by 6,000 people), which will lead to significant reductions in Cardiovascular (including a reduction of approximately 200 heart attacks per annum), Diabetes and cancer. The physical activity component is expected to get about 10,000 adults more active, which will also reduce the prevalence of Cardiovascular, Diabetes and cancer.

HfL implementation

These two initiatives contribute to the HfL Staying Healthy and stroke care pathway projects, just as the Maternity initiative contributes to the HfL maternity project. This goal therefore complements HfL in its implementation.

4.3.2 Goal 2 – Care is provided outside hospital, and to ensure the quality of care is of the highest standard wherever it is provided.

To change pattern of Healthcare to reflect the needs of the local people and requirements of Healthcare for London, so that, wherever appropriate, care is provided.

Although most all initiatives will contribute directly and indirectly to changing the pattern of care, two initiatives, namely Care Outside of Hospital and Older People Services will make the most contribution to moving care from hospitals, into the community.

Quality, outcomes and inequalities

These initiatives will contribute to improve patient experience, improved access to Primary Care Services, and will contribute to reductions in inequalities.

HfL Implementation

This initiative includes the development of Polyclinics, which are part of the implementation of HfL projects.
4.3.3 Goal 3

To make the most cost effective use of the resources available to the Trust, and in doing so, shift a proportion of spend from treatment to prevention.

All the initiatives contribute to this goal by ensuring the effectiveness and cost-effectiveness of all programmes and interventions. In addition, the Staying Healthy and Children’s Services initiatives will ensure more focus on prevention.

Quality, outcomes and inequalities

The prevention activity in the Staying Healthy initiative will add in excess 3,000 QALYs annually, prevent more than twenty incident cases of Diabetes, and also reduce the incidence of Long Term Conditions. By focusing on the most vulnerable people, this will contribute to the reduction of inequalities.

HfL Implementation

This will contribute to the implementation of HfL Health and well-being priorities.

4.3.4 Goal 4

To establish partnerships or strengthen existing partnerships to respond to the Joint Strategic Needs Assessment (JSNA) and work towards joint commissioning of services achieve these aims.

Four initiatives (Staying Healthy, Children’s Services, Older People Services and Care Outside Hospital) contribute to this goal through strengthening partnership and interagency working. The LAA programme and Collaborative Commissioning are embedded in this strategy.

Quality, Outcomes and inequalities

Pooling of budgets for joint projects will contribute to a seamless service, thereby improving patient experience, access and service quality and reducing inequalities. Pooling of budgets will also remove barriers for service development.

HfL Implementation

Achieving this goal will contribute to the HfL theme of developing integrated and connected services.

4.3.5 Goal 5

To ensure that the Trust is fit for purpose in terms of World Class Commissioning (WCC) and is compliant with all requirements of governance and national standards for better health.

This goal is a means to an end: by improving its capabilities, NHS Havering will be well-placed to deliver the CSP.
4.3.6 Overall impact on activity, finance and the provider landscape

Activities and Finance

The baseline activity for 2007-08, as detailed in the Finance and Activity spreadsheets (attached) has been constructed utilising the HfL model. The underlying activity baseline for the full duration of the CSP in entirely consistent with the HfL model. A further set of Local Planning assumptions has been incorporated into the Finance and Activity worksheet. These include the impact of the initiatives, demand management and Referral to Treatment.

Provider Landscape

The HfL model is constructed upon a baseline year for activity (2007-08) and then factored for changes in demographic growth, expected growth in activity not driven by demographic, primarily informed by historic growth.

These growth factors produce a forecast level of activity for each year, with growth being compounded upon a straight line basis. The model applies a set of complex rules to the activity output, allocating activity to the future setting of care.

These settings of care include: -

- Major acute/specialist hospital
- Elective Care
- Local Hospital
- Polyclinic
- Home
- Not done i.e. activity avoided

NHS Havering intends to review these outputs to determine the appropriate pace of change in the movement to future settings of care. This will be premised upon a range of strategies, including the CSP and the Primary Care Strategy. The Finance and Activity templates will be reviewed to ensure the activity settings of care are consistent with the strategy.

5. Delivery

5.1 Past delivery performance

5.1.1 Performance on Initiatives

Since the inception of the existing CSP and Operating Plan for 2008/09, NHS Havering has achieved some successes in commissioning services in relation to the key initiatives as described below

(i) Out of Hospital care

A major initiative covering the Outer North East London (ONEL) PCT and Boroughs of Havering, Barking and Dagenham, Redbridge and Waltham Forest, has been developed focusing on Rapid Response services, Integrated Discharge, Telecare/Telehealth, Single point of Access and End of Life Care, with specifications for tendering in 2009.
• Havering has established an Urgent Care Centre at Queens Hospital alongside A&E, and a Whole Economy Group meets weekly to manage and improve on Delayed Transfers of Care (DTOCs) of patients safely back to their homes.
• A new low level convalescence facility is due to be opened at the Royal Jubilee Court in Romford, to ease the transfer of older people back to their homes.
• NHS Havering has substantially increased investment in St Francis Hospice, the Marie Curie Palliative Care Services and a Liverpool Care Pathway Specialist nurse to train and support Care Home staff as part of the implementation of the End of Life Care Strategy for Havering.

(ii) Stroke Care Pathway

• We have developed a local stroke strategy and work plan. This forms the basis of future investment in stroke services.
• A Local Stroke Strategy and Plan has been drafted in line with the National Stroke Strategy.
• A National Stroke Strategy has been published by the DOH, and the Diabetes Implementation Plan for Havering is currently being specified and commissioned with some additional investment identified. There is a draft local stroke strategy.

(iii) Maternity Services

• This initiative is being retained for the new CSP and in line with “Maternity Matters”. The PCT will be working in collaboration with the ONEL sector for the future commissioning of this service.

(iv) Long term conditions in children and young people

• The Havering Children’s Trust has undertaken a Needs Assessment for children with Disabilities and the partnership has prioritised the implementation of the recommendations from this assessment. This has helped to inform our refreshed initiative for the new CSP.
• NHS Havering has set out a plan for developing a comprehensive CAMHS service by 2014, in advance of a National Review and Strategy for CAMHS.

(v) Brief intervention for Alcohol

• The partnership implemented this initiative successfully through a series of training sessions. Subsequently to this, the Havering Alcohol Harm Reduction Strategy will be implemented over the next three years.

(vi) Eating Disorders

• This Key initiative has been commissioned from NELFT with implementation due from October 2008 and will be monitored closely by the Havering Mental Health Partnership Board.

(vii) Diabetes

• A Diabetes Improvement Plan has been approved by NHS Havering and is being Commissioned.
5.1.2 Progress from Operating Plan

In addition to the progress on the CSP there has been a number of notable developments and performance since NHS Havering’s Strategic Plan (2005-2008) and Annual Operating Plan for 2008/09, which have all contributed to the Vision and Goals of the Trust: -

- 2475 successful smoking quitters.
- 24 training courses for smoking cessation.
- 600 places a year on the new improved exercise referral scheme.
- 130 people trained in brief interventions for alcohol harm reduction.
- Local services established for eating disorders.
- Integrated sexual health service rolled out.
- New, modern, up-to-date primary care/clinic facilities in Harold Hill, Cranham and South Hornchurch.
- Phlebotomy services (blood sample taking) in the community, thereby avoiding unnecessary trips to hospital.
- Pilot project for Telecare, promoting the independence of older people.
- Establishment of the Spinal Assessment Service.
- Reduction in the mortality rate for coronary heart disease.
- Strong improvement in the retention rates for substance misuse from 63% to 82%.
- Additional investment in Marie Curie nurses and St Francis Hospice as part of the End of Life Care.
- Achievement of LAA1 targets over the 3 years to 2008.
- Establishment of a community Heart failure service.
- Establishment of a community Pulmonary Rehabilitation service.

5.1.3 Long-term performance on health outcomes and service quality

Over the last ten years, Havering has seen a significant improvement in early death rate from heart disease and stroke, early death rate from cancer, and all-age all-cause mortality. In each case, the improvement has been equivalent to or better than the national average improvement.

In addition, Havering has also benefited from:

- Significant improvements in access to Primary Care Services.
- Reductions in waiting times of elective treatments and cancer services.
- Reductions in waiting for A&E.
- Introduction of patient choice and Choose and Book.

5.2 How the CSP will be delivered

NHS Havering, through its structure and partnerships with LBH, Collaborative and Co-commissioning Groups (for Specialist, Acute and Mental Health Services), and internal functions of the PEC, PBC Steering Board, and Commissioning Board will monitor progress against the milestone plans of each Initiative in the CSP. The organisational requirements and enablers are described at 5.4 below.
The Commissioning Cycle set out below shows how NHS Havering’s Strategic Plan will be achieved, following the key business processes of World Class Commissioning (WCC).

1. Joint Strategic Needs Assessment (JSNA)
3. Commissioning Strategy Plan (CSP) (Agreed Initiatives)
4. Commissioning Development Plan (Business Function Project Initiation Documents PID’s)
5. Procurement (Service Specifications Market Assessment Tendering, Contract’s)
6. Performance Management of Providers
7. Reports of Progress to Trust Board (Outcomes achieved)
5.3 Risk Management

Risk Analysis:

NHS Havering recognises the importance of being able to manage and control risk successfully. This is set out in the PCTs updated Risk Management strategy, which was approved by the Trust Board in July 2008. The PCTs policy is to minimise risk wherever possible to patients, staff and members of the public and other stakeholders.

Initiatives

NHS Havering has risk assessed each initiative. For each risk identified, the probability of the risk occurring and severity of impact (Low, Medium or High) on delivery has been estimated. A risk score based on the produce of probability of occurrence and severity has been calculated. For each risk, mitigation actions have been identified to ensure that the risk is effectively managed. A risk scores of 1.5 or higher e.g. 50% probability with management. These risks are presented here. All other risks i.e. with a score of less than 1.5 are documented locally as part of the project management and are not presented here.

Table: Initiatives with a risk score of 1.5 or greater (High Risk)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Risk</th>
<th>Impact</th>
<th>Likelihood (%age)</th>
<th>Severity (Low 1, Medium 2, High 3)</th>
<th>Risk Score (Likelihood * Severity)</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability of Initiatives</td>
<td>Unaffordable initiatives would expose the PCT to financial risk and may result in the project being withdrawn at a late stage with a resultant loss of PCT credibility and reputation</td>
<td>50%</td>
<td>High 3</td>
<td>1.5</td>
<td>All initiatives will require a business case identifying the costs associated with the project and how they are funded.</td>
<td></td>
</tr>
<tr>
<td>Availability of funding (e.g. allocating less than expected)</td>
<td>Not able to fund initiatives at the rate it was costed.</td>
<td>50%</td>
<td>High 3</td>
<td>1.5</td>
<td>Need to monitor, reprioritise and rephased the delivery of the initiatives.</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Weight</td>
<td>Priority</td>
<td>Impact</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Value for Money</strong></td>
<td>Expose the PCT to unnecessary financial risk</td>
<td>50%</td>
<td>High 3</td>
<td>1.5</td>
<td>VFM will be a key criteria in the business case. This will be tested through option appraisal, benchmarking, tendering/market testing and defining key performance indicators including quality and outcomes.</td>
<td></td>
</tr>
<tr>
<td><strong>Effective Project Management of initiatives</strong></td>
<td>Result in delays to projects. Projects may not materialise</td>
<td>60%</td>
<td>High 3</td>
<td>1.8</td>
<td>All projects will need to adhere to the PCTs project management/Business Development procedures. Key skills need to be reflected in Organisational Development Plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Ability to successfully commission and influence new models of health delivery</strong></td>
<td>Innovative initiatives may not be delivered resulting in inefficient healthcare delivery and poorer outcomes</td>
<td>60%</td>
<td>High 3</td>
<td>1.8</td>
<td>Robust engagement of key Stakeholders Develop a reputation for innovation Key skills need to be reflected in Organisational Development Plan.</td>
<td></td>
</tr>
</tbody>
</table>
5.4 Organisational requirements and enablers

NHS Havering has undertaken a comprehensive assessment process reviewing current capability and capacity and mapping the outputs to the future requirements of WCC. The review identified a number of actions that will be required to deliver World Class Commissioning.

The following three key elements of organisational requirements and enablers have been identified which will help us to deliver the CSP.

- Organisational Development Plan
- Governance and Programme arrangements
- ONEL/HUB

**Organisational Development Plan**

*This is submitted separately as an attachment to the CSP.*

**Governance and Programme arrangements**

The following identifies specific responsibilities of governance of the programmes.

- PEC provide clinical guidance for commissioning across the different phases of the Commissioning cycle and scrutinise Service Specifications to ensure they deliver the right outcome, reduce inequality and promote equality.
- The Clinical Standards and Quality Committee set strategic direction for NHS Havering in regards to expectation for clinical standards and quality of all providers and ensure that there are adequate clinical governance arrangements in all providers with whom we commission.
- The Commissioning Board oversees the delivery of the CSP and the Operating Plans. The Director of Healthcare Procurement and Performance reports progress on Performance to the Trust Board.
- Practice Based Commissioning – PBC Clusters could be assigned to each strategic change.
- Programme sponsor – each programme within the Plan, will have an executive sponsor from NHS Havering and a Lead Commissioner.

**ONEL/HUB**

The development of the NHS London (NHSL) ‘Central Hub’ will enable NHS Havering to receive/access centrally held information. At a London level significant benefit should be achieved by producing high quality, detailed and accurate analysis that enable NHS Havering to better plan for its population. The four PCTs in ONEL will, in mutual support of one another, work together to develop a joint plan using the ‘HUB’ resources as its lay planning reference service.
5.5 Market Management and Procurement Strategy

5.5.1 Current Position

NHS Havering is revising its current Procurement Strategy (2007-2010) to incorporate market management and provider stimulation, and the results of the London-wide market analysis and research commissioned by NHS London. The analysis should identify key findings in relation to NHS Havering’s market segments. In addition, local market intelligence will be used to complete the analysis taking into account Havering specific issues and local developments with other commissioning partners such as the London Borough of Havering (LBH).

NHS Havering has a new resource limit of £---- million, the majority of which is invested through the commissioning of healthcare services from an existing segmentation of NHS Acute Hospitals, Mental Health and Learning Disabilities, Community Services, Primary Care, Voluntary Sector and Independent Providers.

The current commissioning portfolio includes Pan-London, Specialist Commissioning, ONEL, NEL Collaboration; NHS Havering led procurement and joint arrangements with LBH.

We have worked in close collaboration with the Leads for Specialist Commissioned Services such as Cancer. Likewise, we are committed to the LPP on contracting for NHS Funded Continuing Care placements. We are represented on the LPP Steering Board and has contributed to the market analysis, specification development and tendering process.

In addition, we are part of the Collaborative Commissioning Group (CCG) and is working with ONEL on the procurement of a number of Care Outside Hospital initiatives.

London Ambulance Services (LAS) are commissioned on a Pan-London basis with local Performance Management at North East London level and at the NHS Havering level for Havering specific performance.

The largest single Acute Hospital SLA is with BHRT and Mental Health Services Contract is with NELFT, which became a Foundation Trust in June 2008. These agreements are co-commissioned on behalf of ONEL, by Barking and Dagenham PCT and Redbridge PCT respectively.

We have SLAs with several other Acute Hospital Trusts, Specialist Mental Health Providers, the Provider Arm, the ISTC, Essex Medical Consortia (EMC) and Local Enhanced Services (LES) with Primary Care Contractors.

Joint commissioning with LBH is undertaken for services such as Drug and Alcohol Treatment (DAAT) and Learning Disabilities. Discussions are underway to explore opportunities to further develop joint commissioning for some Children and Young People Services, Adult Services and Services from the Voluntary Sector.
5.5.2 Market Management and Provider Stimulation/Engagement, Procurement, Choice and Plurality

NHS Havering, whether as part of collaborative commissioning, joint commissioning, or, as a single commissioner has been identifying new potential Providers in the market for healthcare services through:

- Tendering for services such as Psychological Therapies, Continuing Care (through the LPP), new DAAT provision, and arrangements for Individual Service Agreements (ISAs)

- Using opportunities to contract for some limited cost projects such as CAMHS needs assessment, children with Palliative Care needs assessment, and the scoping for Integrated Case Management Services within the governance of Standing Financial Instructions (SFI).

- Developing relationships with new and/or growing locally based Providers such as the EMC, Havering Age Concern, and Primary Care Contractors including GP Practices, Community Pharmacists, Dentists and Optometrists.

- Responding to Providers offering new, high quality, and accessible services, which may fit with our Commissioning Intentions.

- Accommodating patients exercise of choice, their satisfaction ratings of services and their suggestions through their involvement in setting priorities and in the tendering processes.

- Using outcome based specifications to encourage innovation, high quality provision, and value for money.
5.5.3 Plans for Implementation

Building on the current position as described above, including the analysis of the strengths, weaknesses and capacity constraints of existing providers and examples of good practice, we plan to further develop its Marketing and Procurement functions as follows:

- Produce a Market Management Strategy incorporating existing knowledge of Providers within each segment of service provision, actions to stimulate existing and new Provider interest in Havering, and Commissioning Intentions to deliver on the stated Goals and Initiatives in the CSP as well as in the Operating Plan.

- Set up and maintain a Register of existing Service Providers, contracts or SLAs, Key outcomes/targets, and contract value, by market segment.

- Build up the Register to include potential providers from the NHS, Private Sector, Voluntary and Social Enterprise sectors.

- Encourage innovation in the market place through outcome based Specifications along Care Pathways so that plurality of provision is possible. An example of this is in the Commissioning of Diabetes Services along an agreed Care Pathway which allows different Providers opportunity to bid for parts of the Pathway that they are best placed to deliver the expected outcomes. Our Commissioning Leads and APO have participated in the development of a new national Service Specification template and contract for Community Services.

- Promote the Commissioning Intentions as an ‘Investor’ for services and not just as a ‘funder’ encouraging bids.

- Use the electronic based JSNA as one vehicle to capture patients/public comments alongside a formal analysis of patient, public and staff data, surveys, focus groups (for example, the Priorities Forum), and complaints. This should help inform Service Specifications.

- Maintain an active database of best practice, innovation and service improvement linked to NICE guidance.

- Negotiate and use contracts that encourage provider modernisation, continued efficiency, quality and innovation. Create incentives where necessary, to drive innovation and quality.

- Streamline the tendering function internally to ensure that the process operates quickly and efficiently to effect the required service changes. We are discussing the potential to work with LBH on joint procurement where this is feasible and mutually beneficial.

- Ensure that clinicians, patients/users and other stakeholders are engaged in the procurement process without compromising confidentiality and avoiding conflict of interest.
6. Declaration of Board Approval

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**Board self certification**

**BOARD INTERACTION**
- The Board and the wider PCT executive team are aligned on the overall direction and priorities for the PCT
- The Board and the wider PCT executive team are aligned on the key challenges and opportunities the PCT faces in strategy, execution, talent management, performance, and governance
- The Board helps shape and challenge the PCT’s strategy
- The Board divides its time appropriately between strategic and operational issues, and between commissioning and provision
- Board members constructively challenge each other to ensure the Board arrives at the best outcome
- Board members work together effectively, and stay connected between formal meetings

**ORGANISATION**

**Structure**
- The structure of the organisation helps rather than hinders the work of the PCT
- Within the organisation, roles and responsibilities are well defined and appropriate

**Capability**
- The PCT executive team has a full understanding of both the organisation’s current capability gaps and its future needs
- The organisation is taking the right steps to build these capabilities, and these are supported by a clear plan

**Culture**
- The organisational culture supports both delivery of current operational priorities and longer-term development aims, and this culture is modelled by the Board
- Staff within the organisation understand and support the goals and values of the PCT, and understand how their work contributes to the PCT’s success

**PROCESS**

**Performance**
- Clinical, service and financial performance are tracked effectively
- The progress of key initiatives is tracked and corrective actions are implemented as required
- The Board helps to ensure that the PCT achieves national and local targets
- The Board regularly reviews performance management information and ensures appropriate actions are taken as required

**Risk**
- There is a process in place to identify and mitigate risks, and this is both appropriate and regularly reviewed

**Information**
- Timely and accurate data collection and reporting processes are in place to support management on a day-to-day basis
- The Board receives the input and information it needs to support effective decision-making

**Delegation**
- Delegated authority is clear, performance-managed and lines of accountability are clear
- Where the Board has delegated budget and/or commissioning responsibilities to partners or other commissioning groups, it has ensured that the governance arrangements support best practice commissioning

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Ralph W McCormack  
Chief Executive

Diane Jenkin  
Interim Chair

20 October 2006

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## Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>APO</td>
<td>Autonomous Provider Organisation</td>
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<td>BHRT</td>
<td>Barking, Havering and Redbridge Trust</td>
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<td>BLT</td>
<td>Barts and Royal London Trust</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BP</td>
<td>Blood Pressure</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<td>CCG</td>
<td>Commissioning Collaborative Group</td>
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<td>CCI</td>
<td>Collaborative Commissioning Initiatives</td>
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<tr>
<td>CDS</td>
<td>Community Dental Service</td>
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<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
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<td>CHPP</td>
<td>Child Health Promotion Programme</td>
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<td>CKD</td>
<td>Chronic Kidney Disease</td>
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<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
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<tr>
<td>CSP</td>
<td>Commissioning Strategic Plan</td>
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<td>CVRA</td>
<td>Cardiovascular Risk Assessment</td>
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<td>CYPP</td>
<td>Children and Young People</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>EDI</td>
<td>Early Development Instrument</td>
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<td>ESDT</td>
<td>Early Supported Discharge Teams</td>
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<td>EU</td>
<td>Europe</td>
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<tr>
<td>FHSC</td>
<td>Family Health Service Consortium</td>
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<tr>
<td>GLA</td>
<td>Greater London Authority</td>
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<tr>
<td>GOL</td>
<td>Government Office for London</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HALS</td>
<td>Health and Lifestyle Survey</td>
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<tr>
<td>HAVCO</td>
<td>Havering Association of Voluntary and Community Organisations</td>
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<td>HCC</td>
<td>Health Care Commission</td>
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<tr>
<td>HfL</td>
<td>Healthcare for London</td>
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<td>HSP</td>
<td>Havering Strategic Partnership</td>
</tr>
<tr>
<td>ICAT</td>
<td>Intermediate Care Team</td>
</tr>
<tr>
<td>IMD</td>
<td>Indices of Deprivation</td>
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<tr>
<td>ISDC</td>
<td>Interface Discharge Co-ordination Service</td>
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<td>ISTC</td>
<td>Independent Sector Treatment Sector</td>
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<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>JCPCTs</td>
<td>Joint Committee of Primary Care Trusts</td>
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<tr>
<td>LAA</td>
<td>Local Area Agreements</td>
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<tr>
<td>LAS</td>
<td>London Ambulance Service</td>
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<tr>
<td>LBH</td>
<td>London Borough of Havering</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
</tr>
<tr>
<td>LES</td>
<td>Local Enhanced Services</td>
</tr>
<tr>
<td>LIFT</td>
<td>Local Investment Finance Trust</td>
</tr>
<tr>
<td>LPP</td>
<td>London Procurement Project</td>
</tr>
<tr>
<td>LSBU</td>
<td>London South Bank University</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Conditions</td>
</tr>
<tr>
<td>MSLC</td>
<td>Maternity Service Liaison Committee</td>
</tr>
<tr>
<td>NCMP</td>
<td>National Child Measurement Programme</td>
</tr>
<tr>
<td>NEL</td>
<td>North East London</td>
</tr>
<tr>
<td>NELFT</td>
<td>North East London Foundation Trust (Mental Health)</td>
</tr>
</tbody>
</table>
NHS  National Health Service
NHSL  NHS London
NI  National Indicators
NTA  National Treatment Agency
ONEL  Outer North East London
OoH  Out of Hours
OSC  Overview and Scrutiny Committee
PALS  Patient, Advice and liaison Service
PB/MA  Programme Budgeting and Marginal Analysis
PBC  Practice Based Commissioning
PbR  Payment by Result
PCT  Primary Care Trust
PEC  Professional Executive Committee
QALY  Quality Added Life Years
QOF  Quality Outcome Framework
SALT  Speech and Language Therapy
SFI  Standard Financial Health
SLA  Service Level Agreement
TB  Tuberculosis
TBCU  Tuberculosis Commissioning Unit
TIA  Stroke and Transient Ischaemic Attack
UCC  Urgent Care Centre
UDAs  Unit of Dental Activities
UOAs  Unit of Orthodontic Activities
VfM  Value for Money
WCC  World Class Commissioning
APPENDIX 1

Joint Strategic Needs Assessment (JSNA)
Joint Strategic Needs Assessment (JSNA)

Havering Primary Care Trust and the London Borough of Havering has undertaken a Joint Strategic Health and Social Care needs assessment for the population. This enabled NHS Havering to ensure that the services commissioned are based on assessed need, and that these services will deliver the health outcomes that the PCT expects.

An easy to read version of the JSNA is enclosed in Appendix 1.

The JSNA can be accessed at www.healthandwellbeing@haveringpct.nhs.uk

The approach adopted included: -

- Consulting local people through different media, which included open sessions in Romford Market Place.
- Analysing available information on the main causes of ill health and death in Havering.
- Using information from National and local patient and resident surveys.

The information has been sorted to present several views as follows: -

- **Perceptions:** What people feel and understand about the issue.
- **Competencies:** Do we have the skills and knowledge to do the job properly?
- **Socio-economic:** How people’s circumstances, such as where they live or the job they do, affects their sense of well-being.
- **Services:** Are the services that are provided in the right place and giving the help people need?
- **Environmental:** Are the buildings and transport system having an effect on people’s well-being?
- **Epidemiological:** This means looking at where the problem is located and how many people it affects in the community

**Main issues for Havering**

Based on the information obtained so far the following issues have been identified within particular age groups and the wider community.

**Early years**

- More babies are being born to women aged 25-34 and more needs to be done to help all parents prepare for their baby’s arrival.
- Too few midwives at local hospitals to deliver babies.
- A child born in Gooshayes ward in Harold Hill can expect to live, on average, 6 years less than a child born in Emerson Park. There is a higher rate of still birth and infant death in areas of deprivation in the Borough.
- Only 66% of babies are breast fed at birth, compared to 70% nationally. Breast feeding gives babies a good start in life so we need to encourage more women to do this.
- Status of birth weight as this is a sensitive indicator for inequality.
Children aged between 5 and 11

- Seventeen out of every 100 children in Havering are living in poverty.
- 11% of four to five year old children in Havering are obese. This figure rises to 20% (or 1 in 5) for eleven year olds.
- Some families say some local services are not satisfactory and it is difficult to access these services.
- Some parents say they want help with learning to cook.
- Local services are aiming to increase safe environments for looked after children by improving stability of where care is provided.

Children and young people between eleven and eighteen years old

- Most young people do well in their General Certificate for Secondary Education (GCSE) exams when compared to the England average, but more needs to be done to 'close the gap' between the achievement of those doing the best and those not doing so well.
- Three out of four young people think Havering is a good place in which to live.
- The number of girls under eighteen who become pregnant has remained about the same for the last three years, but the rate is higher in poorer areas when compared to more affluent parts of the Borough.
- Some young people have a problem with alcohol and drugs (some need specialist help) and special training is needed for staff working in substance misuse services.
- The recommended intake of fruit and vegetables is five a day, but only 23% of young people say they eat this amount.

Adults

- The health of the adult population is generally as good as the England average, but this varies depending on the geographical area within Havering.
- More people are admitted to hospital from poorer areas.
- Smoking and obesity is more common in poorer areas (for instance, only 7% of people say they smoke in the fifth best off areas, compared to 24% in the fifth worst off areas).
- Based on figures for 2002-6 for people under seventy-five, we know that circulatory disease accounts for 31% (or 31 in 100) of all deaths and cancer accounts for 41% of all premature death.
- Middle age is the time when obesity is most common.
- There are over 800 problematic drug users in Havering and twenty-five to twenty-nine is the age group when the problem is greatest.
- There is an increasing need to provide services for people who use cocaine.
Older people aged over Sixty-five

- Older people in Havering say they have more health problems when compared to England as a whole. For instance, only 32% of local people aged sixty-five to sixty-nine say they have no health problems. Nationally, 41% say they have no problems.
- Many pensioners live on low income and there is variation in income across the Borough. Over 45% of people in Brooklands ward live on less than £10,000 a year, compared to 20% of people in Emerson Park.
- Older people have told us there is a lack of information about social opportunities and the difficulty they have with new technology.
- Some older people say they feel lonely, particularly after bereavement.
- More older people trust their neighbours when compared to younger people (65% of older people say ‘people look out for each other in the neighbourhood), but more older people report feeling depressed than younger people.
- Older people in Havering have few formal qualifications.
- Circulatory disease causes 39% of deaths in the over seventy-five’s, whilst 21% of deaths are caused by cancer.
- 23,000 people in Havering are carers, providing unpaid care. Many are over sixty-five and female.
- Family doctors need to be more aware of their patients who are ‘carers’ and need to understand their needs.

Community wide issues

- A local residents survey shows that people’s satisfaction with their local area varies depending on where they live. Overall, 68% of people are satisfied with their local area (this varies from 86% in Upminster to 55% in Harold Hill). 46% feel unsafe after dark.
- 42% think local leisure services are good and 62% said local health services were good.
- People in Harold Hill have concerns about the state of pathways and roads, litter and street cleanliness.
- Some local people are concerned about the changing face of Havering.
- People identified a number of issues that affect their well-being. These include financial security, childcare, health services and local transport.
- People say they want to know how to get information and advice (on local services and socialising opportunities).
- Admissions to hospital vary across Havering. The highest rate for admissions is for people who live in Harold Hill, South Hornchurch and Brooklands wards.
- 10% (or 1 in 10) people live on means-tested benefits.
- Road injuries and deaths are reducing in Havering.
Next steps for the JSNA

The PCT and its partners continue to work together to ensure that:

- People can live longer, healthier lives with better quality of life or better knowledge of how to deal with any long-term illnesses.
- Gaps in life expectancy and poor health across the Borough are reduced.
- The local NHS and local Council work together to ‘buy’ the services people need.
- We know that the services we buy actually work and give people a better sense of well-being.
- We are prepared for changes in the local population, for instance, people living to a longer old age, or more young people moving to live in Havering.
- Work together to ensure that public money is used efficiently.
- Local communities are informed about their local well-being issues.

In order to do this, additional work is being undertaken to ensure that:

- All strategies address the identified need.
- There is better understanding of the needs of specific groups, such as people with learning disabilities.
- Any changes in the population are considered. For instance, anticipated increase in the numbers of older people living in the Borough, which will create more demand for health and social care services.
- Having a full picture of how any changes in the lifestyles that people lead might affect their health in the future.
- NHS Havering and London Borough of Havering work to improve any identified weaknesses in services provided.

The JSNA can be accessed at www.healthandwellbeing@haveringpct.nhs.uk
APPENDIX 2

Havering Demographic Trends
Demographics Trends

- NHS Havering’s responsible population in 2006 was 227,340. Greater London Authority (GLA) projections estimate the Borough population as 227,338 in 2008.
- 8.8% of the Havering population is aged seventy-five years or older, higher than for London (5.7%) and England (7.7%).
- Havering has an older age structure: 17.5% of the population is aged 65 years or older, again higher than for London (11.8%) and England (15.9%).
- 17.7% of the population is under fifteen years old; lower than for London (18.1%) and England (17.7%).
- GLA estimates that in 2008, 93.1% of males and 92.8% of females are White.
- The population is projected to increase by 4.3% in the next twenty-five years, whereas the population of London will increase by 12.6% over the same period.
- Havering is a relatively affluent area of London, with half of its area in the green belt.
- It enjoys a relatively low crime rate, a high level of owner-occupancy and relatively good housing stock, and a lower level of unemployment than the London average in 2007 – 2.2% unemployed (4% in London) but with low wage rates.
- A low proportion of people with degree level qualifications. The proportion of population with no qualifications is higher than the London average. In Jan 2006 – Dec 2006, the proportion of persons with no National Vocational Qualifications (NVQ1) in Havering is 18.5% as compared to Bexley (9.8%), London (13.9%), and Great Britain (13.8%).
- The current educational performance is high. The percentage of GCSE achievements (for fifteen year olds gaining five or more GCSEs at grades A-C levels) in 2007 is 64.4 for Havering as compared to 60.5% for London, and 60.8% for England.
- It has developed a transport strategy setting out new investment needed to establish sustainable community in south of Borough.
- A potential for five to six thousand new homes in South Havering in London Riverside development.
- An urban strategy for Romford agreed to guide future growth of the town centre, which could include one to two thousand new homes.
**NHS Havering Population (2006) by age and sex**

<table>
<thead>
<tr>
<th>Age band</th>
<th>Male</th>
<th>Female</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>6,219</td>
<td>6,051</td>
<td>12,270</td>
</tr>
<tr>
<td>5-9</td>
<td>6,665</td>
<td>6,372</td>
<td>13,037</td>
</tr>
<tr>
<td>10-14</td>
<td>7,689</td>
<td>7,324</td>
<td>15,013</td>
</tr>
<tr>
<td>15-19</td>
<td>7,653</td>
<td>7,201</td>
<td>14,854</td>
</tr>
<tr>
<td>20-24</td>
<td>6,783</td>
<td>6,518</td>
<td>13,301</td>
</tr>
<tr>
<td>25-29</td>
<td>6,596</td>
<td>6,377</td>
<td>12,973</td>
</tr>
<tr>
<td>30-34</td>
<td>6,435</td>
<td>7,019</td>
<td>13,454</td>
</tr>
<tr>
<td>35-39</td>
<td>7,866</td>
<td>8,366</td>
<td>16,232</td>
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<tr>
<td>40-44</td>
<td>8,443</td>
<td>9,265</td>
<td>17,708</td>
</tr>
<tr>
<td>45-49</td>
<td>8,321</td>
<td>8,366</td>
<td>16,687</td>
</tr>
<tr>
<td>50-54</td>
<td>6,886</td>
<td>7,376</td>
<td>14,262</td>
</tr>
<tr>
<td>55-59</td>
<td>7,435</td>
<td>7,911</td>
<td>15,346</td>
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<td>60-64</td>
<td>5,808</td>
<td>6,497</td>
<td>12,305</td>
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<tr>
<td>65-69</td>
<td>4,652</td>
<td>5,495</td>
<td>10,147</td>
</tr>
<tr>
<td>70-74</td>
<td>4,315</td>
<td>5,354</td>
<td>9,669</td>
</tr>
<tr>
<td>75-79</td>
<td>3,776</td>
<td>5,109</td>
<td>8,885</td>
</tr>
<tr>
<td>80-84</td>
<td>2,471</td>
<td>4,071</td>
<td>6,542</td>
</tr>
<tr>
<td>85+</td>
<td>1,440</td>
<td>3,215</td>
<td>4,655</td>
</tr>
<tr>
<td>All Ages</td>
<td>109,453</td>
<td>117,887</td>
<td>227,340</td>
</tr>
</tbody>
</table>

London Borough of Havering’s projected resident population increase is as follows:

**Resident Population Projections growth for Havering**

This does not include the expected population gross for Thames Gateway, which is estimated to be around 10,000 by 2016.

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>% Increase</th>
<th>% Cumulative increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>227,338</td>
<td></td>
<td>0.44</td>
</tr>
<tr>
<td>2011</td>
<td>230,726</td>
<td>1.5</td>
<td>0.43</td>
</tr>
<tr>
<td>2016</td>
<td>232,346</td>
<td>0.7</td>
<td>0.42</td>
</tr>
<tr>
<td>2021</td>
<td>232,528</td>
<td>0.1</td>
<td>0.46</td>
</tr>
<tr>
<td>2026</td>
<td>233,693</td>
<td>0.5</td>
<td>-0.09</td>
</tr>
<tr>
<td>2031</td>
<td>235,259</td>
<td>0.7</td>
<td>3.5</td>
</tr>
</tbody>
</table>

**Expected population growth**

<table>
<thead>
<tr>
<th>Year 0 (Baseline)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons</td>
<td>227,338</td>
<td>228,328</td>
<td>229,303</td>
<td>230,262</td>
<td>231,315</td>
</tr>
<tr>
<td>Men</td>
<td>110,039</td>
<td>110,596</td>
<td>111,142</td>
<td>111,675</td>
<td>112,254</td>
</tr>
<tr>
<td>Women</td>
<td>117,299</td>
<td>117,732</td>
<td>118,161</td>
<td>118,587</td>
<td>119,061</td>
</tr>
<tr>
<td>Growth (%)</td>
<td>0.44</td>
<td>0.43</td>
<td>0.42</td>
<td>0.46</td>
<td>-0.09</td>
</tr>
</tbody>
</table>

**GLA population projections**
Current population health status and projected needs

(a) Current health and well-being status

(i) Life Expectancy

The health of Havering residents is generally good and in line with expectations compared to neighbouring Boroughs. Life expectancy in Havering is similar to Bexley, our most comparable Borough, higher than that for England as a whole and continues to increase. However, there is a gap between the life expectancy and health experienced by people living in the most prosperous wards and the poorest wards in Havering, particularly in the North and South of the Borough. Residents in areas of deprivation in Havering continue to experience worse life expectancy than residents of the least deprived wards.

*Life Expectancy at birth for Havering, Bexley and England*

<table>
<thead>
<tr>
<th>Year</th>
<th>Havering Males</th>
<th>Havering Females</th>
<th>Bexley Males</th>
<th>Bexley Females</th>
<th>England Males</th>
<th>England Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-2001</td>
<td>76.6</td>
<td>80.9</td>
<td>77</td>
<td>80.9</td>
<td>75.7</td>
<td>80.4</td>
</tr>
<tr>
<td>2000-2002</td>
<td>76.5</td>
<td>80.8</td>
<td>77</td>
<td>81.2</td>
<td>76</td>
<td>80.7</td>
</tr>
<tr>
<td>2001-2003</td>
<td>76.7</td>
<td>80.9</td>
<td>77.1</td>
<td>81.2</td>
<td>76.2</td>
<td>80.7</td>
</tr>
<tr>
<td>2002-2004</td>
<td>77.1</td>
<td>81</td>
<td>77.6</td>
<td>81.5</td>
<td>76.6</td>
<td>80.9</td>
</tr>
<tr>
<td>2003-2005</td>
<td>77.8</td>
<td>81.4</td>
<td>78.3</td>
<td>81.9</td>
<td>76.9</td>
<td>81.1</td>
</tr>
<tr>
<td>2004-2006</td>
<td>78.2</td>
<td>81.9</td>
<td>78.5</td>
<td>82.5</td>
<td>77.3</td>
<td>81.6</td>
</tr>
</tbody>
</table>

Source: National Centre for Health Outcomes Development (NCHOD)
(ii) Inequalities in Havering

- Out of the 33 London Boroughs NHS Havering ranks 26th in deprivation (1st is the most deprived) and similarly it ranks 200th among the 354 Local Authorities in London.
- Havering has 18 wards and 149 Super Output Areas (SOA) with an average population size of 1,500). Only one of these SOAs (Mardyke) ranks among the 10% most deprived SOAs in England.
- Gooshays, Heaton, South Hornchurch, and Havering Park wards feature among the 20% of most local deprived wards within Havering.
- The age standardised mortality rate for males under seventy-five years in the most deprived 20% of the Havering population is 42.6 per 1,000, whereas the least deprived 20%, it is 29.0 per 1,000. For all ages, the mortality rates are 82.2 per 1,000 for the most deprived 20% and 62.1 per 1,000 for the least deprived quintile.
- The age standardised mortality rate for females under seventy-five years in the most deprived 20% of the Havering population is 29 per 1,000, whereas the least deprived 20%, it is 20.6 per 1,000. For all ages, the mortality rates are 57.9 per 1,000 for the most deprived 20% and 48.7 per 1,000 for the least deprived quintile.

### Deprivation and Premature Mortality

| 2004-2006 EASMR-European Age Standardised Mortality Rate per 10,000, for deaths under the age of 75 |
|---|---|---|---|---|---|---|---|
| | Male | | | Female | | | |
| | Average number deaths per year | EASR | UL | LL | Average number deaths per year | EASR | UL | LL |
| 1 (most deprived) | 91 | 42.6 | 51.3 | 33.9 | 71 | 29.0 | 35.8 | 22.2 |
| 2 | 74 | 46.7 | 57.3 | 36.1 | 55 | 29.8 | 37.7 | 21.9 |
| 3 | 91 | 38.5 | 46.4 | 30.6 | 67 | 25.5 | 31.6 | 19.4 |
| 4 | 63 | 37.2 | 46.4 | 28.0 | 44 | 23.3 | 30.2 | 16.4 |
| 5 (least deprived) | 74 | 29.0 | 35.6 | 22.4 | 59 | 20.6 | 25.9 | 15.3 |
| Havering | 393 | 38.1 | 41.9 | 34.3 | 296 | 25.4 | 28.3 | 22.5 |

Source: Office for National Statistic Public Health Mortality Files

UL = Upper Limit (95% Confidence Interval)

LL = Lower Limit (95% Confidence Interval)
**Infant Mortality (deaths under 1 year per 1,000 live births)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Havering</th>
<th>Bexley</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
</tr>
<tr>
<td>2006</td>
<td>5.8</td>
<td>14</td>
<td>4.3</td>
<td>12</td>
</tr>
<tr>
<td>2005</td>
<td>2.8</td>
<td>5</td>
<td>4.8</td>
<td>13</td>
</tr>
<tr>
<td>2004</td>
<td>3.9</td>
<td>10</td>
<td>5.6</td>
<td>15</td>
</tr>
<tr>
<td>2003</td>
<td>2.5</td>
<td>6</td>
<td>6.1</td>
<td>16</td>
</tr>
<tr>
<td>2002</td>
<td>6.6</td>
<td>15</td>
<td>3.6</td>
<td>9</td>
</tr>
<tr>
<td>2001</td>
<td>2.9</td>
<td>7</td>
<td>5.3</td>
<td>14</td>
</tr>
<tr>
<td>2000</td>
<td>3.9</td>
<td>9</td>
<td>4.1</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: ONS Vital Statistics

(iii) **Comparing Havering to England as a whole**

- Less of its local authority housing is of poor quality.
- The number of unfit homes per thousand dwellings is thirty-eight in Havering as compared to seventy-five for England as a whole.
- The percentage of GCSE achievements (for fifteen year olds gaining five or more GCSEs at grades A-C levels) in 2007 is 64.4% for Havering, which is higher than England 60.8%.
- Less teenage pregnancy than the England average.
- Lower estimated levels of smoking and binge drinking, but higher levels of obesity.
- Road injuries and deaths are more common than average for England, as they are in most London Boroughs.
- People in Havering are less likely to report feeling in poor health than average for England.
- The number of people registered with a GP for severe mental health problems is low.

(b) **Projected health needs**

Two main areas are likely to be of major importance in forthcoming years. These are:

- The increase in the number of older people.
- The development of Thames Gateway.

(i) **Older People**

Population growth of Older People is expected to rise by 11.5% between 2006 and 2021. It is anticipated that there will be an extra 17,500 in the sixty-five and over age group during this period and that there will be an increase of 88% in the eighty-five and over age group by 2026 (an extra 3,000 people). This will have implications for health care since older people are generally higher users of health services than younger people. The model of care for adult services is designed to address the demographics impact on demand for health and social care.

The needs of the increasing number of older people will be largely met by the development of comprehensive, locally accessible out of hospital services (initiative four and five).
(ii) Thames Gateway

The Thames Gateway Developments provide a stimulus and excellent opportunity to improve people’s health and to accelerate the modernisation of health services that have already begun in Havering. The Thames Gateway is likely to attract a younger, more ethnically diverse population with different health needs to the current resident population of Havering.

A larger and more diverse population is likely to increase demand for primary and community care services and hospital care. The increase in demand will be proportionately greater in primary and community care, reflecting current thinking about the most effective ways to provide health services.

Specifically, an increase in young children and young adults is likely to result in increased demand for maternity care, urgent care for children, child health screening and promotion. Better mental health services for adolescents and young adults will be required, and easy access to integrated sexual health services.

A mixed ethnic profile is likely to lead to an increased demand in services for diseases suffered disproportionately by specific ethnic groups.

Better management of LTC will lead to increased demand for diagnostic tests, recall and review sessions and support from community teams and case managers. A need to reduce health inequalities will involve more demand for health promotion and disease prevention services.

(c) Key Health Needs by care groups and disease conditions

(i) Children and Young People

The needs of children and young people have been addressed in the Director of Public Health Annual Report published in 2006, and the joint Children and Young People’s Plan (CYPP) produced by Havering Children’s Trust.

These documents identified the need to have high quality integrated services for Children and Young People with long-term conditions; especially those with complex needs where the prevalence is low but the needs are severe. An initiative has been developed to address these needs (Initiative 3).

(ii) Long Term Conditions

Some thirty-nine thousand persons in Havering have one or more LTC. About nine hundred of these persons account for approximately 25% of all hospital bed days (or 38% of all emergency bed days). The evidence from around the world suggests that when patients with LTC receive proactive effective treatment within an integrated system, with self-management support and regular follow-up, they have better clinical and functional outcomes. The evidence also suggests that organised systems of care, not just individual health care workers, are essential for these outcomes.

In Havering the admission rates for ambulatory care sensitive conditions (for which good outpatient care can potentially prevent the need for hospitalisation or for which early intervention can prevent complications or more severe disease) is higher than expected and varies from practice to practice. This is associated with high A&E
attendance rates and admission conversion rates in the A&E department at Queen’s Hospital.

The needs of these people are addressed in the key initiative to improve Care Outside Hospital (Initiatives) and the disease specific initiatives on cardiovascular disease (a LAA project), stroke and Diabetes (Initiative 6) and older people services (Initiative 4).

(iii) Maternity

Initiative 2 on Maternity Services aims to address the following priorities: -

- Parentcraft initiative including breastfeeding.
- Midwife led birthing unit.
- Additional investment in the workforce to ensure safe services and improve quality standards.

(iv) Health Improvement

Initiative 1 on Staying Healthy is intended to work with our local partners to address the following priorities: -

- Healthy Eating.
  Increase uptake of school meals.
  Increase numbers of children being taught to cook basic healthy meals.
- Physical Activity.
  >85% of schools to offer a minimum of two hours of Physical Education per week.
  Increase % of children with access to additional physical activity options through extended schools.
- Emotional and Mental Well-being.
  Include and implement emotional and mental well-being section in all childhood obesity strategies.

(v) Child and Adolescent Mental Health Service (CAMHS)

There is a requirement to deliver a comprehensive CAMHS by 2014, including extending working hours to provide 24/7 services. Initiative 3 on Children and Young People Services is intended to address the following needs and priorities on a joint commissioning basis with the Havering Children’s Trust.

Local needs

- Care pathways and services for Children and young people with Learning Disabilities; (LD).
- The impact of an increasingly diverse population.
- Including the Voluntary Sector in care pathways and planning services.
- Screening and early identification of complex behaviours and management of children and young people with complex and persistent severe behaviour.
- Access to Tier 4 services (Highly Specialised Service) and reduction of high cost out of area placements.
Priorities

- Comprehensive care pathway for LD with cross Borough collaboration to provide mental health services to severely disabled young people.
- Develop local multi disciplinary services for persistent complex behaviour.
- Develop multi agency local placements options for complex challenging conduct and other disordered young people at tier 3/4 (specialised and highly specialised services), with regional services for issues such as Eating Disorder.

(vi) Reducing Cardiovascular Disease risk in older people and number of deaths

Cardiovascular Disease is the largest cause of death in the UK; in Havering, it is responsible for 36% of all deaths and almost eight thousand years of life lost annually. Preventative work has been established in Havering GP practices and this work aims to reduce the Cardiovascular risk of identified patients. However, data from a health equity audit in Havering has shown that the most deprived 20% of practices area have 18% higher Coronary Heart Disease (CHD) registrations than expected even before correction for need of deprivation. NHS Havering intends to target cardiovascular risk assessment services in four wards, Gooshays, Heaton, South Hornchurch and Brooklands, through a case finding approach, which aims to identify people at risk and provide appropriate advice and treatment.

Stroke (one group of conditions within cardiovascular disease) has been identified in the Healthcare for London Framework for Action, and locally as a high priority. It is also a collaborative commissioning initiative for the NE sector.

Stroke care locally has poor outcomes, and long lengths of stay in acute wards with inadequate rehabilitation. Stroke care pathways are being defined by a clinical group.

Initiative 6 on Cardiovascular Disease incorporating Stroke, Diabetes and Vascular Risk is intended to address the above needs and priorities.
(vii) Increasing physical activity levels

The health effects of an inactive lifestyle are serious – inactivity is thought to account for a third of deaths from heart disease. However, according to the latest Sport England survey, only 18.9% of people in Havering are sufficiently active to benefit their health. As part of our Local Area Agreement Stretch Targets, Havering has set a target to increase by 4% the amount of activity undertaken (3 x 30 minutes per week) by residents in the wards of Gooshays, South Hornchurch and Brooklands. A separate target for the same geographical areas of 1 x 30 minute session a week (acknowledging that some people are inactive and need help and support to make the transition to an active lifestyle). There are benefits to people with LTC from becoming more active and this group will be targeted through the revised exercise referral programme. Initiative1 on Staying Healthy aims to address this issue.

(viii) Obesity Management interventions

Obesity is an ever increasing problem, both nationally and locally, since it has long-term implications for health, as well as for an individual’s self esteem. Havering’s obesity management interventions are targeted both at the whole and specific groups, both in terms of prevention and treatment. Once the data collection exercise in schools has been completed, a local analysis will reveal which geographical areas have the highest prevalence and where the interventions should be targeted. Healthy Schools are a key setting for delivering the obesity target, since schools can offer a universal service to all children in the Borough through the promotion of whole school food policies and opportunities for physical activity. Initiative 1 on Staying Healthy aims to address this issue.

(ix) Alcohol

The PCT and its partners have an agreed Alcohol Harm Reduction Strategy, which is being implemented.

Disease incidence and prevalence

The table below summarises the expected incidence of growth for key LTCs in Havering:

<table>
<thead>
<tr>
<th>Disease group</th>
<th>Year 0 (Baseline)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average prevalence (%) - CHD</td>
<td>3.35</td>
<td>3.4</td>
<td>3.45</td>
<td>3.5</td>
<td>3.55</td>
<td>3.6</td>
</tr>
<tr>
<td>Average prevalence (%) - COPD</td>
<td>1.32</td>
<td>1.34</td>
<td>1.36</td>
<td>1.38</td>
<td>1.4</td>
<td>1.42</td>
</tr>
<tr>
<td>Average prevalence (%) - Asthma</td>
<td>4.85</td>
<td>4.9</td>
<td>4.95</td>
<td>5</td>
<td>5.05</td>
<td>5.1</td>
</tr>
<tr>
<td>Average prevalence (%) - Diabetes</td>
<td>3.65</td>
<td>3.7</td>
<td>3.75</td>
<td>3.8</td>
<td>3.85</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Further analysis of currently available information from the GPs Quality Outcomes Framework (QOF) show how the PCT compared to national prevalence information in 2006/2007.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Register Size</th>
<th>Prevalence %</th>
<th>Z score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Heart Disease CHD</td>
<td>8,206</td>
<td>3.3</td>
<td>-0.2</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>0.7</td>
<td></td>
<td>-0.5</td>
</tr>
<tr>
<td>Stroke and Transient Ischaemic Attack (TIA)</td>
<td>3,619</td>
<td>1.4</td>
<td>-0.4</td>
</tr>
<tr>
<td>Hypertension</td>
<td>32,316</td>
<td>12.7</td>
<td>0.1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>9,765</td>
<td>3.7</td>
<td>0.1</td>
</tr>
<tr>
<td>COPD</td>
<td>3,610</td>
<td>1.4</td>
<td>-0.1</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1,418</td>
<td>0.6</td>
<td>-0.2</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>6,818</td>
<td>3.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Cancer</td>
<td>2,615</td>
<td>0.9</td>
<td>-0.1</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>0.1</td>
<td></td>
<td>-0.6</td>
</tr>
<tr>
<td>Mental Health Illnesses</td>
<td>1,372</td>
<td>0.5</td>
<td>-1.3</td>
</tr>
<tr>
<td>Asthma</td>
<td>11,868</td>
<td>4.8</td>
<td>-1.3</td>
</tr>
<tr>
<td>Dementia</td>
<td>0.4</td>
<td></td>
<td>0.1</td>
</tr>
<tr>
<td>Chronic Kidney Disease (CKD)</td>
<td>3.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Atrial Fibrillation (AF)</td>
<td>1.1</td>
<td></td>
<td>-0.4</td>
</tr>
<tr>
<td>Obesity</td>
<td>8.2</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td>0.2</td>
<td></td>
<td>-1.2</td>
</tr>
</tbody>
</table>

Source: Quality and Outcomes Framework (QOF) Z Score is a measure of how far the PCT is from the average.

**Health Outcomes and Health Inequalities**

Tackling health inequalities is of a key aim of Commissioning for health and well-being. Inequalities occur for different reasons. The issue of inequality tend to show in geographic concentrations as a result of a combination of factors that contribute to these inequalities.

Gooshays ward, Mardyke, and Brooklands, are the most deprived areas in Havering (Indices of Deprivation (IMD), 2007). Inequality issues among these deprived communities (see map, Havering Super Output Areas (SOAs) can be described as follows:

- About 22% of adults in deprived wards smoke while the comparable figure for Upminster is about 7%. Obesity levels are also much higher in more deprived areas than the Havering average.
- A child born in Gooshays and Harold Hill can expect to live, on average, six years less than a child born in Emerson Park. This gap can be reduced by taking a multi-approach action with the communities.
- Morbidity / illness is more prevalent in the deprived areas. For example, the Mardyke estate has a cancer incidence rate 33% higher than Havering average.
- 19.5% of working age people in Mardyke estate live with long term limiting illness. The comparable figure for Havering is about 11.8%.
- More people are admitted to hospitals in poorer areas. The age standardised admission rate for cardiovascular diseases for Gooshays’ residents, 2004-2006, was 133.8 per 10,000 persons. The comparable figure for Havering was 99.5. This means that admission rate for Gooshays was about 35% higher than Havering average.
• 2006 birth data shows that the birth rate per 1000 women aged 15-44 are higher in Gooshays (56.4), Brooklands (55.2), Squirrel’s Heath (60.4) than Havering (51.4).
• There are a high proportion of pensioners living on low incomes in deprived areas. Over 45% pensioners in Brooklands live on less than 10K a year. The comparable proportion for Emerson Park is about 20%.
• Overall satisfaction level about where they live is lower among people from deprived wards of the Borough. 55% of Harold Hill residents are satisfied while the comparable figure for Upminster is 86%. Harold Hill residents are also concerned about the state of pathways, roads, litter, and street cleanliness.

As a result of the above, several of our initiatives have a focus on these geographical areas in order to target inequality and address our overall vision and goal 1.

The following is a summary of the PCT’s health outcome, inequality and service delivery targets for 2007/8 in line with the PCT’s 2005-8 Local Delivery Plan (LDP) and the 2007/8 Planning Framework for London.

• **Reducing health inequalities and promoting health**

  The national Public Sector Agreement (PSA) target aims for life expectancy in England overall to increase to 78.6 for men and 82.5 for women for 2010. Havering has made good progress on male life expectancy, which has increased in recent years and risen to 78.2 years (during 2004-6). Similarly, life expectancy for women has risen to 81.9 years during the same period.

• **Cancer mortality**

  The PSA requires the three-year average age-standardised cancer mortality rates among those under age 75 to be reduced by 20% between 1996 and 2010. The cancer mortality rate in Havering has decreased over recent years. During 2004-6 the rate was 116.5 per 1000, which is ahead of the LDP target of 117.0 per 1000.

  Havering is one of the few London PCTs that has been marked ‘green’ on the traffic light monitoring system (London Health Observatory Q4 Performance Management Report) for breast cancer screening (age 53 to 64) for 2006-7; our coverage of 74% was ahead of the national target.

• **Cardiovascular Disease Mortality**

  Cardiovascular mortality has decreased in Havering over recent years. During 2004-6 the rate was 76.1per 1000, which is ahead of the LDP target of 90.0 per 1000. Havering is doing reasonably well on the percentage of patients on CHD registers who are taking standard CHD therapies (83.2% compared to 84.2% nationally).
• **Obesity**

Adult obesity is a key national target, and obesity is a predictor of Cardiovascular and Diabetes and can contribute to a reduced life expectancy. The Havering Health and Lifestyle Survey showed that the prevalence of obesity in adults was 19.3% (men 19.7%; women 19.0%). It also showed that 54% of the adult population (60% of men and 51% of women) were obese or overweight. In contrast, of the 34% of patient’s aged 16+ who had their Body Mass Index (BMI) recorded on GP systems, 28.5% had a BMI value of 30 or more. Further progress needs to be made to record more BMI levels across the 16+ population so that targeted support and intervention can be delivered to persons who are obese and reduce their risk of developing other long-term conditions.

• **Infant Mortality**

Infant mortality rates are in important indicator of health in a population. The trend in infant mortality rate in Havering has remained flat: During 2004-06, the infant mortality rate was 3.9 per 1000 live births; the rates for the previous periods were 2.8 (2003-05) and 4.3 (2002-03). Smoking during pregnancy has remained fairly static in Havering over the last few years (just under 10%) but there have been marked improvements in the recording of information about the smoking status of mothers such that it is available for virtually all mothers. In order to tackle the challenging issue of smoking in pregnancy, a new initiative is ongoing in one our identified areas of inequality, whereby the stop smoking clinic operates alongside the Sure Start midwife clinic, for quick and easy access.

• **Breastfeeding**

Breastfeeding initiation rates remain a challenge for Havering (69.1% during Q4 2007/8 compared to the London average of 84.2%). The rates are below the LDP target of 74.9%. The initiative around antenatal care will address this issue by providing information and support to pregnant women at a critical time in their pregnancy, when choice about breastfeeding may be influenced.

• **Teenage Pregnancy**

The trend of Havering’s teenage pregnancy rate has been relatively flat over recent years. During 2006 the rate was 39 per 1000, which was lower than the London average of 45.4 per 1000 but behind the LDP target of 29.8 per 1000, and was also 4.3% lower than the 1998 baseline rate. A coordinated multi-agency approach to preventing teenage conceptions has been adopted across Havering.

• **Sexual Health**

There have been major improvements in access to Genito-Urinary Medicine (GUM) services (again a NHS Operating Framework priority). All patients attending Genito-Urinary Medicine clinics are seen within forty-eight hours of contacting the service (Q4 2007/8), hitting the LDP target.