NHS West Essex
Strategic Plan
2009-14
Foreword

Welcome to NHS West Essex Strategic Plan for improving health and healthcare services across west Essex for the next five years. NHS West Essex is the organisation responsible for the NHS in west Essex - ensuring people get the best possible local healthcare and enjoy the best possible health.

This document builds on our Strategy for Healthcare in West Essex, published in 2007. Our Strategy for Healthcare was the result of an extensive three-month consultation with local people, service users, primary care practitioners, health partners, within the NHS and the private sector, social services, local authorities, including parish, district and county councils, the voluntary sector education the East of England Strategic Health Authority and our staff.

This new document takes the strategic vision and goals outlined in our Strategy for Healthcare and describes in more detail how we intend to achieve these goals. We also detail how we will ensure the strategic goals and clinical vision outlined in the East of England documents Towards the Best, Together and Improving Lives, Saving Lives are delivered for local people and the national Our NHS, Our Future, The NHS Next Stage Review led by Lord Ara Darzi.

These documents, together with the views of local people and stakeholders and a thorough assessment of health needs in our area, form the basis for our strategic plan for the next five years.

This plan sets out our overall vision and goals. It does not encompass all our business or plans, neither does it go into operational detail. Separate strategies for commissioning, finance, IM&T, estates, communication, patient and public involvement and workforce underpin this strategy. The business as usual elements are dealt with by our operational planning cycle, ensuring we meet national targets set by the Department of Health and Healthcare Commission. A summary of our goals, initiatives and priorities this plan details are set out in Appendix 1 of this document.

Overall, the original strategy was very well received and our ambitious and far-reaching proposals were noted and welcomed in several quarters. As a result of the feedback we have strengthened our strategy relating to patient experience and patient safety. In addition, people wanted specific priorities and targets to be set so we can be measured on the delivery of our promises over the coming months and years.
Our strategic plan emphasises our commitment to working with partner organisations and the public to improve the health and wellbeing of the people of west Essex and to achieve maximum value from the money we spend. We will do this by concentrating our resources on areas of greatest need, and by using hard evidence to indicate where the greatest benefit will be gained.

We are still a relatively young organisation at just over two years old. In that time we have already achieved a great deal, particularly in:

- consulting local people on their view of local healthcare services so we understand how we should improve and extend them
- finding out what support local people will need for improving their health
- reducing waiting times for people needing an operation
- improving the care people get at home so they can avoid having to go to hospital unnecessarily, particularly at the end of their lives.

We are justly proud of our achievements, which are listed in detail later on in this document and of the hard work of NHS staff in west Essex. However we are aware there is still much work to be done.

As the local leader of the NHS in west Essex, we strongly support the valuable contribution the thousands of staff that form all our providers of NHS services make to the health and wellbeing of the people we serve. The existing network of acute hospitals, community hospitals and community nursing teams, health centres, GP practices, dentists, optometrists and pharmacies has given the public access to a wide range of healthcare services, in hospital and, increasingly, in the community. The challenge is to build on these strengths to improve local access whilst ensuring services are safe and sustainable into the long term.

We are committed to ensuring local people have an opportunity to work with us in making this a reality and we will urge people to hold us to account for achieving what is set out in this strategy. We are also committed to enabling local people to become more actively involved in the PCT.
Our Strategy for Healthcare in West Essex was the starting point of a journey towards better health. This strategic plan is the next stage in that journey and describes where we are now and what the next steps will be. Local people can expect yearly reports on the progress of our plans, the benefits achieved and, if things haven’t gone as planned, an explanation as to why.

We are confident we can fulfil our plans and look forward to working with you in realising our corporate goal of aiming to achieve the best in local healthcare. We thank all those who contributed to the development of this plan and for the comments and feedback we received during the original consultation for a Strategy for Healthcare and subsequently. These contributions have been invaluable in ensuring our plan will meet local needs.

Alan Tobias OBE
Chairman

Aidan Thomas
Chief Executive
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Chapter 1 Our Vision, aims and values

We know people in west Essex:

- suffer from poor access to services, including health care, compared to most areas of the country - particularly in Epping Forest and Uttlesford
- are most often affluent but there are communities with high levels of deprivation which can adversely affect health and quality of life - this is particularly true for parts of Harlow, Waltham Abbey, Shelley and Debden
- have a higher than average older age range in Epping Forest and Uttlesford compared to other parts of the country
- in common with many other areas, people, particularly if they are elderly or suffering from a long-term condition, spend too long in hospital and are often admitted when alternatives in the community could prevent this
- face massive levels of planned population growth and housing development which will place pressure on health services
- have good primary care services but do not feel these can always be easily accessed
- use a local NHS which has mostly been financially stable but will not have the same level of growth in the future that it has seen in the last ten years.
- use an NHS which faces a big challenge to maintain financial balance and meet its national and essential local NHS targets over the next two to three years.

In summary, west Essex faces the following challenges:

- the need to make services more accessible for our communities
- the need to manage the hugely increased pressure placed on institutional (hospital) services by the combination of population growth and the growth in numbers of older people
- the importance to the health of older people and also to those suffering long-term conditions of ensuring hospitalisation only happens when absolutely necessary.

Our vision for meeting these challenges is to adopt the following seven strategic aims which have been supported by local people and local partner agencies in our consultation.
We will:

1. move health services into, or closer to, people’s homes wherever this is safe and viable. In particular we will do significantly more to support older people and people with long-term conditions at home, avoiding the need for hospital admission wherever possible

2. work closely with our partners in local government, schools and the voluntary sector to demonstrably improve health particularly in the more deprived parts of west Essex

3. work closely with GP practices, dentists, pharmacists, optometrists and community staff to significantly improve access to, and the scope of, primary care avoiding the need for hospital-based care wherever possible, including mental health and children’s services

4. establish services that work more effectively and directly with A&E departments to avoid unnecessary emergency admissions

5. work with providers of NHS services in west Essex to ensure services are of the highest quality, safe and offer a positive experience for all who use them

6. ensure we stay within the budgets provided by the taxpayer:
   a. by prioritising all investments
   b. improving efficiency
   c. stopping services which are not cost effective or evidence based

7. meet the national Government and Healthcare Commission targets for the NHS.

If we realise this vision in five years we will have transformed the health of local people and the health services they access. A summary of our goals, initiatives and priorities this plan details are set out in Appendix 1 of this document.

Every town will have modern, high quality, accessible and responsive primary care offering an additional range of diagnostic and outpatient services open at convenient times and to the wider community.
People living in the poorer parts of west Essex will have specifically accessible services to encourage and support healthier lifestyles, and evidence will be emerging of people living longer and healthier lives in these areas.

People with long-term conditions will have comprehensive support managed across pathways including case management based in every town and in each neighbourhood in Harlow, specialist nursing care for each of the major conditions, self-help for each of the major conditions as well as focused help for carers jointly and self-commissioned with social services. Fewer people will need to be admitted to hospital and they will report improvement in their quality of life.

Services will be designed to offer older people suitable alternatives to hospital care wherever possible. When they do need to go into hospital, enabling them to return home as soon as possible will be a major priority.

If people need to be referred to hospital they will have a choice of providers similar to today but they will experience services that are more effective, safer and individualised to their needs. Fewer people will attend Accident and Emergency (A&E) because of more accessible and responsive local primary care and effective signposting to appropriate urgent care services.

Children and their families will be supported by generic assessment services which will then offer a range of specialist services and case management for the most needy. By supporting children to have healthy lives we will start to see a reduction in childhood obesity. Services will be particularly, although not exclusively, focused on the poorer parts of west Essex. Teenagers will be able to access health services designed for them and by them, providing a range of specialised sexual health and healthy lifestyle services. We will start to see a reduction in teenage conceptions.

There will be an accessible primary mental health service in every town for people with mild to moderate mental health problems, and assertive care in the community, supported by in-patient provision where necessary, for those with severe and enduring problems.

There will be a network of services for those suffering from dementia and for their carers, closely integrated with social care services and the voluntary sector.

Services will allow people to die at home if that is their preference - over 76% of people in west Essex say they would prefer to die at home.

We will have achieved all this by working closely with patients, their carers, the local community, our partners in the voluntary and statutory sectors and providers of local services.
Delivering our strategic aims - five-year promises

A year ago, when we consulted local people and partners on our strategic aims we promised that within five years we would deliver a set of goals and initiatives that would achieve these aims. Some of these promises we have already delivered (see chapter 4). The remainder we have reviewed and revised in the light of new policy and guidance. These are set out below together with the 11 pledges that form the vision for improving health for everyone living in the east of England region, which we are committed to delivering locally in west Essex.

By 2014 we will have met our strategic aims by delivering the following.

1. Moving health services closer to people’s homes.

*We will have:*

- improved the lives of those with long-term conditions by increasing the availability of primary care and home-based support and, in particular, self-help programmes for people with long-term conditions (pledge 7)
- reduced elective referrals to acute hospitals to a level below the current monthly average
- reduced the number of outpatient hospital appointments by 25% from 2008-9 baselines for certain specialty

2. Working closely with our partners to improve health particularly in the more deprived parts of west Essex.

*We will have:*

- addressed areas of inequality identified in our health need assessments, reducing the gap in life expectancy as determined by gender specific Middle Super Output Areas (MSOAs) between the lowest and highest to no more than ten years, and to ensure the highest life expectancy does not fall below 85 years (pledge 8)
- halted the rise in childhood obesity, then seek to reduce it (pledge 11)
- reduced levels of adult obesity
- ensured fewer people suffer from, or die prematurely from, heart disease, stroke and cancer, particularly focusing on the poorest 20% of our community (pledge 5)
- reduced the incidence of smoking in the overall population to less than 25% (Pledge 10)
• extended and co-ordinated parenting support in areas identified as deprived
• increased the uptake of MMR immunisations to national levels at a minimum
• further rolled out the chlamydia screening programme to at least 15 per cent of the local population aged under 25
• increase the uptake of cervical and breast screening programmes to the national target levels as a minimum
• ensured the same level of healthcare is as available to looked after children and those with a learning disability as it is to the rest of us (pledge 9).

3. **Significantly improve access to, and the scope of, primary and community care.**

*We will have:*

• improved access to GP practices and introduced more flexible opening hours at each practice (pledge 3)
• developed a clear plan with partner agencies to enhance and mainstream learning disability services
• delivered new health premises in the community as identified in the strategy
• established palliative care and end of life services and extended the Gold Standard Framework to all areas, ensuring people received their preferred place of care
• extended access guarantees to more of our services including mental health services (pledge 2)
• extended the primary mental health services through the Improving Access to Psychological Therapies programme and the wider availability of cognitive behavioural therapy
• ensured NHS primary dental services are available locally to all who need them (pledge 4).

4. **Avoid unnecessary emergency admissions.**

*We will have:*

• developed a seamless urgent care pathway that will integrate services across acute trusts, ambulance trusts, GP out-of-hours services, provider organisations and social services to:
  ◊ avoid unnecessary emergency hospital admissions
  ◊ ensure people needing urgent care can easily access the most appropriate service to meet their needs
• ensure services for people with long-term conditions are focused on preventing the need for hospital admissions (see point 1).
5. Ensure services are the highest quality, safe and offer a positive experience for who use them.

We will have:

- embed patient experience, patient safety and infection prevention and control indicators in all our contracts
- achieved year-on-year improvements patient experience (pledge 1)
- make patient safety a priority for all our services and ensure they are the best in England (pledge 6)
- measurably reduced the MRSA and clostridium difficile infection rates in our key providers.

6. Ensure we stay within budgets.

We will have:

- by prioritising all proposed investments to ensure we get the most for local people
- improve efficiency where NHS west Essex is not as efficient as it can be
- systematically review all services to ensure they are cost effective and based on need and sound evidence of effectiveness.

7. Meet national government and Healthcare Commission targets and standards for the NHS.

We will:

- continue to meet all national targets for access to services including maximum 18 weeks referral to treatment, maximum four-hour wait in A&E and ambulance response times
**Investment priorities**

To achieve our vision and goals we will need to make sound financial decisions that ensure investments are targeted at achieving our strategic goals. The last decade has seen unprecedented investment in the NHS. This is unlikely to continue, particularly for west Essex where growth funding is less, due to our historically higher levels of investment compared with areas of greater need. We have therefore developed a financial plan to support our strategy that takes account of this more stringent financial environment.

We anticipate growth in funding over the period of this plan to be at a modest 5.2% and 5.1% for the next two years and then 4% per annum for the following three years. After inflation and increased demand as a result of population increase, this will give us approximately £16m to invest over five years. Our investment priorities will be:

- meeting our aim of shifting services closer to people’s homes requires a shift of resources from the acute hospital sector to primary and community care. Over five years we estimate this will see a significant reduction in acute activity. Although there will be some one-off costs to shifting services, we do not envisage any additional recurrent investment requirement

- significant investment in primary and community health facilities will be required to meet our commitments of improving access to and scope of primary care. Over the next five years this will be about £2.6m revenue cost

- investment in strategic initiatives, detailed in Chapter 3, of £13.2m over five years.

We will also review, over time, all our investments. Where money is being spent on services that are not cost effective, do not help us meet our strategic goals or are not effective or evidence-based, we will discontinue funding and re-invest the money more effectively. These decisions will always be taken within our ethical framework for decision-making.
Core values

In developing our plan to achieve this vision, we have been guided by a set of core values. These values are those that patients, local people, staff and our partners have told us are important to them. They are:

- patients and their carers are at the centre of all we do
- our staff are our most valuable resource and we will ensure they are trained, developed and supported in fulfilling their roles
- we will always work in partnership with:
  - local people
  - Patients
  - local authorities
  - voluntary organisations
  - local strategic partnerships
- we will treat everyone (patients, carers or staff), with dignity and respect and promote equity and diversity
- we will comply with all statutory, Department of Health and Strategic Health Authority requirements.
Chapter 2  West Essex today

This chapter sets out the context in which we have developed our strategic plan, the national policy and priorities; the factors that affect the health needs of our local population; the views and insights of patients, local people, our partners and other stakeholders; the organisations that provide NHS services for local people and the quality of the services they provide; and finally the current and future financial position of the PCT.

The national context

There are national and local factors that will influence how health services are provided and it is important to consider these as we assess future requirements. Planning for future health service provision needs to take account of the particular health needs facing our local population as well as the national health strategies that are developed to improve the health of the nation.

Creating a Patient Led NHS and initiatives like Your Health Your Care Your Say set out the Government’s strategy for health for the future. These describe an NHS where patients have more choice, where there are integrated networks for emergency, urgent and specialist care, where new primary and community services are developed and where all parts of the NHS contribute to health development and promotion for the population.

The White Paper Our Health, Our Care, Our Say set out a vision to provide people with high quality and responsive NHS services in the communities they live with a focus on bringing services closer to people’s homes and shifting care safely away from hospitals.

Lord Darzi’s next stage review final report High Quality Care for All describes the new foundation for a health service that empowers staff and gives patients more say and the right to choose. It ensures health care will be personalised and fair, include the most effective treatments within a safe system and help patients to stay healthy.

The White Paper Choosing Health— Making Healthy Choices Easier establishes a clear agenda for health development, setting out the responsibilities of PCTs and their partners to work together to improve the health of the population through a range of interventions. The aim is to set targets for all agencies which encourage and expect public and private bodies to work together focusing particularly on more deprived communities. This is reinforced in guidance issued to Local Government in Strong and Prosperous Communities. Recently, all statutory agencies and Local Strategic Partnerships have agreed the second Local Area Agreement (LAA) for Essex, which sets out our joint goals and targets for improving the health and wellbeing of people in Essex. The LAA will ensure we work effectively with our partners to deliver better outcomes for local people.
Local context

NHS West Essex\(^1\) covers three local authority areas Epping Forest, Harlow and Uttlesford plus the extra ward of Steeple Bumpstead in Braintree\(^2\).

The Epping Forest district is in the south east of Essex\(^3\) and is a mixture of rural and urban areas. It stretches northward from its boundary with Greater London into the heart of rural Essex covers 131 square miles. The key population centres are the commuter towns of Loughton (the largest town in the district), Chigwell and Buckhurst Hill, as well as the market towns of Epping and Ongar, and Waltham Abbey which lies in the Lea Valley.

Harlow is a small district on the west side of Essex bordering Hertfordshire. It is one of a number of new towns built in the 1950s to provide social housing to people living in London. Covering 12 square miles, the town was designed by architect Sir Frederick Gibberd and built on a theme of neighbourhoods around the town centre. Each of the original seven neighbourhoods has necessary amenities - shops, schools, church, health centre and district council neighbourhood offices. The aim across the town was to have large areas of green open spaces - most of which have been preserved.

Uttlesford district is in north-west Essex covering about 250 square miles. Uttlesford is predominantly rural but has major road networks running through it allowing easy access to London. It is just off the M11, making transport links into Cambridge to the north easy. It also has Stansted Airport within its boundaries. The main residential areas of Saffron Walden, Great Dunmow and Thaxted are all historic market towns with a wealth of beautiful and distinctive architecture.

\(^1\) Throughout this document NHS West Essex is used to refer to the area covered by all of this PCT including the ward in Braintree, while west Essex refers to the area covered by the three districts of Epping Forest DC, Harlow DC and Uttlesford DC.
\(^2\) When comparing information at a district level the ward of Bumpstead is not included unless stated.
\(^3\) Throughout this document Essex is used to refer to the county of Essex, which includes the unitary authorities of Southend-on-Sea and Thurrock. Where information only applies to the Essex County Council locality, the term ECC is used.
The health of people living in west Essex

As a whole, west Essex has better health than many other parts of the UK, however there are still huge challenges that need to be met to improve the health of local people, particularly those with more deprived backgrounds. Appendix 2 details the current health of the west Essex population. The following section highlights the key challenges for improving the health of our communities.

Demographics - key challenges

*Population growth and an aging population*

The registered population in west Essex is 283,123\(^4\). Projections for west Essex suggest increases up to 11% by 2021, with about a 63% rise in the number of people aged 85+ years and a 33% increase in 65+-year-olds. The major increase in the ageing population will be in Uttlesford and Epping Forest which presents challenges as are large rural areas with poor access to services.

Population increases due to housing developments will mean changes to the make-up of the population with more families with young children expected. An ageing population will mean an increase in patients with long-term conditions such as diabetes and dementia. These long-term conditions are important co-morbidities that impact on the ability to treat episodes of acute ill-health.

*Projected population changes*

West Essex is one of a number of growth areas in Essex identified for regeneration and growth. West Essex is expected to have a minimum of 27,500 new dwellings by 2021\(^5\).

These will be in the Harlow District Council area. There is also large-scale housing planned north of Harlow, in east Hertfordshire. This growth will have an impact on the health of the population with people from this area accessing services in Harlow and also people from Harlow accessing any new facilities developed as part of the new housing schemes.

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\(^5\) When comparing information at a district level the ward of Bumpstead is not included unless stated.

\(^4\) Throughout this document Essex is used to refer to the county of Essex, which includes the unitary authorities of Southend-on-Sea and Thurrock. Where information only applies to the Essex County Council locality, the term ECC is used.

\(^4\) this figure relates to the number of people registered with a West Essex GP. The figure for the resident population is 274,891 residents

\(^5\) Population and Housing Research Group at Anglia Ruskin University (Dec 2006)
Life expectancy and mortality in west Essex - key challenges

Mortality is a direct measure of healthcare need, reflecting the overall disease burden on the population, both the incidence of disease and the ability to treat it. Rates may be improved by reducing the population's risk (eg encouraging healthier lifestyles and reducing exposure to smoking) by earlier detection of disease and by more effective treatment. Life expectancy is correlated to mortality in that it is the number of years the average person is expected to live considering the mortality rates of the area.

Increasing inequalities

Overall west Essex is not considered to be deprived but it includes some of the most deprived areas in the country such as Staple Tye, in Harlow, as well as some of the least deprived in Uttlesford. Areas of high deprivation often experience significant health inequalities. Areas of high deprivation include large parts of Harlow, the north-east area of Waltham Abbey and small parts of Loughton and the Limes Farm area in Chigwell.

These inequalities are persistent and significant and are increasing in terms of death rates in people aged under 75. They are much larger for males and show few signs of reducing. Death rates for the general population have reduced over time due to treatment of circulatory disease but this is not the case for men from the most-deprived areas of NHS West Essex.

Figure 2.1: IMD 2007 by MSOA for west Essex
The average life expectancy of west Essex is 80.5 years, with the highest life expectancy by middle super output area (MSOA) of 83.5 years and a lowest of 74.9 years. There is considerable difference between males and females as can be seen in figure 2.2, with males in some parts of Waltham Abbey having a life expectancy of 72.9 years. Areas of low life expectancy in west Essex do not always map with the areas of highest deprivation, particularly in Harlow.

Figure 2.2: Life expectancy in west Essex by MSOA for 2005-2007 by gender
Harlow men

Harlow men have the lowest life expectancy across the three west Essex localities, and the second lowest across Essex. There is a 5.7 years difference in life expectancy between men and women in Harlow. The Harlow areas with the lowest life expectancy for males are Toddbrook, Bush Fair and Harlow Common.

Harlow men also have the highest mortality rate out of the three localities for most of the major causes, with particularly high rates in bronchitis, emphysema and other COPD mortality for all ages, circulatory disease mortality in under 75-year-olds and suicide and undetermined injury mortality for all ages.
Life expectancy at birth


Directly age-standardised rates mortality from all all causes per 100,000 population for <75 year olds (three year rolling average)

Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 2.3: Life Expectancy by gender and district 1991-2006

Figure 2.4: All causes mortality rate for under 75 year olds
Mortality by different causes

The chart below shows mortality rates in west Essex for the major diseases

![Pie chart showing causes of death in West Essex, 2006]

Source: Vital Statistics tables 2006, ONS

Figure 2.5: Causes of death for all people in west Essex in 2006
Key points to note are:

- deaths from circulatory disease in under-75s are lower than national rates in all localities except for Epping Forest males and females, which in recent years have been increasing

- cancer mortality rates overall are similar to or lower than national rates with the exception of Epping Forest where it has recently increased to above the national rate. Particular trends to note on cancer mortality are:
  - lung cancer mortality is increasing in females
  - prostate cancer mortality is increasing in Uttlesford
  - in Uttlesford cancer mortality for women had been increasing but has recently shown signs of decreasing again
  - there is a two-fold difference in premature cancer death rates between MSOAs in west Essex. With the lowest in the rural patch east/south east of Saffron Walden and the highest in the north area of Great Dunmow (both are in the Uttlesford locality)

- mortality from respiratory diseases causes a higher proportion of deaths in Harlow (17.3%) than in either Epping Forest (14.6%) or Uttlesford (16.5%). A large proportion of respiratory disease mortality is linked to smoking

- Harlow and Uttlesford have had high and increasing suicide rates in men in the last few years though they now show signs of decreasing. Recently there have been increasing suicide mortality in females for all localities

- men have higher death rates than women for a range of causes amenable to healthcare (clustered together as a single indicator) and they are falling at a slower rate than females. Death rates from these causes are lower in all localities in west Essex than nationally.
Long-term conditions - key challenges

Older people and long-term conditions

With a growing and ageing population we are likely to see an increase in the number of people being diagnosed and living with long-term conditions. For example a 44% increase in number of diabetics by 2025. An increase in long-term conditions will exacerbate if current lifestyle patterns persist, for example increasing obesity. All these factors could result in increased hospital admissions and longer length of stay when the long-term condition is a co-morbidity factor impacting on the treatment of an acute period of illness.

Diabetes

The estimated prevalence of diabetes in NHS West Essex is 4.2% - below the national average of 4.5% but similar to the regional average of 4.3%. Of the three west Essex localities, Epping Forest has the highest prevalence of 4.5%. Diabetes is forecast to increase with an ageing population and if trends with obesity persist.

Coronary heart disease

Estimated prevalence of coronary heart disease in NHS West Essex in 2008 for over-16s is 5.4% - just below the national average of 5.6%. Of the three localities Harlow has the highest prevalence with 5.8%, Epping Forest 5.1% and Uttlesford 4.4%. In all localities men have a higher prevalence then females and the prevalence is expected to increase across the board.

Hypertension

Estimated prevalence of hypertension in NHS West Essex in 2008 for over 16-year-olds is 31.5% for 2008 - just above the national average of 30.3%. Of the three localities Uttlesford has the highest prevalence with 30.6%, Epping Forest 29.7% and Harlow 30.2%. In all localities men have a higher prevalence then females and the prevalence is expected to increase across the board.

Cancer

The rates for all cancers in Harlow and Uttlesford fell from 1997-1999 but are above the east of England and national rates. The rate for Epping Forest is just below eastern and national figures.
Urological and prostate tumours occur at the highest incidence in all localities while tumours of the digestive tract are second highest in Epping Forest and Uttlesford and third highest in Harlow.

**Chronic obstructive pulmonary disease (COPD)**

Estimated prevalence of COPD in NHS West Essex in 2008 for over-16s is 3% - below the national average of 3.6%. As men have a higher prevalence then females, prevalence is expected to increase as the male population increases.
Mental health

In west Essex, there is a higher prevalence rate for mixed anxiety and depression compared to the national average (9.9% for west Essex and 8.8% for England). More specifically, anti-depressant prescription data highlights that Uttlesford has a higher rate compared to Harlow and Epping Forest. However both Uttlesford and Harlow have a higher prescription rate than the West Essex average. There are higher suicide rates in males in both Harlow and Uttlesford.

Dementia

With an ageing population the number of people estimated to have dementia will increase over the coming years with most of the increase in the 85+ age group. The impact of this increase on services and carers is likely to be very significant.

Chronic kidney disease

Estimated prevalence of chronic kidney disease (CKD) stages 3-5 for NHS West Essex is 9.1% - just below the regional average of 9.2% with nearly 19,500 people estimated to have chronic kidney disease.
**Lifestyles - key challenges**

**Obesity**

In England two-thirds of adults and a third of children are either overweight or obese and without action this could rise to almost nine in ten adults and two-thirds of children by 2050⁶. Child measurement data in 2007 showed one in 11 reception children and one in six Year 6 children were obese, with particular problems in Harlow and Epping Forest. It is estimated adult obesity in west Essex is about 24%. Harlow has the highest prevalence of obesity in west Essex with 26.8% - the highest in Essex and just above the regional average of 26.6%. Both Epping Forest and Uttlesford are estimated to have a prevalence well below the regional and national averages with 22.9% and 22.6% respectively.

**Smoking**

Smoking is the UK’s single greatest cause of preventable illness and early death, half of all smokers will be killed by their habit with most dying from the three main diseases - cancer, COPD and CHD. With the high mortality rates for these conditions in some of the more deprived areas of west Essex, smoking is a risk factor that contributes to these high rates.

Nationally the prevalence of smoking in the adult population is estimated at 24%. New experimental statistics have estimated Harlow has a smoking prevalence of about 30%, higher than regional averages and the second highest in east of England. The other localities in west Essex are below the regional average.

Work locally on the use of stop smoking services has shown not enough men from deprived groups are accessing the services and those that do are less likely to quit. Targeting these groups with services that more meet the needs of this population will be required.

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**Sexual health and teenage conceptions**

West Essex has significant challenges in the area of sexual health.

The most common sexually-transmitted infection in young people is chlamydia. NHS West Essex has the second highest rate of chlamydia infections in Essex. At a locality level, Harlow had the highest out of all the local authority areas, well above the national average. Recent work locally on the use of the chlamydia screening service has shown we are not getting enough men screened and are not reaching enough 20-24 year olds for screening.

**Figure 2.7: Trends in chlamydia rates in west Essex for 2006 by local authority area**

Source: Essex Health Protection Unit, 2008
Harlow has always had a high teenage pregnancy rate. Baseline figures from the teenage pregnancy strategy show in 1998 the rate was 48.8 per 1,000, compared to an Essex and national average of 36.9 and 46.6 respectively. The National Teenage Pregnancy strategy set targets for local authorities to decrease these figures by 50% by 2010. Harlow’s rate was 49.6 per 1,000 in 2004-2006 (three-year rolling average), the fourth highest in the east of England and an increase on the baseline. Harlow wards which have very high teenage conception rate are Staple Tye, Toddbrook, Netteswell and Sumners and Kingsmoor.

The teenage conception rates for Epping Forest and Uttlesford are below the national and regional rates but have both started to show increases.

*Alcohol misuse*

Alcohol misuse has become a serious and worsening public health problem in the UK. The misuse of alcohol, chronically heavy drinking or binge drinking all pose threats to health such as high blood pressure, mental ill-health and liver disease, and to society through crime and anti-social behaviour. Up to 18% of adults in west Essex are reported to be engaging in hazardous drinking (regular drinking between 22-50 units for men and 15-35 for women each week). Furthermore 15% of adults are binge drinking.

Consequently, the number of hospital admissions attributable to alcohol has been increasing yearly since 2003. This has major complications in terms of cost to the health service and lost working days through alcohol-related absence.
Health protection - key challenges

Access to services

Immunisations and screening services are two areas where there is good provision but low uptake rates in certain areas across west Essex. Epping Forest has low rates of MMR vaccinations and Harlow has low cervical screening rates. Not only do we need to consider the geographical barriers to services but also whether they are; for example are they open at the most convenient times is the population aware of what is available to them.

Childhood immunisation rates

Within west Essex the percentage of children having the relevant vaccinations by the time they are 12 months old is similar to the regional average but below the 95% target (Figure 5.1). By the time children are 24 months old the percentage being vaccinated increases slightly to about the 95% mark except for the MMR vaccination which is about 84%. At a locality level Epping Forest consistently has lower immunisation rates in children than the rest of west Essex.

Cervical screening rates

West Essex coverage is slightly above the national average at 79.4%. However, coverage is considerably lower than would be expected in a population such as west Essex and ranks tenth out of 14 in east of England. The most recent data for 2007-08 is for quarter three and gives west Essex a coverage rate of 78.9%. There is considerable variation between practices in coverage of screening.
Engaging patients, the public, clinicians and local stakeholders

Real engagement is not about ticking boxes it is about us developing constructive relationships, building strong partnerships and communicating effectively. For patients' experience of health services to really change for the better, we have to have ongoing and meaningful dialogue with them, their carers and the public about improving and developing services. By doing so we will:

- learn more about patients’ experience of the local NHS
- make sure our services are designed and adapted to respond better to patients’ needs
- tap into the enthusiasm and energy of patients, the public and local communities to make long-term improvements
- develop and encourage closer relationships between staff and patients
- improve the quality of the care we are providing
- identify ways of meeting patients needs more appropriately
- be able to use the information provided by patients and the public to help them make improvements
- make sure changes make sense to those who are affected by them.

Increasing our community engagement will support us to gain a stronger understanding of the needs and priorities of our community so we can shape services around the patient and target them where they are needed most to help reduce health inequalities.

In this section we set out what we have achieved and our plans to further improve our engagement and involvement with our local community and the wider health economy.

Engagement needs to be embedded at all levels of planning and decision-making, from large conferences with facilitated workshops, where everyone with an interest is invited to attend, through to individual lay representatives who give a patient and carer view to the main decision-making group.
The following diagram illustrates the pyramid of involvement.

- **Reps**
  - Usually time-limited involvement with PCT. Views shape a specific

- **Focus groups**
  - Patient interest groups
  - Small numbers of people - maximum 20

- **Conferences and large public meetings**
  - Large numbers of people – interested parties, voluntary sector, members of the public, patients, carers, staff, managers, partner agencies

- **High numbers, more distance from direct decision-making.**
  - Usually a one-off meeting or repeated annually

- **Low numbers, high influence.**
  - Carer and patient reps on planning groups – meet regularly
How we have consulted so far

NHS West Essex made a firm commitment in its Strategy for Healthcare 2007-2012 to always engage and consult with local people and stakeholders and continues to stand by this promise. We have conducted a number of significant public consultations on a variety of topics. Without exception these generated considerable publicity and feedback. The following outlines the most recent consultations which stakeholders significantly influenced the outcomes.

Strategy for healthcare 2007-2012

We consulted widely on our Strategy for Healthcare 2007-2012 and received more than 300 responses.

Adult mental health services

NHS West Essex, as the host commissioning PCT for mental health services, led a consultation on behalf all PCTs in north Essex and North Essex Mental Health Partnership Foundation NHS Trust. The consultation, about adult and older adult services, detailed proposed changes to rehabilitation and recovery services, the creation of centres of expertise and continuing care for in-patient and day care services.

GP-led health centre

In response to Lord Darzi’s next stage review we worked with local clinicians and stakeholders in developing proposals for a GP-led health centre offering extended hours, enhanced diagnostic facilities and walk-in appointments as well as all routine general surgery activity.

Ongar War Memorial Hospital

Ongar War Memorial Hospital was built in the 1930s and while we recognised the affection with which the facility was held, the building could no longer meet modern standards for privacy and dignity and infection control. Through working with the local community the consultation process was positive and further input on how else the building could be used was received, including use by the mental health services and community groups.

More importantly, the local community is very positive about the new centre and feels it has ownership.
Harlow Walk-in Centre

In partnership with our main acute provider, Princess Alexandra Hospital, we consulted on changes to the Harlow Walk-in Centre and A&E department. It focussed on making the best use of the Walk-in Centre and A&E services so people would receive the right care in the right place.

Stansted clinic

In our Strategy for Local Healthcare we identified services provided to the people of Stansted and the surrounding areas, although of a high clinical standard, the environment they were in was inadequate.

We realised that, due to land pressures, the new health centre would need to be further from the town centre which caused community concern. By working with key stakeholders, we investigated all their concerns and proposed alternatives. This resulted in a consultation document and process which was robust and locally owned.
Engaging in the future

Our most important partners are local people, our service users and carers who know first-hand what the services we commission are like and have direct knowledge of what is needed locally.

For many people the NHS is a distant organisation which they have nothing to do with until they are unwell. Few think of it as a health service that can help them maintain, or improve, their health and wellbeing. The world class commissioning agenda challenges us to think how we change this attitude within our own organisation and, more importantly, in the wider community.

When people are involved in and can influence decisions which directly affect their lives, their self-esteem and self-confidence increases and this in turn improves health and wellbeing. Involvement in discussions about health services can help encourage social networks and cohesion within communities.

We cannot develop relevant services and policies without understanding patients’ needs. Neither is it cost-effective to develop a service only to have to re-design it if we find it does not meet those needs. Investing in engagement methods ensures we invest energy and appropriate resources into developing the right services.

This does not necessarily mean we will be able to respond to all the needs and wishes of the community. However, when we have to make difficult decisions about the allocation of scarce resources, we will endeavour to make sure patients views are taken into account and we will always explain why we came to those decisions.
We will:

- include local people in our decision-making and planning processes
- recruit people who use services as well as appropriate user and carer organisations or individuals when drafting, implementing or monitoring policies
- include user and carer representation on committees
- include user and carer input in all health and social care needs assessments
- provide training and induction for users and carers to help them participate fully in policy and strategy development
- embed engagement into the culture of the organisation through staff training, being part of all job descriptions, part of board reports and as part of staff induction
- recognise we engage with the interested few and there is a silent majority who neither belong to a voluntary group, are disadvantaged or unwell.

Many existing networks are already effective at engaging with local people and local groups. We will work with them where they are appropriate and fit for the purpose.

Local authority engagement teams have a vast experience of engagement through well established links with the community and voluntary sector groups. Through these fora and LINks, we can engage with local people. We will promote innovation in public involvement, where new techniques can be piloted, evaluated and shared to improve the way statutory and voluntary groups engage with each other and the wider public. To do this we will engage a number of methods, some of these are set out below.

**Direct contact**

Working with GP surgeries we will contact every registered patient to advise them of health improvements, practice improvements, service developments and items of topical interest.

The aim is to include a form of incentive to feedback to judge the impact and usefulness of this engagement. We would aim to undertake this, at minimum, twice a year.
Media

In addition to the proactive and reactive press releases we plan to buy half-page advertorial space in the main local papers for the localities every other week. The topics will include health improvement messages, how to access and contact services, changes to opening times, service improvements, healthy lifestyle assistance, competitions and a Dear Doctor problem page.

Patient surveys and questionnaires

The local health services provides us with a national benchmark of our services. Its The previous results can be found later in this strategy. We will continue to use national benchmarking tool however will supplement it with additional surveys and questionnaires on specific topics and will work with GP surgeries in targeting people with specific health needs.

Internet and electronic media

Many people’s first contact with an organisation is through its internet site and we are redesigning our website to provide wider information, improved feedback and links to useful websites, including the extended opening times of local surgeries, dentists and out-of-hours care. Further developments include messaging boards, blogs following people tackling health issues such as stopping smoking or losing weight, and social networking.

Telephone helpline

The Patient Advice and Liaison Service offers a free phone service on weekdays and we plan to extend this to cover a wider information base such as the performance of secondary care providers to assist in the choice process and availability of dentists.

Membership group

We plan to utilise the foundation trust membership model to engage the wider community. We plan to write to all our registered population inviting them to become involved at any level, for example from proof reading information to attending meetings. A training package for lay members has been developed so they can actively participate and have a budget allocated to assist with expenses.
User consultative forums

We have a very successful existing user consultative forum in the Epping Forest locality and plan to expand this model across the other localities. The current forum meets every quarter, has a constitution agreed with the PCT, self selects a chairman and decides on the agenda.

Health fora and panels

We have employed this model when developing the consultation documents for the Ongar and Stansted consultations and will expand this to include exploring local views on specific issues as well as wider decision-making.

Exhibitions

The aim would be to convey information in a visual way to engage audiences such as in shopping centres, at town shows, workplaces and schools.

Seminars and conferences

Topic specific and targeted conferences will be held across west Essex as required. Facilitators, sign language, crèche facilities, transport and disabled needs would be considered.

Meetings with existing groups

We have engaged with the voluntary sector support organisations across west Essex to identify and directly engage with established groups.
Be held to account

We are monitored and scrutinised to make sure we carry out our duty under Section 11 of the Health and Social Care Act (soon to be Section 242 of the Health and Social Care Act 2006). We need to be accountable to the local people we are involving for the process we use.

Given the complexity of decision-making, we will be more accountable to local people by being clear about how decisions were made and how factors are balanced and weighted against each other.

Feeding back

Feeding back to those who have been involved is essential as people have given their time and personal views. This is critical to make sure participants can see how they have influenced change. Positive feedback can lead to feelings of satisfaction, competence, accomplishment and increased self-esteem. People understand practical problems and constraints as long as we are open and honest about them. We will report back with:

- what has been done as a result of what has been said
- what is going to be done and when
- what is not going to be done and why.

We will be explicit about the results of public involvement by including:

- what the views were and were there any differences
- what was the final decision(s)
- how were the views balanced, used and weighted in the decision-making process alongside other factors
- explaining the basis on which the decision(s) were made.

Having determined what we need to feedback to the public we will make sure we reach as many people as possible through methods described earlier in this section.
Resources

Engagement does not come free. It needs resources - money, people and time.

Community members involved in the planning and decision-making process should not be out of pocket as this can be a major factor in preventing people being involved properly, leading to under-representation. We have an allocated budget and procedure to reimburse people for their involvement.

We plan to expand our engagement team to enable us to facilitate events and support campaigns across the health economy. A dedicated budget to purchase merchandise and provide materiel has also been allocated.

Skills needed to involve the public

Engagement is not one person’s job and must not be seen as marginal to all other peoples’ responsibilities. It will be included in staff induction and added to all job descriptions. We will identify champions in each directorate to feedback into the evaluation process.

We recognise health professionals may need additional skills to help them to effectively involve the public in health and social care decision-making. Consideration will be given to patients as teachers as they are able to offer a different perspective.

Evaluating our engagement

The main purpose of an evaluation is to indicate the level of success achieved or to offer the opportunity to explore and record the reasons for failure. Evaluation should also be a learning process embedded in the development of the initiative. It will help us check whether the information and views obtained from our initiative have been put to good use.

Evaluation will be undertaken through processes such as questionnaires, focus groups, discussions with groups and individuals.
Engaging our clinicians

We have a successful history of engaging with the clinical community in its wider sense. We believe clinical engagement and clinical leadership is essential in commissioning effective services. It is recognised clinicians have the vision to re-design services to ensure they are both responsive and effective for the people of west Essex.

We have established and effective Practice Based Commissioning groups, a Professional Executive Committee (PEC) which represents the whole of the health economy and strong PCT locality teams that support practices and independent contractors on a one-to-one basis.

Strong clinical leadership is essential to effect transformational change which helps to overcome barriers across organisations both within and outside of the NHS. Clinicians are uniquely placed to lead change by utilising evidence-based practice whilst keeping the focus on the patient.

Practice based commissioning (PBC)

PBC is a key lever for change and development of services in west Essex and our PBC groups will be instrumental in the delivery of this strategy.

As well as taking a lead role in driving commissioning strategy, we will encourage practices to extend the scope of services they provide. We will achieve this through a Market Management and Procurement Strategy that will support the development of new providers and attract new providers where plurality of provision is needed to drive up quality or provide choice.

Professional Executive Committee (PEC)

The PEC will support the PCTs’ central roles of tackling health inequalities and improving health through commissioning and provision. This will be achieved through strong clinical leadership and active clinical engagement.

The PEC will also take a lead role on behalf of the Board in examining PBC proposals and setting the agenda for practice based commissioning groups. The group, chaired by an elected GP who is also a Board member, is reflective of the west Essex health community.
Engagement with social care and secondary care providers

We have established links with social care however recognise much of the health inequality work cannot be achieved without strengthening partnership working. We play an active part in the Local Strategic Partnerships and will continue to drive forward this agenda.

Our relationships with all our secondary care providers will also need to be further developed. Delivery of the world class commissioning agenda will see us review and possibly tender for work that has traditionally always been placed with the local secondary care provider.

To improve engagement further we plan to assess gaps and agree on a process of engagement so service development and service re-design can be enhanced with all our secondary care providers.
Managing our performance

NHS West Essex has been in existence since October 2006 and has therefore undergone two Healthcare Commission Annual Health Checks. Below is a summary of our overall performance for 2007-08 and 2006-07.

The combined ratings for 2007-08 have put us in the top four in the east of England and among the top performers in the country.

<table>
<thead>
<tr>
<th></th>
<th>2007-08</th>
<th>2006-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of services</td>
<td>Fair</td>
<td>Good</td>
</tr>
<tr>
<td>Use of resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of services</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>Use of resources</td>
<td></td>
<td>Fair</td>
</tr>
</tbody>
</table>

Use of resources

For use of resources our score moved up from ‘Fair’ to ‘Good’.

<table>
<thead>
<tr>
<th>Target areas</th>
<th>2007-08</th>
<th>2006-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial reporting</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Financial management</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Financial standing</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Internal controls</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Value for money</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
Quality of services

For 2007-08 we fully met all our core standards and fully met our existing national targets but were weak on achieving the new national targets which took our rating from good to fair on the quality of services indicator.

The drop from ‘Fully Met’ to ‘Weak’ for the new national targets was a disappointment. However the targets where performance was poor were areas already known to be problematic. There are now plans in place to address them. The Healthcare Commission reviews performance over the previous year and in some areas where we failed, such as infection control, we have already seen huge improvements since April 2008 when the commission undertook its review.

<table>
<thead>
<tr>
<th>Score</th>
<th>Dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/12</td>
<td>Safety and cleanliness targets</td>
</tr>
<tr>
<td>7/7</td>
<td>Standard of care targets</td>
</tr>
<tr>
<td>2/4</td>
<td>Waiting to be seen targets</td>
</tr>
<tr>
<td>9/11</td>
<td>Dignity and respect targets</td>
</tr>
<tr>
<td>6/7</td>
<td>Keeping the public healthy targets</td>
</tr>
<tr>
<td>15/16</td>
<td>Good management targets</td>
</tr>
<tr>
<td>13/15</td>
<td>Commissioning services targets</td>
</tr>
<tr>
<td>15/21</td>
<td>Planning for local improvement targets</td>
</tr>
</tbody>
</table>
New national targets

A breakdown of our performance in this domain shows we achieved well for the following indicators:

Indicators achieved:

- improve the quality of life and independence of vulnerable older people by increasing the proportion of older people being supported to live in their own home by 2008
- increase the participation of problem drug users in drug treatment programmes by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes
- reduce health inequalities by 2010
- reduce adult smoking rates by 2010
- secure sustained national improvements in NHS patient experience by 2008
- halt the rise in obesity among children by 2010 as part of a broader strategy to tackle obesity in the population as a whole
- improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk
- reduce emergency bed days by 2008 through improved care in primary care and community settings for people with long-term conditions.

Weak indicators:

- achieve year-on-year reductions in MRSA levels, expanding to cover other healthcare associated infections as data from mandatory surveillance becomes available.
- reduce the under-18 conception rate by 2010 as part of a broader strategy to improve sexual health.
- substantially reduce mortality rates by 2010 from suicide and undetermined injury.
- substantially reduce mortality rates by 2010 from cancer.
- substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases.
- Ensure that by December 2008 nobody waits more than 18 weeks from GP referral to hospital treatment.
Of the indicators where our performance is ‘weak’ we have either already taken action or highlighted it as an area for improvement within this strategic plan. These are:

**Action taken:**

- MRSA levels
- 18 Week from referral to hospital treatment

**Areas for improvement:**

- reducing under-18 conception rates forms part of our plans for reducing health inequalities
- reducing mortality rates from cancer is a key goal in our strategy, as is reducing heart disease mortality rates
- reducing deaths from suicide also falls into our strategy for improving mental health services.

We have action plans for improvement in place for other areas where we performed below average. These are:

- access to general practice
- offering patient choice as to where they are referred, and being able to book a convenient appointment at the time of their referral
- achieving the target of screening for chlamydia.
What patients think about our services

Below is a summary of the national patient survey results for the PCT. The questions are grouped together by theme and based on patients’ responses in this year's survey. We scored as follows:

<table>
<thead>
<tr>
<th>Score (out of 10)</th>
<th>For questions about</th>
<th>How this compares with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3</td>
<td>Making an appointment with a doctor</td>
<td>about the same</td>
</tr>
<tr>
<td>5.0</td>
<td>Visiting the GP practice or health centre</td>
<td>worse</td>
</tr>
<tr>
<td>8.8</td>
<td>Seeing a doctor</td>
<td>about the same</td>
</tr>
<tr>
<td>8.2</td>
<td>Medicines</td>
<td>about the same</td>
</tr>
<tr>
<td>5.3</td>
<td>Being referred to a specialist</td>
<td>about the same</td>
</tr>
<tr>
<td>7.4</td>
<td>Seeing another professional from a GP practice or health centre</td>
<td>about the same</td>
</tr>
<tr>
<td>7.9</td>
<td>Overall views and experiences</td>
<td>about the same</td>
</tr>
<tr>
<td>5.8</td>
<td>Health promotion</td>
<td>about the same</td>
</tr>
</tbody>
</table>

A more detailed analysis of the survey results has been used to inform our strategy for improving patient experience. See chapter 3.
National comparisons

The following were areas respondents (86% of whom had seen a GP in the last 12 months) thought we had performed well:

- 83% thought the doctor listened carefully to what they had to say
- 76% thought they had enough time with the doctor
- 70% were involved as much as they wanted to be in decisions about their care and treatment
- 77% had confidence and trust in their doctor
- 82% thought the doctor knew enough about their condition/treatment
- 93% felt they were treated with respect and dignity.

Appointments

The survey showed an increase in the number of patients allowed to make an appointment three or more days in advance:

- 62% [61%] seen within two working days and 14% had a pre-planned visit. About one in five patients (20%) wait more than two working days, a slight improvement from the 2005 survey
- 44% gave the reason as unable to see any doctor, 36% wanted to see their own GP
- 57% reported they were able to make appointments three or more working days in advance. The remainder were either unsure if they were able to' (23%) or felt this option was not open to them (20%). A 3% improvement in awareness from 2005.

Visiting a GP practice or health centre

It appears the courtesy of the receptionists in the surgeries increased slightly however the time patients have to wait after their appointment time worsened and remains high, with little communication of how long this will be.

- 86% felt the courtesy of receptionist as excellent or good. Whilst 10% rated reception as fair and only 2% as poor
- 71% [68% in 2005] of patients were seen within 15 minutes of their appointment time. 24% [28% in 2005] were waiting for 16 minutes or more
- Only 10% of respondents were told how long their wait would be. 41% ‘would have liked to have been told’ how long their wait would be but were not. 46% of respondents were not told ‘but did not mind’.
Seeing a doctor

The survey showed a slight improvement in doctors listening carefully to what the patient was saying (1% increase) and a significant increase (3%) in the number who thought they had been treated with dignity and respect.

A quarter of patients (26%) felt they should be more involved with the decisions about their care but 90% felt they had received answers to their questions that were easy to understand.

There was a slight decrease (1%) in the confidence and trust that patients had in their doctors. However in the other areas the PCT was broadly in line with the national indicators.

Medicines

The latest survey shows patients are not receiving as much information as they would like about the medicines they are taking but have received slightly better service with checking how they are getting on with the medicines. The specifics are:

- 53% the respondents had been prescribed new medicine(s) in the last 12 months
- 60% [59%] felt ‘definitely’ involved as much as they wanted to be in the decisions about the best medicine(s) for them. However, 28% [28%] felt only involved ‘to some extent’ and 10% [12%] felt not’ being involved
- 80% [79%] felt they had sufficient information about the purpose of the medicine
- One in four patients (38%) [36%] lack enough information on side-effects
- 84% [85%] had information on how to use medication. However 11% [10%] would have liked more and 4% [3%] got no information
- Of those taking medicine(s) for 12 months+, 22% [21%] had not had their medication reviewed during this period.
Referrals

There has been a sharp decrease (6%) in the specialist not having the correct information on referral. However the number of patient recollecting as having been offered a choice of provider remains worryingly low:

- 34% of patients were referred to a specialist/hospital consultant
- 40% [24% in 2005] were given a choice of hospital for the first appointment

For patients (56%) not given a choice, 3 out of 4 (75%) did not receive an explanation from their GP as to the reason why they had no choice.

Out-of-hours care

There are two out-of-hours care providers for the PCT and across the west Essex area 82% had heard of NHS Direct.

- 16% tried to contact their GP when the practice was closed
- 58% had their call answered within a few minutes, 16% felt they had to wait a long time, and 23% of respondents were unable to get through to someone
- 46% felt the main reason for that contact had been dealt with to their satisfaction, 24% reported the reason for contacting the GP practice out-of-hours was dealt with ‘to some extent’ and ‘not at all’ was the answer from 22%.

Overall about your GP practice

Throughout each of the three surveys, the patients felt the GP surgeries were clean and tidy. The results between the 2005 and 2008 survey show an increased number of patients have experienced problems in getting through to their GP/health centre on the telephone (4%).

- Only 1% reported the GP practice or health centre to be not very clean
- 64% experienced a problem getting through to the practice on the telephone
- 23% have been put off going to the GP practice or health centre because the opening times are inconvenient.
Health promotion

Further questions were asked in the 2008 survey which were not previously included. On the whole there was only a small percentage of people who felt they were not given advice in the health promotion areas of diet exercise, weight loss and smoking. Other key areas were:

- more than a third (36%) of respondents had a long-standing condition (deafness, blindness, physical, learning disability, mental health, chronic illness etc). 40% of these patients had difficulty with ‘everyday activities that people their age usually do’
- 46% of respondents with a long-standing condition stated they had definitely received enough support from local services or organisations in managing their condition.

Dental Care

The 2008 survey shows 21% of respondents visit the dentist regularly with 78% being totally satisfied with the care they received.
Summary... positive, but room for improvement.

Have we improved since the 2005 survey?

A total of 24 comparable questions were used in the 2008 survey. Compared to the 2005 survey, your Trust is:

- Significantly BETTER on 6 questions
- Significantly WORSE on 0 questions
- The scores show no significant difference on 18 questions

The Trust has improved significantly on the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>2005</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment: should have seen a GP sooner</td>
<td>22%</td>
<td>16%</td>
</tr>
<tr>
<td>GP: did not listen carefully to what patient had to say</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>GP: not given enough time to discuss health/medical problem with GP</td>
<td>28%</td>
<td>21%</td>
</tr>
<tr>
<td>GP: did not explain reasons for treatment/action in understandable way</td>
<td>27%</td>
<td>22%</td>
</tr>
<tr>
<td>GP: didn't always treat with respect and dignity</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>GP practice/health centre: reason for visit not satisfactorily dealt with</td>
<td>28%</td>
<td>22%</td>
</tr>
</tbody>
</table>
The healthcare market in west Essex

Provider landscape

This section gives an overview of the network of providers that deliver healthcare services for the west Essex population, an analysis of the macro environment in which they operate and of the micro health-economy market locally.

The provision of services in west Essex largely conforms to a traditional model of healthcare. Most specialist services and treatments are provided from an acute hospital site with community services predominately provided by a single NHS provider (currently NHS West Essex provider arm). Similarly, mental health services are provided by one large NHS organisation, North Essex Mental Health Partnership Foundation Trust. Primary care is delivered through a network of mostly small independent contractors.

Changing environment

There have been many changes to the NHS over the last decade resulting in much improvement, particularly improved access. At the same time attitudes towards the NHS have also changed. Expectations have risen at least as fast as services have improved, while people are more aware of health issues and have access to more information about health through the internet and other media.

New medical technology and innovation has always been a feature of health services. Life-saving and life-extending drugs and treatments are adopted by the health service, improving the lives of many. Increasingly new technology will also focus on the way healthcare is delivered. As the population ages and demand grows, remote monitoring and management of conditions as well as supporting people to manage their own conditions, will become critical in the future development of services. An example that is already developing quickly is tele-medicine. It is proving successful in managing long-term conditions, particularly for older people and seems popular with patients.

In the next couple of years Connecting for Health will also start to deliver the improved patient information systems that will allow better integration of services resulting in more seamless and efficient delivery across different providers and agencies. These technological developments will enable health services to meet the growing demand effectively and allow our most precious resource, our workforce, to use their skills to best effect.
The NHS has had unprecedented increases in funding over the last decade. This will not continue. Growth is likely to be restricted to little more than inflation. This is particularly the case for NHS West Essex as historically it is an area that has received above average funding. The consequence of this more stringent financial environment will be the need for ensuring efficiency in all our services through robust commissioning, including the decommissioning of services that are not effective, are poorly performing or not value for money.

System management and the opportunities that come with a more open - if still regulated - health marketplace will require PCTs to become much more commercially savvy, taking a professional approach to managing the market and using it to lever choice and quality. Increasingly we will use market analysis to identify opportunities for market interventions, including the introduction of competition, to drive up quality, improve choice and extract efficiencies.
West Essex providers

The table below shows the main providers of services for the west Essex population, segmented by type of provider.
General hospital services providers

Patients in west Essex can choose between eight acute hospitals if they need to be referred. The concentration of acute providers is relatively low at 0.19 (East of England average 0.30)\(^7\). The majority of patients use six main acute providers. These contracts account for more than 95% of emergency admissions, 91% of first out-patient appointments and nearly 90% of elective admissions.

*Princess Alexandra Hospital NHS Trust (PAH)*

PAH is a relatively small district general hospital (turnover £153m) which is applying for foundation trust (FT) status. We support the application and every indication is it will achieve FT status in 2009-10. We are the lead commissioner for PAH which is our largest contractor, providing a near full range of hospital services. PAH is the only acute provider located within the PCT’s boundary.

PAHs FT plan includes assumptions about housing growth in west Essex and east Hertfordshire. In addition, reconfiguration of services in Hertfordshire is likely to impact on the level of activity that PAH will experience over the next five years. The transfer of acute services from QEII Hospital at Welwyn Garden City to the Lister Hospital in Stevenage may well see an increase, particularly in emergency activity, from Hertfordshire. Conversely the introduction of a network of Urgent Care centres may reduce A&E attendances from the Hertfordshire population. Planned changes at Chase Farm Hospital will also have an impact.

*Cambridge University Hospitals Foundation Trust (Addenbrookes)*

This is a large, internationally renowned Foundation Trust. Although it is the second largest provider of services to the PCT, providing both general and specialist services. This activity represents a very small part of their business.

*Whipps Cross University Hospital NHS Trust*

Whipps Cross is our third largest provider contract. The hospital is in Waltham Forest PCT’s boundary, in outer London, and they are the lead commissioner. Whipps Cross has been in financial difficulties for many years and is currently in the ten worst performing trusts. A recent service reconfiguration review (which included nearby Barking, Havering and Redbridge Hospitals NHS Trust) did not result in any significant change in provision.

\(^7\) PWC analysis on 2006/7 data
**Mid-Essex Hospitals NHS Trust**

This is the fourth largest provider of general services and includes the specialist burns unit. They are rated ‘excellent’ for quality of service and ‘fair’ for use of resources in the most recent Healthcare Commission ratings which show an improvement in use of resources from ‘weak’ in 2006-07.

**Barts and the London NHS Trust**

Although this contract is primarily for specialist services, there is a large element of general activity included in the contract. This is due to practices within the south of the patch referring into London through patient choice. They continue to be our key provider for specialist cardiac services.

**Barking, Havering and Redbridge Hospitals NHS Trust (BHRT)**

The trust provides a small level of activity mainly for patients of a single practice in Chigwell as it is in the London borough of Redbridge.

**Tertiary referrals**

We have a small number of patients who access other specialist hospitals such as Papworth and Great Ormond Street.
Independent sector providers

We contract mainly with two local private hospitals, Ramsay Rivers in Sawbridgeworth and Holly House in Buckhurst Hill, for a range of services available through the patient choice menu.

As west Essex is generally an affluent area there have been historically high levels of private referrals to local independent hospitals. In 2006-07 NHS West Essex had one of the lowest levels of expenditure with independent sector providers in the east of England. This is now changing. Since the reduction in waiting times and the introduction of the extended choice menu, we have seen a steady increase in the number of people choosing to access local independent hospitals for their NHS treatment. Although a proportion of the increased activity can be attributed to patients choosing an independent hospital rather than a local NHS provider, we estimate the majority of the increase is from patients who previously accessed health services privately. We are working with GPs and the local independent providers to estimate the impact of this increase in demand.

Patient flows (based on 2007-08 information)

Elective inpatient and day case:
- PAH accounted for 54% of all elective episodes
- the total number of elective episodes has grown at 8% per annum since 2005-06, with PAH growing more slowly at 5% per annum. Mid Essex Hospital and Barts and the London have shown significant growth of 22% and 17% respectively, suggesting a loss of share for PAH.

Out-patient attendances:
- PAH accounted for 57% of all first out-patient episodes with 4% growth per annum since 2005/06
- Mid Essex and Whipps Cross have show growth of 36% and 12% in first out-patient episodes
- follow-up rates have also grown by 4%, however PAH has reduced its follow-up rate by 1% whereas Cambridge University Hospitals Foundation Trust (Addenbrookes) has increased by 6%.

Emergency:
- PAH accounted for 63% of all episodes
- the total number of emergency in-patient episodes has grown at 6% per annum since 2005-06, with PAH slightly gaining share with growth of 9% per annum from Addenbrookes, which reduced activity by 6% in the same period.
Quality and safety

Healthcare Commission ratings for providers in west Essex range from ‘weak’ to ‘excellent’, with PAH improving in 06-07 and 07-08.

NHS Acute Trust Healthcare Commission Ratings

Of the 4 most frequently used acute trusts, Cambridge University hospital is rated most highly in the most recent healthcare commission ratings.

- Princess Alexandra hospital has improved rating in moth 06/07 and 07/08, with use of resources improving from fair to good in 07/08
- Cambridge University has maintained top ratings for both use of resources and quality of services
- Of West Essex’s key providers Whipps Cross has the weakest ratings, although improved for quality of services in 07/08

Source: HealthCare Commission, Deloitte analysis
HCAI Indicators

Princess Alexandra hospital is above the average for MRSA and CDiff in the top 10 acute providers. As the key provider for the PCT, this is highly relevant to West Essex.

MRSA cases per 10,000 bed days

CDiff cases per 1000 bed days

Source: WCC dataset
Better Care, Better Value Indicators

West Essex PCT’s top acute care providers performed broadly in line with national averages for reducing length of stay and increasing day cases in Q4 2007

Reducing length of stay, 2007 Q4
Potential bed days that could be saved as % of total
*The lower the score, the better

<table>
<thead>
<tr>
<th>Provider</th>
<th>Potential Bed Days Saved as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Ormond Street</td>
<td>13.0%</td>
</tr>
<tr>
<td>Barts And The London Nhs Trust</td>
<td>12.1%</td>
</tr>
<tr>
<td>North Middlesex</td>
<td>12.0%</td>
</tr>
<tr>
<td>Basildon &amp; Thurrock General Hospital</td>
<td>12.0%</td>
</tr>
<tr>
<td>Whipps Cross University</td>
<td>12.0%</td>
</tr>
<tr>
<td>Royal Free</td>
<td>12.0%</td>
</tr>
<tr>
<td>The Princess Alexandra</td>
<td>12.0%</td>
</tr>
<tr>
<td>University College London</td>
<td>12.0%</td>
</tr>
<tr>
<td>Mid Essex Hospital</td>
<td>12.0%</td>
</tr>
<tr>
<td>Guy’s And St Thomas’</td>
<td>12.0%</td>
</tr>
<tr>
<td>Papworth Hospital</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

Increasing day rate surgery cases, 2007 Q4
% of all operations performed as day cases
*The higher the score, the better

<table>
<thead>
<tr>
<th>Provider</th>
<th>% of All Operations Performed as Day Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whipps Cross University</td>
<td>70.6%</td>
</tr>
<tr>
<td>Royal Free</td>
<td>69.8%</td>
</tr>
<tr>
<td>North Middlesex</td>
<td>69.8%</td>
</tr>
<tr>
<td>Basildon &amp; Thurrock General Hospital</td>
<td>69.8%</td>
</tr>
<tr>
<td>Whipps Cross University</td>
<td>69.8%</td>
</tr>
<tr>
<td>Royal Free</td>
<td>69.8%</td>
</tr>
<tr>
<td>The Princess Alexandra</td>
<td>69.8%</td>
</tr>
<tr>
<td>University College London</td>
<td>69.8%</td>
</tr>
<tr>
<td>Mid Essex Hospital</td>
<td>69.8%</td>
</tr>
<tr>
<td>Guy’s And St Thomas’</td>
<td>69.8%</td>
</tr>
<tr>
<td>Papworth Hospital</td>
<td>69.8%</td>
</tr>
</tbody>
</table>

Source: BCBV Indicator data
Patient Experience

Self reported patient satisfaction rates for the four main providers indicate that there are areas for significant improvement in three of our main providers. The table below summarises patients views across a number of indicators compared with the national average.

<table>
<thead>
<tr>
<th>For questions about</th>
<th>PAH</th>
<th>Mid- Essex</th>
<th>Addenbrookes</th>
<th>Whipps Cross</th>
</tr>
</thead>
<tbody>
<tr>
<td>the emergency/A&amp;E department</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>waiting lists and planned admissions</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>waiting to get to a bed on a ward</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>the hospital and ward</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>Doctors</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>Nurses</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>care and treatment</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>operations and procedures</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>leaving hospital</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
<tr>
<td>overall views and experiences</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
<td>◀</td>
</tr>
</tbody>
</table>

◂ better
◂ about the same
◂ worse
Mental health providers

In-patient beds, community mental health teams, substance misuse, child and adolescent mental health services, older peoples' mental health services and specialist services are predominantly provided by North Essex Mental Health Partnership Foundation NHS Trust. This effectively makes them a monopoly provider for all but a few highly specialist services and a small amount of primary care counselling services.

We spend about 20% of our budget on mental health. Analysis shows although indicators for access to mental health services are above the national average, quality indicators appear to be relatively poor in relation to dementia services. It is worth noting that in general, the Quality and Outcomes Framework (QOF) scores are very high and emergency admissions low in relation to mental health, indicating a relatively good service in primary care and the community.

General Practice

There are 40 practices across the three localities. GPs within west Essex offer a full range of services including enhanced long-term conditions management, minor injury and minor surgery. Eighty per cent of practices provide extended opening hours.

Uttlesford

There are 11 practices, mostly medium to large, operating out of a variety of premises; all owned by the GPs. There are significant issues of both capacity and quality for some premises. There is a particularly urgent need for the redevelopment of Stansted surgery. Capacity for expanding services in Saffron Walden and Dunmow is limited and therefore new facilities will be required within the lifetime of this plan.

Harlow

Harlow has 10 practices working from premises largely owned by Harlow Health Centres Trust, a not-for-profit organisation. They maintain all but one of the practices. As part of the planned housing growth in the Harlow area, three of the practices will have new facilities by 2011. The remaining premises are of good quality.
Epping Forest

There are 19 practices ranging from large (15,000 patients) to . The quality of primary care premises varies significantly in the locality. Plans are underway for the relocation of the two Ongar practices to a new facility in 2011, a new surgery in Nazeing and plans are advanced for new facilities in North Weald. However there are a number of other premises that require replacement over the next five years and these are detailed in this strategy.

By national and east of England standards, west Essex is not under-doctored. It can be seen from the diagram below that practices are concentrated in populated areas. This has resulted in a good choice of providers for people living in towns in west Essex, but little or no choice for those living in rural areas. When comparing the concentration of practices against areas of deprivation, these areas are also well served.
**GP Provider Landscape: Population and Availability**

West Essex has a higher ratio of GPs to population compared to many other PCTs in the East of England. GP practices are clustered in more densely populated areas of the PCT.

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>GP WTE per 'Primary Care' 1000 weighted population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridgeshire PCT</td>
<td>0.77</td>
</tr>
<tr>
<td>West Hertfordshire PCT</td>
<td>0.73</td>
</tr>
<tr>
<td>Norfolk PCT</td>
<td>0.72</td>
</tr>
<tr>
<td>Bedfordshire PCT</td>
<td>0.7</td>
</tr>
<tr>
<td>West Essex PCT</td>
<td>0.68</td>
</tr>
<tr>
<td>Suffolk PCT</td>
<td>0.66</td>
</tr>
<tr>
<td>Mid Essex PCT</td>
<td>0.66</td>
</tr>
<tr>
<td>East and North Hertfordshire PCT</td>
<td>0.64</td>
</tr>
<tr>
<td>Peterborough PCT</td>
<td>0.6</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney PCT</td>
<td>0.57</td>
</tr>
<tr>
<td>South East Essex PCT</td>
<td>0.56</td>
</tr>
<tr>
<td>North East Essex PCT</td>
<td>0.56</td>
</tr>
<tr>
<td>Luton Teaching PCT</td>
<td>0.55</td>
</tr>
<tr>
<td>South West Essex Teaching PCT</td>
<td>0.48</td>
</tr>
</tbody>
</table>

Note: Other includes categories such as Gynaecology, Dermatology, Homeopathy and Diabetes Services.

Source: NACS, Deloitte analysis

Financial year 2006/2007

Key:
- GP Practices
- Out of Hours
- Walk in Centres
- Other

Population Density Index

Most densely populated

Least densely populated
Access and quality in primary care

Satisfaction with access to primary care remains one of our key challenges. Although practices in west Essex improved their performance against the four main indicators in the national access survey by an aggregate 2% from 2007 to 2008; satisfaction with opening hours declined by 2%.

**GP Access Survey**

GPs in West Essex (both rural and urban) performed marginally below the East of England average for patient satisfaction on 3 key criteria

- Average of People with 3-5 appointments last year: % satisfied with opening times
- Average of Urban areas: % satisfied with opening times
- Average of Rural areas: % satisfied with opening times

**Note:** Results for the survey are not weighted and based on the medical practices included in the survey.

Quality and Outcome Framework

Practices in west Essex perform well in the Quality and Outcomes Framework (QOF), with an overall average achievement for 2007-08 of 96.6%, the lowest practice scoring 85.4% and with two practices scoring 100%.

Practice based commissioning (PBC) in west Essex

Practices in west Essex have formed into three PBC commissioning groups. All have focused primarily on the commissioning element of PBC, working with us on major projects of pathway redesign, and as yet have not developed into provider organisations. PBC Commissioning plans reflect our strategy and are a significant influence on our operational plans.

Management support for the consortia is provided through the PCT, with a locally-enhanced service to support the engagement of clinicians. There are a number of successful and innovative new services developed and established through PBC, including a Rapid Assessment Centre for older people, and primary care ‘at the front door’ of A&E. In 2007-08 an innovation fund was established to further support the development of PBC initiatives.

Wave four of the national PBC survey shows GPs in west Essex are more positive about PBC than in other areas with particularly positive views regarding relationships with the PCT, the provision of information and the process for approving business cases.

Out-of-hours primary care provision

Out-of-hours GP services are provided by the Partnership of East London Co-operatives (PELC), a large provider covering most of north east London as well as Epping Forest and Harlow. PELC is a not-for-profit, community interest company.

T Uttlesford locality is served by The Emergency Doctors Service (TEDS) which is directly managed by the PCT

There are three primary care centres used by these providers; Harlow Walk-in Centre, St Margaret’s Hospital and Dunmow Clinic. Patients also access the Urgent Care Centre at Whipps Cross Hospital, (provided by PELC).

Although out-of-hours services in west Essex mostly meet all the national quality standards with high levels of patient satisfaction reported by both providers, the recent MORI survey on attitudes to healthcare showed people in west Essex were significantly less satisfied with out of hours services than other parts of the region.
Primary dental care provision

The 32 NHS practices are mostly concentrated in the more populated parts of west Essex such as Loughton and Waltham Abbey. There is very much less coverage in the Uttlesford locality and rural parts of Epping Forest. Currently 51% of the population of west Essex have accessed NHS dental services within the last 24 months.

Access to NHS primary dental services continues to be a high priority for the population of west Essex. However, the MORI survey of attitudes to healthcare undertaken in August and September 2008 indicated that more people were accessing an NHS dentist than in previous years and significantly fewer of those who accessed a private dentist said they did so because of a lack of NHS dentists.

Primary optical provision

There are 28 optometry practices with mandatory contracts in west Essex. Of these 32 have additional service contracts. The practices are in Harlow (eight), Uttlesford (six) and Epping Forest (20).

We have developed a primary care-based ophthalmology service which optometrists can directly refer to. There are also plans for developing other services in the community which have the potential to utilise optometry skills.

Pharmacy provision

The 47 pharmacies are an even mix of multiples and independents. These are mostly located in the populated parts of west Essex. There is much less coverage in Uttlesford, which has resulted in the predominance of dispensing practices in this locality. Since the introduction of the new pharmacy contract, there has been some commissioning of enhanced services but there remains significant under-utilisation of the skills and capacity of pharmacies in many parts of west Essex.
**Community services provision**

Community nursing services, health visiting, other children's services, health improvement, physiotherapy, occupational health services and other therapy services plus community hospital services are all provided by our provider arm, now operating as an Arms Length Trading Organisation which will be fully separate within two years.

Provider arm staff are discussing with local clinicians including GPs and other local stakeholders, the future of the provider arm. There are a number of options being considered. However, the senior management team and PCT Board are recommending a model of integration with primary care and the formation of a Social Enterprise organisation. If staff wish to proceed with this model, the new organisation should be formed by the end of 2009.

With the exception of some small-scale voluntary sector provided services, mostly focused on support for carers and parenting, there are currently no other providers of community services in west Essex.
Social care provision

Social care services are commissioned by Essex County Council. Historically there have been good working relations between local health and social care manager, enabling some good examples of collaborative working. There are few joint posts across the services or shared budgets.

Social Care Landscape: NHS and Private providers

This map displays the landscape for Social Care within West Essex. It includes 6 different categories of social care in the area.

- The Social Care landscape is a varied one, with a number of different types of providers. The concentration of services appears to map well to the areas of deprivation in West Essex.
- Residential Care Homes appear to have the largest offerings in the area with approximately 45 homes within West Essex and many more outside of the PCT borders.
- Note: This analysis shows all social care providers registered with NACS.

Key:
- Adult Placement Scheme
- Care Home (Non Medical)
- Care Home with Nursing
- Home Care Agency
- Nursing Agency
- Residential Care Home

Source: NACS, Deloitte analysis
Voluntary sector providers

We commission a number of services from voluntary sector providers, including parenting support, support for carers and people suffering mental health problems and services for young people. The financial value of these contracts is small compared with the potential the voluntary sector can bring in terms of supporting service delivery. This is an area we will prioritise when procuring services to meet our strategic plan.

Service analysis

As well as undertaking an analysis of the provider landscape, we have also looked at the quality, cost and demand for services across providers. This analysis compared the amount we spend in each disease area with the rest of the region, and as a proportion of our total spend. It then looked at the quality of services provided and the future level of expected demand. This analysis has highlighted a number of areas where there is potential for us to develop the market to improve quality, increase access and choice, and increase efficiency namely:

- Diabetes
- mental health
- CHD
- maternity services
Diabetes

Spend and quality:
- we spend less than the average in the region on endocrine, nutritional and metabolic services (including diabetes services)
- the quality of long-term condition management in diabetes is not as good as other areas
- patient-reported metric of lack of provision for self management of the condition

Demand:
- demand is expected to rise at a rate faster than population growth, driven by demographic factors
- growth is expected to be greater for GP/primary care services.

The market:
- the market for these services in west Essex is less concentrated than elsewhere in the region and that expenditure on non-NHS provision is below average
- expenditure is largely in acute trusts and our provider arm, with some spend in primary care.

Market development options:
- options include:
  ◊ (a) introduce more competition into the market, particularly in the non-acute sphere
  ◊ (b) manage some services away from the acute trusts to existing non-acute providers.

- some diabetes care services may not be suitable to shift to the community and for these services we will look to improve existing contract structures particularly where choice or competitive tendering are not feasible or appropriate.
Mental health services

Spend and quality:
- we spend 20% of our total expenditure on mental health, significantly higher than the regional average
- access to services is good but service quality indicators are relatively poor in relation to dementia services
- primary care services appear to be good.

Demand:
- demand is likely to grow in line with the population.

The market:
- the market is relatively concentrated.

Options for market development:
- introduce diversity of provider to create competition
- increase provision in the community based services and shift corresponding resources from acute provision.
Coronary heart disease

Cost and quality:
- spend on CHD services is slightly lower than the regional average
- primary care services are good with high QOF scores and low rates of emergency admissions
- length of stay is significantly longer than the average.

Demand:
- demand will rise more quickly than population growth
- demand for community and primary care based service will more quickly.

The market:
- the market is relatively concentrated with few providers
- 75% of activity is with non-FT NHS providers.

Options for market development:
- increase community provision, particularly for prevention and risk reduction elements of the pathway
- more effective management of provider of complex care and high cost, low volume activity.
Maternity services

Cost and quality:
- spend on maternity services is slightly above the average for the east of England
- access is significantly poorer than the east of England and national averages, at 3.5 weeks wait from referral to first appointment, east of England and national are 2.3 and 2.6 weeks respectively.

Demand:
- demand is forecast to grow in excess of the general population growth. At the same time there will be an increase in the propensity to use primary and community services rather than acute hospital services.

The market:
- currently most services are provided by non-Foundation acute NHS trusts.

Options for market development:
- given the predicted rise in demand and the preference of women to choose community-based services, there may be scope for reviewing the maternity pathway and the potential introduction of new providers.

The options for developing the provider market in these service areas will be further outlined and appraised and will inform our commercial strategy. Plans for provider market development and procurement are outlined in chapter 4.
Summary of the financial position

Since its inception in October 2006, NHS West Essex has operated within a surplus position. The surplus at the end of 2006-07 was £1.5m and this helped us lodge a reserve with the Strategic Health Authority in 2007-08. That lodgement currently stands at £3.0m and will be utilised over the next five years to help implement key strategies.

Financial position for 2008-09

We received a resource uplift of over £18m for 2008-09 which, together with the carried forward 2007-08 surplus, has enabled a programme of service developments to be delivered. These developments, outlined in our operational plan, have kept us on track to achieve the national targets. They have also supported areas of service redesign and initiatives outlined in our earlier Strategy for Healthcare and enabled us to meet local objectives and improve the health and healthcare experience of our population.

We forecast a breakeven position for the financial year 2008-09 while maintaining the £3.0m lodgement with the Strategic Health Authority.

Financial trend

Over recent years we have had good levels of growth funding enabling us to achieve high levels of service within the context of the NHS programme of improvements.

From 2009-10 onwards those high levels of growth will reduce. While the last few years have seen enormous changes in the NHS, funded by these high growth levels, this is unlikely to continue. NHS West Essex is funded above the target level for its population demographic and this will be addressed through lower than average growth over the next few years. Additionally although the current financial climate may have a downward pressure on general inflation levels, health inflation has historically been much higher.

With reduced growth levels, increased cost pressures and continued change, we will need to drive forward efficiencies and robust commissioning decisions if we are to maintain our sound financial base, achieve the vision and goals set out in this plan and our reputation for excellent healthcare.

We know our population will grow over the next five years and have made an assumption that this will be between 8.8% and 10.3%, resulting in a general increase in demand for all healthcare services. As our financial allocations are set on a three-yearly basis, this increase will not necessarily result in increased resources, which means a higher level of cost pressure.
Future assumptions

We have set out our strategic objectives, goals and initiatives, many of which require either significant additional investment or changes to the way funding is currently directed. Our vision to move services closer to people’s homes (particularly for older people and those with long-term conditions) means a shift of services from hospitals to primary or community care settings. This needs a significant investment in community health services over the next two years. This approach to providing care will require us to work with our health and social care partners to utilise the total available funding to best effect. The objective is that partnership agreements will result in the pooling of fund on a larger scale with more collaboration than has been achieved to date.

We have already gone a long way to improving access to primary care services but the five-year vision is to work even more closely with primary care contractors to increase the scope of access (later opening times for example) and widen the area for access (broaden the range of services offered within primary care). Clearly both of these require investment within primary care but should produce savings by either reducing or redirecting demand from the more expensive hospital setting.

Avoiding unnecessary emergency admissions (another key objective) should help contain the cost of hospital-based activity by reducing the number of spells in hospital. Part of working towards this goal involves managing the health of people with long-term conditions. We will look to participate in a pilot scheme to empower those people by allowing them a personal budget. It is hoped this will show a more effective and efficient use of resources on the premise that an individual knows their own condition best and will make a more informed decision around the method in which their condition is treated. This is a very exciting and innovative way in which to use NHS resources, but will need careful monitoring if it is expected to produce good results.

We will still need to deliver national targets and plan to invest in areas necessary to achieve this.

Whatever the approach to the delivery of services it is clear our strategies and objectives have to be affordable and financially sustainable. It is our strategy to stay within available resources (thereby fulfilling our statutory breakeven duty). Therefore the financial model we will follow has paid close attention to the prioritising of investment, the identification and increase of efficiencies to ensure resources are not used unwisely and the scrutiny of current services to assess their efficacy. Robust commissioning decisions will be made as a result of these assessments, including disinvestment where appropriate.
Activity commissioned and forecast

We have made a number of broad assumptions in the development of the five-year plan and these will be developed in more detail in each contract year with each of our providers. The charts and narrative in this section demonstrate trends to date and explain the basis and assumptions that we have made across each of the main work streams.

The chart above shows our emergency admissions, alongside excess bed days for emergency admissions. Although the chart fluctuates, there is no growth across the period from January 2007 to June 2008. We have projected this forward and the only adjustment made for emergency activity is to take account of housing growth. In the latter years of the plan and beyond we would expect emergency admissions to reduce due to admission avoidance schemes and better management of patients with long-term conditions.
The above chart shows A&E attendances for our population. The trend is a reduction in attendances and this is particularly the case from July 2008 when the A&E and Walk-In Centre diversion scheme was introduced. Our activity plan assumes this reduction and shift to primary care continues over the next five years both as a result of the development of the Walk-In Centre and improved access to GP practices.
The above shows GP referral rates which have been increasing since April 2007. Although a trend line has been added to this chart this needs to be treated with care as the working days in each month vary significantly which can skew the trend. Our strategy will involve working closely with practices and PBC groups to develop demand management schemes but to also better understand and plan for the shift from private to NHS care as a result of the introduction of Free Choice, which has already started to impact in 2008-09.

Our plan for elective care assumes the need to commission based on 2008-09 outturn to maintain achievement of the 18-week access target. There is no indication that although backlogs have been cleared the activity requirement will reduce. In addition are aware patients are seeking NHS care as a result of Free Choice and reduced waiting times. The maintenance of current elective activity levels will provide for this.
Chapter 3 - West Essex - the future

Introduction

In this section we detail the initiatives and goals set to meet our vision for the next five years; providing a greater focus on prevention, promoting wellbeing, while delivering services that are more flexible, integrated and responsive to peoples’ needs and wishes.

These are ambitious but realistic plans. We are confident that by empowering people to take responsibility for their own health we can deliver better and more local health services.

- The goals have been chosen as priorities for west Essex based on:
  - their fitting with our overarching strategic aims (see chapter 1)
  - the health needs of our population (see chapter 2)
  - local peoples’ views
  - national policy and targets
  - East of England Strategic Health Authority Improving Lives, Saving Lives pledges
  - evidence of best practice
  - financial viability and feasibility.

We have organised our goals and initiatives into the pathways of care described in Lord Darzi’s report, *High Quality Care For All* and the East of England clinical vision, *Towards the Best, Together*. This enables a clear picture to be drawn of how our plans will affect each pathway of care and fit with local, national and regional priorities. We have also added two sections, Patient Experience and Patient Safety to reflect the organisations commitment to these important work streams.

For each pathway we have outlined:

- our goals - what we need to achieve and the impact they will have on the health of local people
- what we will do to achieve the goal - what actions and initiatives we will take
- how we will measure success.
Deciding the priorities

The initiatives described in this chapter have been developed through bringing together evidence of what works, national and regional guidance and the priorities of our community. We are confident implementing these initiatives will deliver better health and health services in west Essex. As a public body we are accountable for the use of public funding in the most effective way to provide health services and improved health outcome for our population. We have developed and costed our strategic initiatives based on a prudent estimation of our funding over the next five years.

Based on these assumptions, we will have sufficient funding to deliver all the planned initiatives. However, in the current economic environment, funding may not reach this level or there may be unforeseen cost pressures and demand that could threaten achievement of these initiatives. We have therefore prioritised all the initiatives to help determine future priorities should difficult decisions need to be made. This will also provide a benchmark to measure the new priorities that will inevitably emerge over the life of the plan.

To help decide which initiatives are most important we examined each priority for two main attributes:

- whether the initiative had any financial impact in terms of savings or did it just require a change in working patterns
- if investment was required, what was its relative importance based on a set of criteria
Each initiative has been assessed against the criteria set out below, with each criteria being weighted for importance. A scoring and pairing method was used to attain a ranking.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current relative performance against benchmarks if available</td>
<td>4</td>
</tr>
<tr>
<td>Meets a national requirement, target or policy</td>
<td>5</td>
</tr>
<tr>
<td>Is an East of England pledge</td>
<td>4</td>
</tr>
<tr>
<td>Evidence of need</td>
<td>4</td>
</tr>
<tr>
<td>Health impact on population</td>
<td>4</td>
</tr>
<tr>
<td>Impact on health inequalities</td>
<td>4</td>
</tr>
<tr>
<td>Patient and stakeholder importance</td>
<td>4</td>
</tr>
<tr>
<td>Difficulty of implementation</td>
<td>2</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>2</td>
</tr>
<tr>
<td>Cost</td>
<td>3</td>
</tr>
<tr>
<td>Fit with other strategies (does it cut across or conflict with other strategies, internal or external)</td>
<td>4</td>
</tr>
</tbody>
</table>

A summary of our goals, initiatives and priorities this plan details are set out in Appendix 1 of this document.
Staying healthy

The health service tends to focus on getting people better rather than helping them not to become ill or manage their own health needs so they are in more control. While there will always be medical emergencies we are committed to helping people make healthy life choices and take responsibility for their own care and long-term health. In chapter 2, we outlined the health challenges facing our population. Here we outline the goals and initiatives designed to meet these challenges.

Our key goal is to develop parts of west Essex into Healthy Towns or Healthy Areas. These include Harlow, Waltham Abbey, Loughton and the Limes Farm estate in Chigwell. We will continue to work as partners of the strategic partnerships and ensure this is a key goal within our partner agencies.

We will commission specific health services for these areas - e.g. stop smoking, primary care and acute services. In partnership, we shall influence how other agencies provide and commission their specific services and commission services together where there is added benefit in doing so. In both cases, services we commission will have incentives built into them that will ensure these populations are encouraged to engage in healthy behaviours.
Our goals for staying healthy are to:

- improve the health of people who live in west Essex that have the lowest life expectancy as determined by gender specific MSOAs, to reduce the gap between the lowest and highest to no more than ten years, and ensure the highest life expectancy does not fall below 85 years

- reduce the number of deaths caused by cancer and cardiovascular disease by 40% from the 1997 baseline

- halt the rise in childhood obesity and then seek to reduce it for age 5 from 9.35% (2006-07 baseline) to 8.99% in 2010-11; and age 10-11 from 17.5% (2006-07 baseline) to 16.99% in 2010-11

- halt the rise in obesity among adults and then seek to reduce it by increasing participation in healthy activity

- ensure at least 25% of young people between the age of 15 and 24 have been screened for chlamydia by the end of March 2010, rising to 35% by March 2011

- Reduce teenage pregnancy rates to below 20.22 per 1,000 girls aged 15-17 years by 2011

- halt the rise in hospital admission for alcohol-related harm by 2010, and then seek to reduce it by 1% year-on-year thereafter

- reduce the prevalence of smoking in the overall population by achieving at least 50 quitters per 1,000 smokers by 2011 and by working with partners to reduce the numbers that start smoking with a particular focus on Harlow and Waltham Abbey and Loughton.
Key initiatives

- target groups with lower life expectancy with tailored services to reduce cardiovascular disease risk and smoking, using social marketing and enhanced primary care
- reduce the risk of cardiovascular disease in the general population through a locally enhanced service for vascular risk assessment
- extend and improve cancer screening services
- work with partners, increase programmes to support children and families in living healthier lifestyles, including MEND and Mini-MEND to prevent and treat childhood obesity
- increase access to specialist weight management programmes for adults.
- work with partners, improve the uptake of walking and cycling, healthier towns and villages schemes and healthier workplace programmes
- increase opportunities for young people to access chlamydia screening through extending outlets and postal screening
- increase smoking services, targeting them at specific groups using social marketing techniques
- work with partners, introduce smoking prevention programmes in schools and establish a baseline for the prevalence of smoking in children and young people.
- introduce targeted screening of ‘at-risk’ groups for harmful alcohol misuse and brief interventions
We will measure achievement of these goals by:

- all age, all cause mortality rates per 100,000
- cancer and cardiovascular mortality rates per 100,000
- reduction in the prevalence of obesity in reception year and year 6 children
- percentage of adult population who participate in moderate physical activity three times a week for at least 30 minutes (as per Sport England annual survey).
- percentage up-take of chlamydia screen in relevant age group
- pregnancy rate in girls aged 15-17 years
- alcohol-related harm hospital admission rate per 100,000 population
- establish a baseline for alcohol related harm emergency attendances
- prevalence of smoking amongst the adult population
- smoking quit rate per 1,000 population aged 16 years plus.
Improving health as to reduce the gap in life expectancy in west Essex

We have identified there are some groups and populations that have poorer health outcomes and life expectancy. We are committed to reducing the gap in life expectancy as determined by gender specific MSOAs (Multiple Super Output Areas), between the highest and lowest to no more than ten years, and to ensure the highest life expectancy does not fall below 85 years. These interventions will be targeted at seven key MSOAs in Harlow and Waltham Abbey and involve the GP practices in Waltham Abbey, Keats House (both practices) and Lister House in Harlow. We will tailor services to meet particular needs.

Specifically we will:

- engage with the worst off men, pregnant women and their partners who smoke, by commissioning specialist tailored outreach services which use social marketing principles and practice to engage the target group. Smoking is higher in manual groups and PCT health equity audits have shown the worst off men, who have low-life expectancy and higher rates of chronic disease than their female counterparts are underrepresented in our population based services.

- in partnership with Harlow Council leisure and community services and funded through LSP partnership funding, commission programmes to support healthy lifestyles are targeted at those who are inactive and in the target Multiple Super Output Areas (MSOAs) of lower life expectancy. These are our areas where life expectancy is lowest and unhealthy lifestyles and chronic disease are more prevalent. This will involve social marketing techniques of market segmentation, segment-specific messages, and service redesign to better engage those with most health gain potential.

- introduce a Locally Enhanced Service (LES) to identify those at risk of cardiovascular disease, with particular emphasis on vascular risk checks in target MSOAs. Coronary heart disease (CHD), stroke and related conditions are a major cause of early death (under 75 years) and are largely preventable through living a healthy lifestyle. Systematic risk stratification across the whole population, followed by evidence based interventions targeting those at most risk is a sound strategy for investment in early intervention towards population risk management in the longer term.
increase the black and minority ethnic (BME) community development worker role in west Essex to improve mental health services for BME communities by tackling stigma and isolation faced by people with mental health difficulties, promoting social justice and social inclusion. The service also supports early intervention and access to primary care with the aim of eliminating ethnic inequalities in mental service experience and outcome. The community development worker service is a vital component of Delivering Race Equality in Mental Health Care, the Department of Health’s action plan for tackling the acknowledged inequalities in mental health services for black and minority ethnic groups. We envisage that through this project we shall also tackle other key health outcome indicators that are pertinent to these populations, eg diabetes, obesity and smoking.

recommend Epping Forest District Council conducts a health impact assessment in respect of its consultation on gypsy and traveller sites in the district. We will then develop primary care and community based services in response.

Reducing the risk of cardiovascular disease

Estimated prevalence of coronary heart disease in west Essex is 5.4% - just below the national average of 5.6%. Of the three localities, Harlow has the highest prevalence with 5.8%. In all localities men have a higher prevalence than females and in future the prevalence is expected to increase across the board. To reduce the risk of cardiovascular disease (CVD) we have set up risk registers 67% of practices and will introduce a locally enhanced service (LES) for systematic identification of those at risk of CVD and to provide appropriate lifestyle and other interventions. As this will be a new LES, our baseline is negligible.

Currently 40% of practices have a register of those at risk of CVD. By 2010-11 a 100% of practices will have a register in place. Vascular risk checks for all those eligible will be introduced from 2009, starting with those practices that cover the 20% with lowest life expectancy and then rolling out to all practices by 2011/12.

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of practices with a risk register</th>
<th>Percentage of eligible population on a risk register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>67</td>
<td>0.2</td>
</tr>
<tr>
<td>2009/10</td>
<td>80</td>
<td>35</td>
</tr>
<tr>
<td>2010/11</td>
<td>100</td>
<td>50</td>
</tr>
<tr>
<td>2011/12</td>
<td>100</td>
<td>75</td>
</tr>
<tr>
<td>2012/13</td>
<td>100</td>
<td>75</td>
</tr>
</tbody>
</table>
Reducing deaths caused by cancer

Cancer rates in west Essex are generally in line with the rest of east of England. However rates in Harlow are higher than the other localities with Uttlesford showing an increase over recent years. As well as ensuring timely access to high quality cancer treatment services, the most effective intervention for reducing cancer mortality is increasing the scope and uptake of cancer screening. We will work with GP practices and the screening service to identify where uptake is low and then work with the practices to raise awareness and ensure that appropriate advice and counselling is provided.

We will:

- use results from health equity audits and run west Essex campaign on cancer screening programmes
- extend the breast screening programme to nine screening rounds between the ages of 47 and 73 by 2012
- look to extend the bowel cancer screening introduced in December 2008, (targeting men and women aged 60-69), to include 70 to 75-years-olds by 2010
- ensure women receive the result of their cervical smear within two weeks and increase uptake in the programme of women aged 25 to 35
- introduce the Human Papilloma Virus (HPV) immunisation programme targeting girls aged 12 to 13
- further integrate cancer pathways - working closely with North London Cancer networks.
Childhood obesity

Childhood obesity is rising nationally and the pattern is similar in west Essex with particular problems in Harlow and Epping Forest. Reducing childhood obesity is also a key priority for the Essex Local Area Agreement. Halting the rise and then reversing it is vital to prevent our children from developing diseases related to obesity, such as type II diabetes and hypertension.

Locally, we have targets to reduce obesity rates in:

- reception children (age 5) from 9.35% (2006-07 baseline) to 8.99% in 2010-11
- year 6 (age 10-11) from 17.5% (2006-07 baseline) to 16.99% in 2010-11.

We aim to provide support to families to improve their health and manage their weight through:

- extending the MEND programme to support more families with leading a healthy lifestyle
- preventing obesity by supporting families earlier. We will work with our partners and the LSPs to introduce Mini-MEND to prevent and reduce obesity in the under-fives
- focusing prevention at key life-stages:
  - during pregnancy through the identification and support for mothers-to-be who are at risk and through the general promotion and support ready for breastfeeding
  - at birth through the promotion and supporting increased participation in breastfeeding at 6-8 weeks to 6%
  - under-fives through healthy weaning for toddlers and supporting access to programmes such as mini-MEND
  - for school-age children, through working with our partners and the Children and Young People's Strategic Partnership (CYPSPs) to increase the uptake and participation in the Healthy Schools Programme and the Food in Schools programme through a range of programmes to engage schools, families and children themselves.
Reducing obesity in adults

We will engage with local partners, through the LSPs, to reduce obesity in adults and deliver programmes relating to healthy eating and physical activity within the wards with most need.

We will:

- review local exercise opportunities and schemes that include exercise on referral and walking schemes with a view to developing reward-based schemes
- improve access to support for weight management through primary care and the development of local groups and services
- introduce a specialist dietary and weight management programme, including psychological support, for the morbidly obese
- provide surgical intervention for the treatment of morbid obesity in line with NICE guidance
- improve access by designing schemes for marginalised groups such as men in Harlow
- introduce a preventative community health coach service across west Essex (Big Lottery funded through the well-being in the East programme) for those who wish to be supported in achieving a healthier lifestyle
- work with our partners to encourage an active lifestyle through planning and the environment including activities such as:
  ◊ increasing participation in alternative forms of transport such as cycling and walking
  ◊ planning for healthier towns and villages
  ◊ encouraging and promoting workplace-based schemes.
Improving sexual health

We aim to improve sexual health through reducing the rate of unintended pregnancies and sexually-transmitted infections (STIs), including HIV. There are marked inequalities in those who suffer from sexual health problems linked to social class, culture and ethnicity and to attitudes towards gay, lesbian and bisexual people. We will tackle inequalities related to sexual health which affect specific groups of the population by targeting services at these groups using social marking techniques.

A key target for west Essex is to reduce teenage conceptions to 20.22 females per 1,000 from a baseline of 32 per 1,000 by 2011. A particular focus will be on Harlow and Waltham Abbey where rates of teenage pregnancy are higher.

Key activities which support improving sexual health:

- prevent and reduce HIV and STI transmission, particularly in high-risk populations, and reduce the prevalence of undiagnosed HIV and STIs through:
  - maintaining increased Genito Urinary Medicine (GUM) access through ensuring 100% of patients are offered an appointment within 48 hours and increasing the percentage that attend within 48 hours to 95%
  - moving level 1 sexual health services into primary care and the community, to increase access to STI testing and contraceptive services in the community. This will include the provision of enhanced services offered through primary care and more primary care practitioners working alongside local sexual health care experts
  - delivering sexual health services in a range of community settings to target hard-to-reach and vulnerable groups. In particular, we will continue to commission services and projects which promote sexual health, and which support reducing the prevalence and the transmission of HIV and STIs within gay men and men who have sex with men
offering the opportunity of free chlamydia screening to all young people aged under 25 and continuing to increase access and participation in the west Essex chlamydia screening programme. We have a challenging target to screen 25% of our population of 15 to 24-year-olds in 2009-10 and 35% in 2010/11. We will work with partners to identify the most effective methods of reaching young people and increasing uptake, including consideration of call and recall based services in general practice.

raising awareness about sexual health and HIV issues and reducing the stigma around accessing sexual health and STI services and supporting sexual health promotion and education activities

- reducing unintended pregnancy rates and under-18 conceptions through close working with our local partners and CYPSP. This will include jointly commissioning social marketing to engage young people around issues such as teenage pregnancy to support delivery of services and activities which help to reduce teenage pregnancy and support teenage parents. In particular this will include work on self-esteem and aspiration which has been identified through local research as a fundamental underlying problem affecting health in Harlow.

Reducing the prevalence of smoking

Smoking remains the single biggest preventable cause of life-limiting disease, prevalence in west Essex ranges from 19% in Uttesford to 31% in Harlow, with Epping Forest at 21%. Working with the LSPs we will particularly focus on Harlow where we aim to reduce smoking to below 25% by 2012. This will be achieved by supporting people and through our preventative programmes:

Our target is to increase the rate smokers in west Essex quit to achieve 9,000 quitters by 2011-12.

<table>
<thead>
<tr>
<th></th>
<th>09/10</th>
<th>10/11</th>
<th>11/12*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trajectory - quitter rate per 1,000 smokers</td>
<td>40.7</td>
<td>44.8</td>
<td>50.0</td>
</tr>
<tr>
<td>Trajectory - number of quitters</td>
<td>1615</td>
<td>1789</td>
<td>2010</td>
</tr>
<tr>
<td>Additional quitters</td>
<td>135</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Total quitters</td>
<td>1750</td>
<td>1800</td>
<td>2010</td>
</tr>
<tr>
<td>Enhanced target quitter rate per 1,000 smokers</td>
<td>44.1</td>
<td>45.1</td>
<td>50.0</td>
</tr>
</tbody>
</table>

*2011-figures are not trajectory as part of vital signs
We will achieve this increase in the number of quitters and reduction in prevalence by:

- implementing social marketing to target specific groups such as pregnant women, young people and men in Harlow (as outlined above in respect of stop smoking services), ensuring by 2012 we achieve no less than 500 quitters per year for these hard to reach groups

- using social marketing techniques and insight work to engage with children and young people to understand better their attitudes towards smoking and develop a range of preventative measures

- developing an accurate baseline of smoking amongst children and young people and ensure a 1% year-on-year reduction in prevalence is achieved

- ensuring stop smoking services are accessible and acceptable to people in the most deprived wards and in particular by commissioning a new service in response to social marketing insight work

- supporting local businesses and workplaces in implementing the new legislation on smoke-free workplaces

- working with health care partners in redesigning care pathways to help patients stop smoking before any treatment therefore maximising the benefits of surgery.

Reducing alcohol misuse

By 2012 we will address the binge drinking culture with partner agencies. We will develop primary care services known to be effective in reducing alcohol misuse. This will include an enhanced service agreement for the targeted screening of at-risk groups using a standard screening tool to identify harmful and hazardous levels of alcohol misuse, and brief interventions for hazardous and harmful drinkers.

We will also implement strategies to reduce alcohol-related assaults requiring A&E input by facilitating a local level collection of A&E violent crime data across west Essex. Data sharing between the A&E department, Crime and Disorder Reduction Partnership and the police will enable action on reducing alcohol-related assault reduction initiatives.

These initiatives will help deliver East of England Strategic Health Authority pledges 3, 5, 8, 9, 10 and 11.
Mental health

Good mental health is at the heart of wellbeing. We will continue to commission and support the development of community based services which target severe and enduring mental illness, and provide support to prevent admission in crisis. We will ensure the continued development of primary mental health care services focused on moderate mental illness.

Our goals:

- work to de-stigmatise mental illness, and ensure positive promotion of wider acceptance and understanding of mental health problems
- improve the lives of carers and those suffering from mental illness
- improve access to psychological therapies, including cognitive behavioural therapy
- ensure patients wait no longer than 18 weeks from referral to treatment
- help people who suffer with dementia to be cared for at home and to ensure their dementia is identified at an early stage.
Key Initiatives:

- work to de-stigmatise mental illness, and ensure positive promotion of wider acceptance and understanding of mental health problems
- improve the lives of carers and those suffering from mental illness
- improve access to psychological therapies, including cognitive behavioural therapy
- ensure patients wait no longer than 18 weeks from referral to treatment
- help people who suffer with dementia to be cared for at home and to ensure their dementia is identified at an early stage.

By 2010 we will:

- commission appropriate and effective services for black and ethnic minority groups
- commission improved day services
- implement improved access to psychological therapies programme, significantly increasing the number of therapists
- agree maximum referral to treatment waiting times for all mental health services.

By 2011 we will:

- work with Essex County Council to commission an integrated service pathway for those with dementia and for their carers

By 2012 we will:

- further develop early intervention in psychosis services.
- develop more appropriate services for people who have multiple problems.
- improve specialist services for eating disorders, personality disorders and working with learning disability services and for people with Asperger’s Syndrome.
We will measure our achievement through:

- increasing the proportion of people in employment who come into contact with secondary mental health services
- numbers of physiologists and counsellors working in primary care
- improved patient experience reported by the National Patient Survey.
Improving adult services

Our overall approach will be to ensure resources are targeted effectively at particular needs.

For adults this will require:

By 2010:

- providing an adequate range of primary mental health services for people with less serious conditions. We will implement the Improving Access to Physiological Therapies programme, ensuring that by 2010 we have 24 high intensity and 15 low intensity therapists in place across west Essex. We will also commission extended cognitive behavioural therapies from April 2009

- providing effective access, treatment and support for people from black and ethnic minority communities

- implementing the recommendations of the joint day services review. The review is in two stages. Stage 1 is being completed and will result in the re-tendering of all third sector services and the appointment of coordinated services based on the Recovery Model with 'bridge builders' to enable social inclusion. Stage 2 will review day services provided by the statutory agencies, to ensure cohesive pathways between health and social care. This will be undertaken during 2009-10.

By 2012:

- further development of early intervention in psychosis services (target age group is 14 to 35)

- developing more appropriate services for people who have multiple problems, including those who have a physical and or sensory disability in addition to mental health difficulties

- development of other specialist services to meet current gaps. In particular:
  - eating disorders
  - personality disorders
  - working with learning disability services for people with Asperger’s Syndrome.
Improving access to mental health services

By 2010 we will ensure people needing mental health services wait no longer than 18 weeks from referral to commencement of treatment.

Work is underway across the east of England to determine appropriate referral to treatment times. The recommendations from this work will be implemented for local services.

Caring for people suffering with dementia

Currently we estimate we commission care for 1,113 people with dementia. This figure is expected to increase by 38% over the next 15 years and 154% over the next 45 years (Dementia UK Report, 2007).

To meet the challenge of providing high quality care to meet this growing need we are committed to delivering the three key aims outlined in the Government’s national Dementia strategy. Services for people with dementia will be commissioned jointly with the local authority to ensure proper integration of services.

The key aims outlined in the strategy are:

- improved public and professional awareness of dementia, including addressing the stigma associated with a diagnosis of dementia
- early diagnosis and intervention ensuring all patients have access to a pathway of care delivering a rapid and competent specialist assessment and an accurate and early diagnosis that is sensitively communicated
- high quality care and support will enable more people with dementia live at home for longer.
- services will be structured to recognise that dementia is long term and progressive.
In 2009-10 we will develop a strategy for the care of people suffering dementia based on these principles and a thorough analysis of local needs and priorities. This process will include reviewing how to use current resources effectively. We will work with the local authority and other agencies to develop a comprehensive integrated care pathway that will identify the elements against which dementia services will be procured and managed.

By 2011 we will have commissioned an integrated pathway of care for people with dementia that provides early assessment, diagnosis and enable people to stay in their homes longer. We will also ensure the needs of younger people suffering from dementia are recognised and services are tailored to their needs.

We will improve support for people with dementia and their carers through collaborative working between ourselves and social care and through third sector organisations.

We will treat individuals with dementia with dignity and respect, and monitor and measure this with patient and carer satisfaction surveys (see Section 8 for Supporting Carers strategy).

Taken together, these initiatives will help deliver East of England pledges 1, 2, 7, 8 and 9.
Maternity and new born

Every year thousands of women in west Essex access local maternity services throughout the stages of pregnancy, birth and after delivery. The health of the mother and the quality of care provided can have a significant impact on the health and life chances of the baby and on development of the child as it grows up.

We seek to ensure babies born in west Essex are given the best possible start in life. In particular we want to improve health and life changes of more disadvantaged parents and their babies. We know for example rates of breast feeding among some groups are very low.

We are committed to commissioning high quality maternity services which enable women to exercise choice over how and where they have their child. We are also committed to promoting the health and well-being of the baby and supporting women and their partners as they prepare to take on their role as parents, ensuring that services are particularly targeted at more vulnerable groups.
Our Goals

- By the end of 2009 we will deliver the Maternity Matters national choice guarantees:
  - choice of how to access maternity care
  - choice of type of ante-natal care
  - choice of place of birth, i.e. home birth, birth in midwife-led unit, birth in hospital
  - choice of postnatal care.

- By 2010 we will ensure there is much closer integration of services to impact positively on the health of the mother and the newborn baby

- By 2012 we will ensure maternity services are flexible and individualised, giving women and their partners choice and control during pregnancy and birth. Particular emphasis will be given to targeting the needs of vulnerable and disadvantaged women

Key Initiatives:

We will:

- commission up to three cycles of IVF in line with NICE guidance
- commission one-to-one midwife support in established labour
- support the local neo-natal intensive care unit to develop and maintain level 2 status
- strengthen breastfeeding support throughout the maternity pathway. Increasing the proportion of women breastfeeding to 66%

We will measure our achievement of these goals through:

- the proportion of women with breast feeding status recorded at 6-8 week check
- the proportion of women having seen a midwife by the 12th completed week of pregnancy
- the proportion of women accessing a midwife as the first point of contact.
Pre-conception

We will:

- ensure pre-conception information and advice is widely available to women locally and that they have easy access to advice from GPs and other specialists. We will also ensure access to genetic testing and counselling is available if appropriate
- offer up to three cycles of IVF treatment in line with NICE guidance from April 2009.

Ante-natal

We will:

- ensure all pregnant women in west Essex receive full assessment of needs, risks and choices by 12 weeks and six days of pregnancy. Currently 65% of women receive services that meet this standard. By 2009 this will rise to 80%, reaching 90% by 2011.

This will be achieved through:

- offering all women early Nuchal Translucency (NT) scans by April 2009 to encourage women to access services and book earlier
- from 2009-10, complete an equity audit of the total number of maternities to identify whether there are any particular groups not accessing booking by 12 weeks and six days
- use the above information to inform the development of a strategy for promoting early booking.

- ensure all pregnant women and their partners have access to antenatal classes which includes preparation for labour and birth, looking after the newborn baby, promotion of health and well-being, breastfeeding, parenting support, and advice on services available after the child is born

- ensure one-to-one midwifery service is available for women in established labour. We aim to reach the recommended ratio of midwives to deliveries by 2012-13. However this is dependent on the recruitment and training of sufficient additional midwives. We will work with our providers and across the health economy on the development of a workforce strategy that will deliver this goal

- continue to support the popular local midwife-led unit at Princess Alexandra Hospital, recently assessed as ‘Good’ by the Healthcare Commission, and to increase its capacity.
Post-natal

We will:

• ensure women and their partners have access to post-natal visits and a choice in how and where they wish to access post-natal care either at home or in community settings at convenient times

• support and further develop the local Neo-natal Intensive Care Unit to achieve and maintain level 2 status and operate within a local neonatal network to ensure safe and efficient transfer between units

• increase the proportion of mothers breast feeding their babies to six to eight weeks from a baseline of 27.1%, by providing advice and support throughout the maternity care pathway and after birth

• review and improve the integration of services across midwifery and health visiting

• continue to support the ante-natal screening programmes for Downs Syndrome, Sickle Cell and infectious diseases (Hep B, HIV, Rubella, Syphilis), to ensure uptake is high and that following detection further assessment and care pathways are seamless

• implement new ante-natal screening programmes as recommended by the National Screening Programme.

These initiatives will help deliver the East of England Strategic Health Authority pledges 1, 7, 8, 9 & 11.
Children, young people and families

Children are our future and ensuring they have every opportunity to have a healthy start in life will support them in becoming healthy adults. We are committed to maximising the health, well-being and achievement of all children in west Essex and we will commission an effective child health promotion programme and high quality universal, targeted and specialist services to meet the needs of children and young people as they grow up.

We are committed to commissioning services which put the child and family at the centre, that are well integrated and support the child’s needs from age 0-19; ensuring services for children are designed with their needs and their family’s needs in mind. We will seek the views of children, young people and families in the planning and delivery of services. We will also work with our key local partners through the CYPSPs.

Our goals for children reflect the Local Area Agreements (LAA) and Public Service Agreement (PSA) targets and the priorities of the Children and Young People’s plan.
Our goals

We will:

• implement the new child health promotion programme which runs from age 0-5, and continue to promote healthy living throughout school age and to age 19 tackling areas such as obesity, teenage conception, contraction of sexually transmitted infections, and substance misuse
• transform the life chances of the most disadvantaged and vulnerable children by targeting services and support to meet their needs, for example by reducing prevalence of smoking, teenage pregnancy and childhood obesity (also see Staying Health)
• improve the lives of children living with a disability including those with life-limiting and life-threatening conditions
• improve access to the Child Adolescent and Mental Health Services (CAMHS).

Key Initiatives

We will:

• introduce single generic assessments of need supported by specialist services where needed e.g. parenting, CAMHS, lifestyle
• increase the uptake of MMR from current rate of 82.5% (at age 2) to 95% by 2014
• increase parenting programmes
• extend and coordinate services for children with disabilities and complex needs
• significantly increase the capacity of CAMHS services
• introduce specific and targeted health promotion programme, including health checks for looked after children.

We will measure improvement through:

• through annual height and weight measurement of reception and Year 6 children monitor childhood obesity rates
• uptake of chlamydia screening among sexually-active 15 to 24-year-olds
• rates of sexually transmitted infections among young people
• the under-18 conception rate
• rates of substance misuse by young people
• increasing the proportion of children who complete immunisation by the recommended age
• increasing the proportion of children and young people in crisis assessed within one working day.
Child health promotion

We will establish a generic system of assessing the needs of new and growing families, which will start during the ante-natal period and continue into early years and beyond. This will enable access to a full range of universal and specialist family support provided by both the statutory and third sector.

This will include parenting support; breastfeeding support; child development; child and family mental health services and specialist services to support children with complex needs.

Children will be assessed using a single assessment tool and those families which need additional help will be case managed to ensure they are fully able to access necessary services and support.

By 2012 our child health promotion programme will:

- aim to improve the uptake of childhood MMR immunisations to national levels as a minimum and to 95% by 2014
- increase opportunities for positive parenting advice through integrated multi-agency delivery of parenting groups, and through extending training opportunities to statutory and voluntary organisations
- develop parenting services to support families, targeting the most needy; for example, commissioning specific support for teenage parents and for parents with a mental health illness.

We will continue to support the newborn screening programmes for Blood Spot (Phenylketonuria (PKU), Cystic Fibrosis, Congenital Hypothyroidism, MCADD), hearing, Sickle Cell and Thalassaemia. We will ensure uptake is high, quality assurance targets are appropriate and that, following detection, further assessment and care pathways are seamless.

We shall implement newborn screening programmes as recommended by the National Screening Programme.
We will work with local partners to:

- ensure parents and carers of up to 19-year-olds have access to clear, relevant information, support and targeted services to enable their children to enjoy healthy relationships and achieve the five Every Child Matters Outcomes (be healthy, stay safe, enjoy and achieve, achieve economic wellbeing, make a positive contribution)
- deliver programmes of preventative work on obesity in schools and communities, particularly in the wards with most need, to halt the rise in obese children
- reduce smoking, substance misuse, contraction of sexually transmitted infections (STIs) and teenage pregnancy through promotion and prevention programmes, increasing access to STI testing and smoking cessation support to young people.

We are committed to transforming the life chances of the most disadvantaged children under the age of five through early support and intervention including accessible parenting support for parents and carers, involvement in Sure Start children’s centres and generic assessment and support services delivered through integrated multi-agency working

We will implement a new human papillomavirus (HPV) immunisation programme in 2008, targeting girls aged 12 - 13.
Children with disabilities

By 2012 we will work with our local partners from the statutory and voluntary sectors to improve outcomes and experiences for children and young people with a disability, including those with life-limiting and life-threatening conditions.

To achieve this we are committed to:

- learn from local children and their families how they would best like to be supported
- developing co-ordinated pathways across agencies that put the child and family at the centre
- extending the current level of services we commission to support children to live as full a life as possible
- increasing the level and range of specialist short breaks for children with disabilities, including those with life-limiting and life-threatening conditions
- providing choice of preferred place of care and expanding the provision of suitable services in community settings
- ensuring access to specialist end-of-life care and 24-hour support and advice
- developing transition pathways from childhood to adult life.
Care closer to home

The focus of health provision for children will be a reduction in hospitalisation and development of more support at home and in the community. We will:

- by 2009, review the significant number of A&E attendances for children under five, refocusing existing services, such as the provision of out-of-hours support by the health visiting service, to help reduce levels of attendance

- by 2012, develop community paediatric nursing services to support the avoidance of children’s admissions and facilitate earlier discharge wherever possible and safe.

Strengthening child and adolescent mental health services (CAMHS)

The provisional feedback from the recent Joint Area Review concluded capacity issues remain at all tiers of CAMHS provision. Strengthening and increasing capacity in the service is also a priority for the Essex Children and Young People’s Plan.

Verbal feedback following the recent JAR has identified serious capacity issues within tiers 2 to 4. Essex County Council is considering increasing investment by £2.5m in response to this report.
Ensuring a comprehensive CAMHS

PCTs are assessed against proxy measures of access to urgent assessment, specialist CAMHS for children with learning disabilities, and against age appropriate services.

Currently PCTs in north Essex only fully meet the assessment standard. Significant investment will be required to ensure that there is sufficient capacity within the services to meet our standards.

In addition, the forthcoming national targets (access to the service of a maximum six-week wait to assessment and 18 week wait to treatment, and the requirement to commission a full range of CAMHS for children and young people who also have a learning disability) will require additional resources.

Standard nine of The National Service Framework for Children, Young People and Maternity Services (the NSF), which establishes clear standards for promoting the mental health and well being of children and young people, recommends that a service (with teaching responsibilities) for up to 17-year-olds would require 20 WTE per 100,000 population to ensure the overall caseload is compatible with the complexity of care provided and that an appropriate range of interventions are available. This figure should be increased in areas with high levels of deprivation. The number of clinicians for a non-teaching service is 15.

The establishment in North Essex Tier Three services (NEPFT) is:

- West Essex 6.5 WTE per 100,000
- Mid Essex 6.1 WTE per 100,000
- N. E. Essex 5.4 WTE per 100,000

The local service is a teaching service and therefore this represents less than 30% of the recommended level of staff needed to provide a safe and effective service.

Clearly there are explicit gaps to Tiers 3 and 4 CAMH services which must be rectified if waiting times targets are to be met, a full and comprehensive service is commissioned and the health of children and young people with complex mental health needs are to be met.
Proposed actions

Increase the number of staff and range of therapeutic services in the longer term with a year-on-year increase to an average of ten clinicians per 100,000 of population by 2009, rising to 15 per 100,000 of population by 2012, to bring the level to the minimum, ‘non teaching’ level.

The costs are detailed below.

<table>
<thead>
<tr>
<th>Year</th>
<th>West Essex</th>
<th>Proposed provision per 100,000 population</th>
<th>Proposed provision per 100,000 population</th>
<th>Proposed provision per 100,000 population</th>
<th>Proposed provision per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>6.5</td>
<td>11 per 100,000</td>
<td>600</td>
<td>13 per 100,000</td>
<td>300</td>
</tr>
<tr>
<td>2009/10</td>
<td>11 per 100,000 extra 12 clinicians</td>
<td>600</td>
<td>13 per 100,000 extra 6 clinicians</td>
<td>300</td>
<td>15 per 100,000 extra 5 clinicians</td>
</tr>
<tr>
<td>2010/11</td>
<td>15 per 100,000 extra 5 clinicians</td>
<td>250</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011/12</td>
<td>15 per 100,000 extra 5 clinicians</td>
<td>250</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Included in these costs is an explicit service for children with LDD, in partnership with ECC, integrating it with LDD services generally.
Looked after children

We aim to promote the health and welfare of looked after children by ensuring timely initial health assessments and annual dental and health checks. This will be enabled by the appointment of a North Essex Designated Doctor for looked-after children.

Safeguarding children and families

We will:

- in 2009, establish and review monitoring standards to evaluate effectiveness in meeting statutory and local requirements in safeguarding. Work is underway to develop key performance indicators for safeguarding

- in 2009, work with partner agencies in responding to new initiatives to address the impact of Domestic Abuse on families and children, including establishing the multi-agency risk assessment conference (MARAC) process

- establish a fully operational Child Death Review Process across West Essex by 2010

- fully embrace the Children Act 2004 and Working to Safeguard Children (2006) by working with partner agencies and the Essex Safeguarding Childrens Board. A dedicated team of nurse specialists and doctors will provide a service to safeguard children, young people and their families in the West Essex health economy. This will involve ensuring arrangements set out in section 11 of the Children Act are in place and continually reviewed in line with new guidance and legislation


- ensure comprehensive and robust arrangements are in place and adhered to for safeguarding children, both in commissioning and provision of services by NHS West Essex to include external service providers for West Essex children and their families
Looked after children

We will:

• a comprehensive service is developed at strategic and operational level to improve the health outcomes of Looked after Children (LAC). Integral to this will be inter-agency working to ensure a holistic approach is taken to reduce inequalities faced by this group of children

• we will promote the health and welfare of Looked After Children by ensuring timely initial health assessments and annual dental and health checks. This will be enabled by the appointment of a North Essex Designated Doctor for Looked After Children

• we will continue work across the Essex health economy to ensure continuity of service is offered to Looked After Children who are often a mobile population

• work with partner agencies in identifying service needs of asylum and unaccompanied minors, including commissioning of services of children placed outside Essex.

These initiatives will help deliver the East of England Strategic Health Authority pledges 1, 2, 7, 8 and 9.
Planned care

Increasingly we will commission the delivery of planned care in community and primary care settings closer to where people live. However, to achieve this, we need to improve the access, scope and capacity of these services. Our plans will address these issues.

Our goals

- improve access to and the scope of primary and community care
- ensure primary NHS dental services are available to all those who need them
- by 2010, ensure waiting times for treatments within a community setting are no longer than 18 weeks from referral to treatment
- maintain and improve access to hospital services, including 18 weeks and cancer waiting time standards
- ensure wherever possible and safe, care is provided as close as possible to people’s homes

Key Initiatives

- commission the majority of practices to offer extended hours, including a GP-led centre in Loughton and similar services across west Essex
- increase capacity of NHS dental services through commissioning additional activity
- introduce a range of measures to move services closer to people’s homes
- develop eight new health facilities over five years
- improve renal services to
- ensure maximum waiting times for non-consultant services.

We will measure achievement of these goals through:

- improvement in the average aggregate score for the national access survey from 84% to 91% by 2011
- ensuring 100% of our population has access to a GP at times convenient for them
- increasing the proportion of west Essex population that have seen an NHS dentist in the last 24 months from 51% to 60% by 2011
- monitoring the level of outpatient referrals to secondary care
- complying with national cancer waiting time targets
- referral to treatment time for non-consultant services.
Access to general practice

Repeatedly, people tell us that, although they value the services they receive from their GP practices it is not always easy to get an appointment quickly or at a convenient time. We have made some progress, improving levels of patient satisfaction across the four main in hours indicators of the national access survey by 2% from 2007 to 2008. However, the indicator for satisfaction with opening hours worsened by 2%. We will continue to work with our GPs to ensure we address dissatisfaction with opening hours and continue to improve overall satisfaction with access.

In particular we will:

- commission our practices to open extended hours at weekends and/or evenings or early mornings. We will expect the vast majority of practices to be providing extended hours by April 2009

- within normal hours, we will ensure there is year-on-year improvement in the national access survey for all our practices, particularly focusing on those practices that perform below the average for west Essex. This strategy has already proved successful, with the four poorest performers improving by between 10% and 15% in 2008 across the four in hours indicators. However, there is more work to do. We will be agreeing action plans for further improvement to achieve 91% aggregate achievement across the PCT by 2010

- in 2009, we will be opening a GP-led health centre in Loughton providing GP services to registered and non-registered patients in the Loughton area from 8am to 8pm, seven days a week. Patients will also be able to access other services, including diagnostic services and out-patient clinics from the same centre. We will explore options for providing equivalent extended GP services to other localities in west Essex, ensuring access to a GP at convenient times is available to all.
Primary dental services

The overall objective of dental care is to enhance the quality of life by helping to maintain optimum oral health and function for chewing and dietary freedom, comfort, speech and appearance for self-respect and social confidence.

By national and regional standards, oral health in west Essex is good (DMF 2006 data, score of 0.66, against the east of England average of 1.13 and national average of 1.47, ref WEPCT oral health strategy). However this measure can hide the fact that some groups will have significantly worse oral health than the majority. There is strong evidence linking poor oral health with higher levels of deprivation. Therefore, to improve the inequality of oral health in our population, we need to target services to these groups.

This is not just a question of increasing the amount of NHS dentists in west Essex, the poorer areas such as Harlow and Waltham Abbey have some of the best provision. We need to look at other methods of tackling this inequality.

We will work with the East of England Strategic Health Authority to explore the potential for fluoridisation of water within west Essex, or, if this is not feasible, look at other methods of increasing fluoride uptake in this group.

We will develop a targeted oral health improvement programme.

National and local surveys show people still have difficulty finding an NHS dentist. In west Essex we have good provision of NHS dental services in some areas, such as Harlow and Loughton, but very little provision in other parts, particularly Uttlesford. In 2008-09, we commissioned additional services in these areas, with three new practices due to open before the end of 2009. However this is not enough, we will continue to increase services across west Essex to ensure we meet our agreed access standard of:

- no-one travelling more that eight miles for routine dental treatment
- no-one travelling more than 15 miles for urgent dental treatment.

We will commission sufficient services to ensure that everyone who wants to access an NHS dentist will be able to do so.

We commissioned a marketing campaign to promote the new dental practices and increased capacity within our existing practices. This campaign includes advertising on buses and bus stops, direct marketing to patients, features and advertisements in the local press.
To ensure people can easily find an NHS dentist we established a dedicated telephone helpline to give information on the nearest dentist. This number is included in the dental campaign and widely through other communication vehicles.

Currently 51% of people in west Essex saw an NHS dentist within the last two years. We will ensure that by 2011 we have improved this to 60%.

**Pharmacy services**

Pharmacists are a crucial part of the NHS, delivering easy access to high quality services for patients. The government’s white paper, *Pharmacy in England; Building on Strengths, Delivering the Future*, outlines plans to build on the strengths of pharmacy services for the NHS in England.

Our plans for pharmacy services are to:

- commission pharmacy services as part of our wider strategy for commissioning primary and community services
- assist community pharmacies in becoming a primary source for healthy living and health improvement information and advice; fully integrated into public health initiatives such as stopping smoking, sexual health services and weight management
- broaden the range of services provided in community pharmacies, particularly in relation to screening, vaccination and preventative healthcare, as well as proactive support for people with long-term conditions, through routine monitoring, vascular risk assessment and support for making the best use of medicines
- ensure community pharmacy is fully engaged with PBC and the development of clinical pathways that support integrated care
- publicise community pharmacies as the local community leaders in medicines, reducing medicines related harm as well as the first port of call for patients with minor ailments
- support the development of services for self care
- improve access to medicines through the development of Patient Group Directions, targeting hard to reach groups
- support community pharmacists in developing their workforce to deliver new services and ways of working
- facilitate integrated working with others in local health, social care and voluntary sector teams; for example, supporting an ageing population and end of life needs.
Maximum waiting times for more services

The maximum waiting time of 18 weeks from referral to treatment has been achieved for most services provided from hospital. This is a great improvement for patients. However not all services are covered by this guarantee and we will extend the guarantee to cover services predominantly provided in the community. We will ensure that by April 2010 for all services, patients will wait no longer than 18 weeks from referral to treatment and in many cases the maximum wait will be much shorter.

A compete list of all services covered by this commitment is shown, along with current waiting times at Appendix 3.

This will be achieved through contractual arrangements with providers and monitored as key performance indicators. The main provider of these services is introducing IT systems that can collect data accurately for monitoring purposes.

Cancer services

Our aim is to provide the best possible advice and care for avoiding, diagnosing and treating cancer for all people living in west Essex, irrespective of age, ethnicity or social class, and as far as possible, within improved outcomes guidance (IOG), according to patient choice. We will ensure patients and their carers receive the appropriate professional support, care and best treatment for their cancers.

We will strengthen existing communications between primary, secondary and tertiary care, hospices, charities and cancer networks. This work will be developed in line with the cancer and palliative care network plans developed from the NHS Cancer Plan and cancer reform strategy.
Key objectives will be:

- establishing a primary care cancer team
  - improving services in primary care by:
    - improved cancer registers within practices and their use for regular review
    - establishing a cancer lead in each practice
    - establishing carers register in each practice
    - improving the Primary Health Care Team recognition and early investigation of symptoms
    - improving patient information supplied to secondary care at point of referral
    - implementation of new screening and additional screening for breast cancer (see Staying Healthy section)

- increasing radiotherapy capacity:
  - reviewing current levels of activity and developing plans for increased capacity by 2010

- improving palliative care services:
  - PCT Primary Care Cancer Team will develop and roll-out a supportive care programme which incorporates training and record keeping

- health promotion and prevention:
  - to ensure public/users are aware of the risks associated with smoking; poor diet and obesity (see Staying Healthy section)

- improving pathways in secondary care:
  - improve communication between primary, secondary and tertiary care and service users
  - improve communication during treatment

- patient education and information:
  - local information point for patients and carers.
Key to delivering a number of these initiatives is improving the co-ordination and setting of care for cancer patients. We will be working with Princess Alexandra Hospital NHS Trust to look at developing a dedicated cancer unit on its Harlow site. This would mean cancer care could be focused in one unit and avoid patients being placed in different wards around the hospital to improve quality and co-ordination of care.

In addition, out-patient services for cancer patients could be incorporated into this unit to include chemotherapy and specialist clinical nurse support as a minimum. This proposal requires significant further discussion to take it forward but we anticipate significant benefits for patients if this were to be successful.

**Increasing the Scope of Primary and Community Care - shifting services closer to people’s homes**

In this section (and in the section on long-term conditions), we describe a range of initiatives that, over the next five years, will transform how health services are delivered in west Essex.

For most people in west Essex, if they need to see a specialist, or have a diagnostic test, they travel to a hospital. For some this is relatively convenient, but for others, due to the rural nature of the area and poor public transport links, this is a real difficulty. We intend to address this by commissioning more services locally in the communities where people live.

By working with GP practices we will reduce the need for referral to hospital by increasing the availability of direct access to diagnostic tests and by supporting and resourcing GPs to extend the range of services and the level of specialisation that they can provide. This will be achieved through a radical Practice Based Commissioning scheme that will shift resources into primary care and the community. To support this, a range of diagnostic tests will be commissioned locally including radiology.
As part of this work, by 2014, we will shift appropriate activity from a hospital setting to a community setting by up to 25% for some specialties. We will achieve this through:

- reviewing the 90 HRG procedures identified by the NHS institute for Innovation (procedures of limited clinical value or ambulatory care sensitive conditions) to identify those that can be provided in the community, or that are our contractual arrangements with acute trusts. Currently we pay our main acute contract based on their achieving a follow-up to first outpatient appointment ratio within the top 25% of performers in each specialty. We will continue to improve this ratio to achieve within the top 10% of performers for each of our local hospitals

- working with our current and new providers to shift outpatient and diagnostic tests to community settings though the extended use of existing facilities and the provision of new health facilities that will bring together primary, community and specialist care

- reducing length of hospital stay through support services provided at home and integrated with social care services

- reducing A&E attendances (see emergency care section).

**New community health facilities**

Realising our vision of bringing services closer to where people live and increasing the scope and quality of services in the community will require a huge investment in health facilities in the community. Over the next five years we have plans for a ten major new developments (see chapter 3, Delivery).
Planned hospital care - improving renal services

West Essex patients requiring renal dialysis have had a choice of units that they can attend. Patients currently attend either:

- Broomfield Hospital in Chelmsford
- Addenbrookes Hospital in Cambridge
- Lister Hospital in Stevenage
- Basildon Hospital
- Barts and the London and their satellite units in Whipps Cross and King George’s, in north east London.
- However, none of these are within our geographical area.

While these units support patients on the borders of our area and also those who work in London, and have integrated their dialysis as part of their working life, for patients in Harlow and the surrounding area all of the units present significant travel distances.

To identify what is required to meet the standards set out in the Renal National Service Framework (published in 2004) the East of England Specialist Commissioning Group (SCG) commissioned a strategy and capacity plan for the expansion of haemodialysis services which was produced in May 2008. This report highlighted prevalence in west Essex is 12% lower than the expected prevalence but there are no clear indications for this variation.

While we want to improve access for our patients, the development of a new unit will be dependent on there being sufficient demand to allow for the correct and most effective number of dialysis stations.

The development and commissioning of this service will be taken forward by the SCG. More important for the population will be the development of home dialysis in line with NICE guidance and the intention is that we should move to 10% of suitable patients being offered home haemodialysis over the next five years.
Patient choice

People in west Essex have a choice of six local acute providers for their planned care as well as access to the extended choice menu. However, due to the geography of west Essex and the poor public transport links, people who live in more rural parts and some of our towns, find it difficult to exercise that choice.

Our aim is to provide people with a wide range of planned care services in the community, avoiding the need to travel to hospital for most of their care.

Being able to choose a provider and book a convenient appointment at the time they are referred is important to people. West Essex has been slow to make full use of the Choose and Book system. Therefore we will work closely with GP practices to increase the number of people able to have their appointments booked at the point they are referred, and to ensure they are able to choose a time convenient to them.

We will achieve this through:

- ongoing training of GPs and their staff
- adoption of best practice - what has worked in other areas.

These initiatives will help deliver east of England Pledges 1, 2, 3, 4, 5, 7 and 9.
Acute care (urgent and emergency care)

Urgent care should be defined from the perspective of the patient and their family, which includes health and social care. Therefore if the patient perceives the need for urgent assessment this is considered as urgent care.

The term Emergency Care is used to describe a sub group of urgent care, which usually means the patient’s condition needs to be treated immediately and they commonly access their care via a 999 ambulance. Urgent care needs rapid assessment but does not necessarily need immediate treatment.

We will develop a Strategy for Urgent Care which will incorporate the key recommendations of the HealthCare Commissions Urgent care Services Review, 2008.

Our goal
- to reduce the number of attendances at A&E and unnecessary emergency admissions to hospital to the best performing 25% of comparable PCTs.

Key initiatives
- develop an urgent care centre at the ‘front door’ of PAH A&E reducing A&E attendances by 10% by 2011-12
- commission a new integrated pathway for urgent care services
- improve stoke services including thrombolysis and access to TIA assessment.

Measures:
- the number of emergency bed-days per head of population
- national access targets for urgent care: A&E treatment within four hours, ambulance response times
- patient experience of urgent care services as measured by the national patient survey.

The achievement of this goal is directly linked to achievement in other areas of our strategy, such as long-term conditions and improving access to primary and community services.
Additionally, by working with our partners in local hospitals ambulance services, community and primary care we will:

- retain our local A&E department at PAH and develop an urgent care centre at the front door which will provide an integrated emergency and primary care service to enable patients seeking urgent care to be seen by the most appropriate professional. This service will be established following the outcomes and recommendations of the pilot which ended at the end of September 2008. We will explore options for providing a similar urgent care centre in the north of the area to ensure all of west Essex have access to this service.

- design a new integrated pathway for patients needing urgent care to ensure they can easily access the most appropriate service to meet their needs and avoid, wherever possible, the need to attend or be admitted to hospital. Key elements of the pathway will include:

  ◊ an in-reach service to work with A&E to facilitate and co-ordinate alternative support in the community for those patients that do not require an admission to hospital. This will include case managers and urgent care teams providing hospital at home services.

  ◊ ensuring NHS Direct and the ambulance service direct patients to the most appropriate service where a transfer to hospital is not required. This will include access to rapid assessment in the community, direct admission to community hospitals or referral to community based support services.

  ◊ an integrated primary and community care service, available over extended hours, to ensure alternative support for older people and people with long-term conditions, avoiding the need for hospital admission wherever possible.

  ◊ commission and publicise extended access to primary care services, enabling local people to be seen in the evenings and at weekends and improve access to urgent care in hours. These services will be provided at most GP practices, GP-led health centres and in other settings as necessary.

  ◊ improved support in the community for mothers and babies/young children, ensuring effective links between community based children’s services and A&E to identify frequent attendees at A&E.
GP out-of-hours services

We will effectively integrate out-of-hours GP services into the urgent care pathway. Services are currently provided by the Partnership of East London Cooperatives (PELC) in Epping Forest and Harlow, and by The Emergency Doctors Service (TEDS) in Uttlesford. PELC consistently achieve the national standards for out-of-hours care as do TEDS. Despite the apparent good performance, we still experience increasing levels of attendances at A&E departments.

We will ensure GP out-of-hours services are fully integrated into the urgent care pathway through the provision of Urgent Care Centres at Whipps Cross and through the pilot at PAH.

Improving stroke services

The opening of Beach ward at St Margarets’ Hospital greatly improved the specialist neurological rehabilitation services available to west Essex patients. We will continue to work to improve services across the pathway to ensure:

- by July 2009, all stroke patients will be treated on a specialist stroke unit for a minimum 90% of their stay. Currently (quarter four 2008/09) 59% of patients meet this standard

- all those experiencing a transient ischemic event (TIA) at high risk of stroke will be scanned within 24 hours and for low risk patients within seven days. This standard is met by Whipps Cross, Mid Essex and Addenbrookes hospitals covering 14% of west Essex patients. This service is currently not offered by PAH but is in development and will be in place to achieve the target by the end of 2009 for the 24-hour standard and by February 2009 for the seven-day standard

- three hour thrombolysis treatment of stroke will be available 24 hours a day to all west Essex population by autumn 2009. The PCT will make year progress toward achieving thrombolysis within 60 minutes for all appropriate stroke patients.
Improving services for cardiac care

The care of people suffering heart attacks is advancing all the time. Primary Percutaneous Intervention (Primary PCI) is increasingly routinely available within the UK. The publication of Mending Hearts & Brains by the Department of Health in 2006 highlighted the benefits of this intervention and the evidence base supporting early intervention in patients presenting with ST elevation myocardial infarction (STEMI) has grown in recent years.

Three centres in the region provide a 24-hour, seven day a week, primary percutaneous coronary intervention (PPCI) service (Essex Cardiothoracic Centre, Papworth and Norfolk and Norwich)

By 1 April 2009 a 24-hour, seven day a week, primary percutaneous coronary intervention (PPCI) model of service will be available for Essex at Essex Cardiothoracic Centre in Basildon. A maximum call to balloon (CTB) time of 165 minutes (45 minutes from the call to leaving scene, up to 90 minutes journey time, 30 minutes arrival to balloon time (DTB) will also be implemented.

- These initiatives will help deliver east of England Pledges 1, 3, 4, 5 and 6.
Long-term conditions

What we do to improve the lives of people living with a long-term condition (LTC) is key to achieving all our overarching objectives. Almost 60% of hospital bed days are directly attributable to LTC. Modern medicine and medical technologies are helping people to live longer. This means we need to plan for supporting people with an LTC for longer and in ways that enable them to manage their own conditions.

In an attempt to meet the growing challenge of long-term conditions, government policy highlights the need to improve health and social care for people with chronic disease. Key policy documents emphasise the need for services and professionals to provide integrated, efficient and enabling interventions to help people prevent potential chronic disease or manage existing conditions. In response to this challenge there is a growing array of innovative models of LTC strategies within the NHS.

We have commissioned a research project to investigate long-term conditions management at a national level, including:

- evaluating work modelling service provision for children and young people
- long-term conditions self-care training programmes for the mainstream and learning difficulties populations.
The project will consist of four phases. Innovative models of LTC service provision will be identified and sampled, and their potential for the PCT will be evaluated via stakeholder consensus methods previously developed by the research team.

Theoretical work on organisational modelling and knowledge work will provide a theoretical and analytic framework which will include a proposal for the implementation and evaluation of the ideal model.

**Our goal**
- to improve the lives of those suffering a long-term condition by working in partnership to support them to maintain their independence whilst ensuring the services and treatment they receive is personalised, holistic and, wherever possible, provided in a community setting or their own home.

**Key initiatives**
- review and commission new pathways; all pathways to include personal health plans offered to 100% of patients and with a 90% uptake.
- ensure Quality and Outcome disease registers for diabetes and COPD are within 10% of expected prevalence
- increase both generic and condition specific self-help and education programmes
- Commission cardiac and pulmonary rehabilitation programmes to meet National Institute for Clinical Excellence (NICE) recommended levels
- strengthen case management
- pilot patient held budgets.

**We will measure our achievement of this goal by:**
- the proportion of people with a personal health plan compared with the number of people on long term conditions registers
- the percentage of people diagnosed with a particular condition that are on a QOF disease register, compared with the expected percentage
- average length of stay
- the number of education programmes for people with a long-term condition
- Better Care Better Value LTC indicator
- Improved patient experience.
Reviewing services

Over the next three years we will review the services we commission to ensure they focus on the individual and their needs, support people to manage their own conditions and are provided in a community setting or in people’s own homes wherever possible. We will commission whole pathways of care that are integrated and will include direct access to diagnostics and include a range of providers including the voluntary sector.

We will specifically:

- develop personalised health plans for all those with a long-term conditions by 2010/11 use case finding and case management techniques to identify patients with two or more long-term conditions who are most at risk of hospitalisation

- appropriate support to Case Managed patients to manage their condition

- improving patient experience by empowering people to manage their own conditions where they want to do so, and by offering them choices about how their health is managed

- we will increase the number of expert patient programmes and deliver disease specific education programmes for pain management, respiratory disease, heart disease, Parkinson’s, diabetes and muscular skeletal conditions such as arthritis. Currently about 700 places are available on education programmes both generic and disease specific. This will increase to 800 places in 2009, 1,000 in 2010 and from 2011, 1,500 places per annum. Programmes will include:
  ◊ generic self management programmes such as Expert Patient Programme
  ◊ disease specific education programmes such as DAFNE, X-pert, Pulmonary Rehab or Cardiac Rehab
  ◊ disease specific Expert Patient Programme (EPP) sandwich courses providing disease specific sessions in addition to EPP
  ◊ voluntary sector courses such as managing pain commissioned from Arthritis Care
  ◊ web based programmes such as the online EPP as these become available
  ◊ one to one teaching; for example for people with type 1 diabetes.

- work with practices to ensure that disease registers are in line with expected prevalence where robust prevalence models exist (i.e. diabetes and COPD)
The timeframe for this review is:

- by 2009 we will have reviewed and re-commissioned services for diabetes, chronic obstructive pulmonary disease (COPD) and case-managed patients, to include:
  
  ◊ supporting people to manage their own condition by:
    ◊ increasing the number of self-management courses for people with type I diabetes (Dose Adjustment for Normal Eating Programme - DAFNE) to a minimum of five per year
    ◊ increasing the number of X-PERT courses for people with Type II diabetes to a minimum of 22 per year

- from 2008 increase Pulmonary Rehabilitation in each locality so that people can attend near to where they live. Based on NICE recommended levels of programmes offered; in March 2009 places are available for 141 patients. This will increase to 424 by March 2010 and 566 by March 2011. The requirement for additional places will be reviewed based on the numbers of eligible patients

- ensuring at least 80% of people with diabetes continue to receive regular retinopathy screening.

By 2010 we will have reviewed and re-commissioned services for cardiovascular disease; including heart failure, coronary heart disease, arrhythmia and stroke. New services will include:

- increased prescribing of beta blockers for people on heart disease or heart failure registers and who would benefit from this medication from 45% (October 2008) to 60% by March 2010 and 75% by April 2011

- considering the use of BNP to speed up definitive diagnosis of Heart Failure during inpatient admission. BNP is currently already used for the early diagnosis of heart failure in conjunction with an open access echocardiography service in primary care.
By 2011 we will have reviewed, and where appropriate re-commissioned, services for neurological conditions, musculoskeletal conditions to strengthen and extend the level of service provision.

We employ two Parkinson’s Disease nurses and work closely with the Parkinson’s Disease Society. The nurses enable greater personalisation, for instance by working with people to tailor their individual drug regime to their particular symptoms. This has been successful in reducing unnecessary hospital admissions. The focus for re-commissioning of the entire pathway in 2010-11 will be to further increase personalisation and satisfaction.

In developing musculoskeletal conditions pathways we are working with Arthritis Care to offer challenging pain management courses this year, which we expect to continue if they are positively evaluated. We are also working with local PBC groups to develop primary care pain management services.

**Cardiac rehabilitation**

There is evidence that cardiac rehabilitation reduces the risk of total and cardiac related mortality, subsequent revascularisation and occurrence of non-fatal myocardial infarction (MI). Evidence also suggests that it improves people’s ability to work, their physical capacity and perceived quality of life. Currently rehabilitation is routinely offered to patients post MI and revascularisation.

There is growing evidence of similar benefits in patients with stable angina and heart failure of which a small percentage are currently accessing the rehabilitation services. MI and revascularisation patients have been offered a full rehabilitation programme has been available since June 2008. Anticipated referrals for 09/10 are 840 per year. Current resources allow 48 cardiac rehab individual patient consultations per month, 576 per year. This is in line with NICE recommended levels of programmes offered. Heart failure patients – the number of patients completing mainstream cardiac rehab with heart failure is expected to be a minimum of 25 per year.
Case finding and case management

Case Finding and Case Management are strategies for identifying and managing/supporting older people who are not necessarily in touch with health or social care services and people with long-term conditions.

Using established techniques based on a collaborative model, the goal is to promote independence and optimise care outcomes for older people and those with long-term conditions through the delivery of person centred, co-ordinated services.

Each patient receiving this co-ordinated approach to care will have a personalised care/management plan with individual goals which meet their personal needs.

Patient-held budgets

As part of our plans for ensuring services are focused on the individual and support people in managing their own conditions, we will consider participating in a national pilot of patient held budgets.

Personal Health Budgets will give patients greater control over the services they receive and providers from which they receive their care.

We recognise the introduction of such budgets will require significant cultural change to enable the creation of a more personalised health service.

We will carry out an initial piece of work, sharing and clarifying the principles of Personal Health Budgets with three communities:

- patients and service users
- professionals and providers
- general public - tax payers.
We will listen to service users and the general public so we are kept fully informed by service users as to how they consider the benefits of this flexible approach to care. This will enable full citizenship by virtue of which patients are in control.

We will submit an expression of interest to participate in the national pilot once details are received.

The key principles of personal health budgets are to:

- fully support the principles of the NHS as set out in the Constitution - a comprehensive service, free at the point of use
- include tailored support developed to meet the different needs of potential patients, particularly those least well served by existing services
- be purely voluntary - no one will ever be forced to have a budget
- be underpinned by safeguards so that no one will ever be denied essential treatment as a result of having a personal budget
- make good use of NHS resources with appropriate accountability.

We will be sharing the principles of Personal Health Budgets with user groups to shape the development of local plans so Personal Health Budgets help individuals:

- assess the state of their personal health and symptom management skills
- identify their goals and complete an action plan to meet their goals.

We will also work with user groups to evaluate the use of personal health budgets including:

- levels of satisfaction
- rate of uptake
- re-hospitalisation rates.

These initiatives will help us deliver East of England Pledges 1, 2, 3 and 7.
Learning disabilities

Our goal
• ensure people with a learning disability are able to access the services they need in the same way as can the rest of the population

Key initiatives
• improve specialist services for people with a learning disability through redesign and re-tender of services.

• improve access to services in primary and secondary care through the introduction of a locally enhanced service, investment in increased learning disability community nursing and acute liaison, and through the appointment of people with learning disability as Health Access Champions

We will measure achievement through:

Health and social care for adults with a learning disability across the area served by the North Essex PCTs are commissioned within a formal partnership agreement between Essex County Council, as the lead commissioner, and NHS West Essex, as the lead health commissioner.
There are four key strategic challenges facing NHS West Essex and Essex County Council in the next two to three years:

- the closure of NHS campus beds and the resettlement of people with a learning disability accommodated in these units into more appropriate community services, primarily housing with support. The DH has set a deadline for PCTs nationally to complete this resettlement work by 31 March 2010. The EoE SHA has set a target for PCTs in this region to complete this work by 31 March 2009. Work is well underway and will be completed within timeframe. The key policy drivers for this are Valuing People Now 2008 and the NHS Operating Framework 2008.

- the re-tender of the contract to provide specialist learning disability health services, both in-patient facilities and community services. This work is underway with a working target for (i) the publication of a new service specification and (ii) the award of a contract to the new service provider by 1 October 2009.

  A new service specification will be completed and the service tendered and contract awarded in 2009.

The key policy drivers for this are the Department of Health Specialist Service Definitions Set for Learning Disabilities, the Definition of Core and Non-core Services by the EoE SHA, DH Guidance on Commissioning Specialised Services 2007.

- to address the inequalities of access for people with learning disability to primary and secondary health care services. This will require specific and concerted action by individual PCTs and changes to commissioning and contracting arrangements with GPs and acute trusts.
The key policy drivers for this are the DRC report *Closing the Gap 2006*, the Mencap report *Death by Indifference 2007* and the *Michael’s Report 2008*

- New contractual arrangements to strengthen primary care and acute services will be developed, including:
  - local investment in increased LD Community nursing and acute liaison
  - appointment of people with LD as Health Access Champions
  - health self-assessment and major user consultation via LD performance framework (SHA endorsed)
  - setting up locally enhanced service contracts with GPs against performance targets for people with LD
  - linkage with specialist service re-tender to enhance support for primary & secondary access.

- the transfer of social care funding and commissioning responsibility from NHS West Essex, as host health commissioner, to Essex County Council. The DH has set a deadline of 1 December 2008 for joint agency agreement on the amount of revenue transfer and of 31 March 2009 for the completion of the transfer.

The key policy drivers for this are Valuing People Now 2008 and The NHS Operating Framework.
End of life care

In west Essex, 61% (2007 data) of people died in hospital, even though we know that from an audit undertaken within the PCT 76% of people said they would prefer to die at home.

We will support people with a life-limiting condition, and their carers, so that, insofar as is possible, they are cared for and are able to die at home if that is their wish.

In accordance with patients’ stated preferred place of care, we will aim to increase the proportion of deaths that occur outside a hospital setting to 70% by 2013 (50% of all deaths).
Raising awareness and partnership working

We will work with the public and partners to raise awareness of end of-life issues. Advanced care planning will be strengthened and supported through the process of raising awareness with the public and partners. Professionals will be educated to facilitate open and honest conversations with patients and their families and carers as recommended within the End of Life Care Strategy. The Preferred Priorities for Care document will continue to be implemented and monitored throughout the PCT.
Improving services

We will ensure the Gold Standards Framework or equivalent is used to provide a systematic approach to the care of patients in the community. In particular we will work with GPs, the out-of-hours service, voluntary sector providers and care homes to ensure all those identified as being in the last year of their lives are included on a palliative/end of life care register.

We will work with our providers to ensure those included on the registers have advanced care plans in place. We will achieve this through the development and monitoring of core standards within contracts with providers.

We will have advanced care plans in place for 30% of palliative care patients by March 2010, rising to 80% by March 2014.

For those who have reached the last days of their life, we will continue to roll out, implement and embed the Liverpool Care Pathway into practice, and to commission the pathway required to support this process.

The West Essex Partnership End of Life Steering Group, membership which includes primary and secondary care, the third sector, social care and lay members, will be responsible for highlighting gaps within service provision, exploring and identifying ways of improving access and quality. Further, the steering group will advise the commissioners regarding service provision for those individuals with end-of-life care needs.

Strengthening out-of-hours provision

Out-of-hours care will be improved in line with the recommendations in the End of Life Strategy. We will:

- work with partner organisations to guarantee improved access to supportive and palliative care services, particularly out of hours.
- this will include working towards meeting the NICE criteria for specialist face-to-face assessments, 9am to 5pm, seven days a week as a minimum
- explore methods of 24-hour service delivery and ways of improving co-ordination of care, for example the Marie Curie Delivering Choice programme
- provide access to an effective 24-hour helpline for the individual and their carer
- give consideration to a rapid response service in the community for nursing care
- put mechanisms in place to improve communication and co-ordination of out of hours care.
Support for families and carers

There is an estimate of 3,400 known carers in west Essex. Everyone has the potential to become a carer, and it is likely that in the future many more people will do so. With life expectancy increasing, our population of older people is set to double in the next 20 years, with many developing long-term clinical conditions. This will, in turn, affect more families.

There is a recognised need to improve support for carers and acknowledge what they do for those whom they support. This means improving not only the social aspects of their lives but maintaining and improving the good health of carers.

Support for families and carers will be improved through collaborative working between health and social care to ensure adequate respite breaks are offered to those in need. Carers’ support will not only be for those caring for adults, the carers strategy will identify links into children’s services to support young parents who care for a sick child as well as raise an extended family and young carers who are at the beginning of their adult life.

Carers’ registers in each GP practice will be monitored to ensure carers are invited to an annual health check of their own where they are able to liaise with a designated health lead. Account will be taken of the difficulties carers experience in visiting GP practices, since they may have to arrange a sitter or may only be able to attend surgery later in the day due to the care they are providing themselves.

We work closely with third sector organisations, including Marie Curie Cancer Care, to ensure integrated and personalised services that maintain balance in carers’ lives. It is our aim to further improve these relationships to ensure all long-term condition patients that are being cared for have the appropriate support at the time when it is most needed. Links with carers support groups, relevant to each locality, are vital to achieving this. Examples are the local Alzheimer groups linking in with our local dementia strategy and the End of Life strategy.

Carers will be involved in the decisions about the patient’s care and will be made aware of services available to support them in recognising their own needs. This will be done not only through local information centres with trained staff, but through a vision to improve education available for GPs, pharmacists, community staff and the introduction of carers’ leads in GP surgeries.

We will research the needs of carers locally and introduce support services which enable them to continue caring and supporting people with long-term conditions more effectively at home.
This will almost certainly include home support (assistance with domestic chores) brief break services (for example, allowing carers to leave for two or three hours), and longer term support.

These services are an extension of those provided for terminal care but will be commissioned jointly with social services and will be tailored to the needs of carers based upon research into the needs of specific conditions (for example, the needs of carers of dementia sufferers are different to those of heart disease sufferers or the dying).

In conclusion, the carer’s strategy will identify:

- training for all professional staff, including GPs, pharmacists, district nurses, teaching staff and GP reception staff to identify those individuals who may potentially be carers but are not known to health or social services
- potential for improved communications with carers
- the distinct needs’ of carers
- annual health checks for carers
- GP appointments scheduled to the need of the carer
- cost effective breaks
- emergency and urgent care: access to care packages critical for hospital avoidance
- to ensure out-of-hours services are aware potential 999 calls are for a carer who cannot leave their loved ones and that there may be the need to take both parties in an ambulance
- links with children’s services
- greater partnership working between health & social care/expert partners in care
- development requirements for a comprehensive information service
- carers’ leads in GP surgeries or other appropriate locations.

These initiatives will help us deliver East of England Pledges 1 and 7
Patient experience

Our goal
- to continuously improve patient experience across all the services we commission as measured by the East of England composite indicator

Key initiatives
- patient experience indicators in all contracts linked to incentive payments (CQUIN - Commissioning for Quality and Innovation)
- extend the monitoring patient experience across all service areas.

We will measure our achievement of this goal across a number of indicators by:
- self-reported patient experience scores: composite score based on average of acute inpatient score for local trust and primary care score for PCT
- self-reported patient experience via Dr Foster Patient Tracker systems, audit cycles and improvement cycles
- essence of care benchmarking - ongoing audit cycle of each benchmark and standard throughout the year
- Department of Health Dignity Audit - annual cycle
- QOF - annual cycle
- PEAT reports (for in-patients)
- Achievement of national access targets
- National Patient Survey results
- complaints handling, response times and outcomes from recommendations.
We aim to commission services which meet both the physical and emotional needs of the patient. This means:

- receiving high quality treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way
- having the information needed to exercise choice, to feel confident and in control
- being talked and listened to as an equal
- being treated with honesty, respect and dignity (DH Patient experience definition September 2007).

We are pro-active in seeking the views and experiences of public, patients, their carers and stakeholders, especially those least able to act as advocates for them.

Patient experience is not merely patient satisfaction: it impacts on all other commitments within our strategy. It covers all aspects of service from the cradle to the grave, adding to the need to understand and respond to patient and public need.

During 2007-08 we have adopted the following strategies to capture patient experience and satisfaction:

- use of a Patient Tracker to monitor experience within our in-patient and community settings
- Essence of Care benchmarking in all community and patient-based services, together with patient focus benchmarking for all healthcare practitioners
- Expert Patient programme
- long-term condition self help groups
- National Patient Survey
- group discussions - covering different age groups and localities - informed by mosaic
- specific quality measurements included in all service level agreements with the providers of care
- Patient Reported Outcome Measures (PROMS) will be included in all acute contracts from April 2009 for hip and knee replacements, hernia and varicose vein procedures. PROMS will be extended to other areas from 2009-10.
We have introduced and implemented the following strategies to influence service redesign, joint and strategic commissioning:

- essence of care benchmarking in all community and in-patient based services - patient focus benchmarking for all healthcare practitioners
- audit cycle plans for quality indicators including Essence of Care
- performance assessment framework for in-patient areas (launched April 2008)
- Department of Health Dignity Audit Tool - launched July 2008
- for each provider, running patient workshops facilitated by the Lead Nurse to inform service redesign
- annual Patient Environment Action Team (PEAT) audits.

**Measuring patient experience and clinical quality**

We are committed to working with patients to improve how we measure clinical quality and effectiveness. Developing measures that may be used as scored indicators will result from directly working with patients and discovering what is important to them.

We will use the findings of an independent academic researcher to identify a practical and effective tool for collecting patient experience data across the PCT to ensure patients’ experiences are linked firmly into the commissioning process.

The research will be completed by end of March 2009 and provide us with specific tools which we will apply to identified priority areas which will be agreed through current performance and commissioning processes.

We will develop and implement an Improving Patient Experience Strategy 2008-12 in partnership with patients and the public. It will incorporate specific measurements which will demonstrate success with quality and reporting schedules and will clearly define approaches which will capture the experiences and views of our population with a particular focus on the more difficult to reach groups of people. It will include specific goals with immediate effect as outlined above, together with more long-term research initiatives including a longitudinal study of patient experience.

The strategy will address the question “what do patients and the wider public think of the services commissioned on their behalf?”

These initiatives will deliver East of England Strategic Health Authority Pledge 1.
Delivering year-on-year improvements in patient experience

To improve the quality of services we deliver, it is important to understand what patients think about their care and treatment. One way of doing this is to ask patients who have recently used our services to tell us their experiences.

People access services we commission in both primary and secondary care and we acknowledge there is still much to do to ensure the way we measure the overall effectiveness of these services is accurate and meaningful.

We will be investing in people and technology to ensure it understands the needs of patients and can be responsive to issues raised. This is a key component of our strategy to commission world class services.

We are using a number of methods to do this including the Dr Foster patient tracker, complaints and compliments monitoring, direct patient questionnaires (undertaken by the voluntary sector while patients are in hospital) and patient surveys.

We will also participate in the Releasing Time to Care Productive Series, a programme that will enable frontline staff to spend more time with patients, and the implementation of the work is being monitored by the Director of Nursing through the commissioning Directors of Nursing at the East of England.

Of all these methods the patient survey of primary care is the most established. This is undertaken for the PCT by the independent health watchdog The Healthcare Commission. The survey, the fourth it has undertaken, shows how we are performing against a set of national indicators.

It provides a critical insight into patient experience and helps identify areas that should be improved upon. We have developed action plans to address the key issues raised. The respondents broadly reflect the PCT population however there was a lower response from young males and BME groups.
Patient safety

Our goals
• to make patient safety a priority for all our services and to ensure they are the best in England.

Key initiatives
• patient experience indicators in all contracts linked to incentive payments (CQUIN - Commissioning for Quality and Innovation)
• extend the monitoring patient experience across all service areas.

We will measure our achievement of this goal through:
• maintaining a year-on-year reduction in the MRSA rate within the west Essex health economy
• maintaining year-on-year reduction in the the clostridium difficile rate among the west Essex population
• ensuring the Hospital Standardised Mortality Ratio for our acute service providers is below 100.
Infection prevention and control

We will ensure infection control measures remain in place so MRSA and Clostridium Difficile rates continue to reduce.

- We will continue to work with acute service providers to ensure infection prevention continues to be a priority. Specifically we will:
  - continue to take a joint approach within the local health economy to Root Cause Analysis of every case of MRSA bacteraemia and Clostridium difficile and ensure other commissioned acute providers carry out RCAs to the same standard
  - carry out audits across the care pathway for patients whose total care package covers a multitude of providers, eg primary care, acute care, community hospitals, care and nursing homes
  - ensure appropriate screening is carried out which is in line with national policy and allows the microbiology laboratories and health protection agency to monitor new infections and new strains of infections, taking action at the earliest stages
  - improve infection prevention and control support to nursing and care homes in west Essex and work with the regulatory bodies of these homes to ensure that standards are improved
  - continue to ensure education and training programmes are delivered collaboratively across all sections of the health and social care local economy
  - continue to strengthen performance metrics relating to infection, prevention and control within all contracts and enhanced service agreements.

Patient safety strategy

We are committed to ensuring our patients receive high quality and safe health care whether this is in hospital, in the community or their own homes. Specifically we will:

- work with our partner organisations in embedding patient safety at all levels, through the development of patient safety strategies, awareness programmes and action plans
- develop specific patient safety indicators for inclusion in all service contracts
- sign up to be part of the national patient safety campaign and participate in other national learning programmes run by the NHS Institute for Innovation and Improvement
- ensure robust incident and near-miss reporting is in place and action plans implemented that minimise recurrence(s)
- monitor the implementation of issues arising from national patient safety notices and facilitate partnership working as required
In addition, we will focus on specific areas with a view to achieving measurable improved patient outcomes. For years 2008-10, we will:

- review and agree a reduction in the hospital mortality rates for our key acute services
- work with local partners in agreeing a protocol for the management of insulin dependent diabetic patients in the community
- review the prevalence of patient falls within hospitals and in the community, and agree specific interventions with GPs, community teams and hospital staff to reduce these
- work with GPs, hospitals and community pharmacists to reduce the number of medication incidents and errors by:
  - increasing concordance with medicines taken by patients with long-term conditions, through the process of medication reviews and developing a concordant approach to prescribing. This will include raising the number of LTC patients receiving information about their medicines to a locally agreed standard
  - increasing the clinical monitoring of patients prescribed high-risk LTC medication in accordance with local and national guidance; for example anticoagulant and methotrexate therapy
  - reducing the number of hospital admissions resulting from a medicines management problem
  - increasing the level of reconciliation of medicines every time a patient’s care is transferred from one provider to another
  - reducing the number of medication incidents and errors by working with all providers to make reporting processes more robust
- review anti-coagulation services available to patients to ensure they receive timely and effective medication and review
- ensure incidence of pressure sores is fully reviewed and appropriate pressure relieving measures are put into place
- facilitate the development of a healthcare records audit programme.
Chapter 4 - Delivering the best in local healthcare

Introduction

This chapter sets out the underpinning strategies and plans required to deliver this strategic plan. Delivery of our plans can only be accomplished if supported by robust implementation by an organisation that is capable, flexible and innovative and has the ability to work effectively with partners and stakeholders.
Framework for Delivery

**Strategic Aims**

- Move services closer to home
- Improve health and close the gap in Life expectancy
- Improve access to and Scope of Primary Care
- Reduce unnecessary Admissions to hospital
- Safe Services and Increased patient satisfaction
- Stay within budgets and ensure value for Money
- Meet national and HCC targets

**Strategic Initiatives**

- Staying Healthy
- Mental Health
- Maternity and New Born
- Children’s Service
- Planned Care
- Acute Care (Emergency and Urgent Care)
- Long Term Conditions
- End of Life Care

**Underpinning strategies**

- Financial Strategy
- Organisational Development
- Annual Operational Plan
- Procurement and Market Management
- Performance Monitoring
- Partnerships and Engagement

**Patient Experience**

**Patient Safety**
Past delivery performance

When we consulted on the strategic goals for our Strategy for Healthcare in west Essex, we outlined a number of commitments we would make and actions we would take during the life of the strategy.

We promised within one year we would have:

- consulted on the use of the Walk-in Centre and A&E services in Harlow, and established new primary care-based links with A&E
- reduced the need for people to attend A&E by improving access and awareness of alternative and appropriate services
- consulted on the future provision and best use of community hospital beds
- increased direct admissions to urgent and scheduled care teams in the community and community hospitals
- be on target to achieve the national 18-week access target
- implemented major improvements to stroke services
- implemented a new pattern of care for older people with mental health problems
- developed comprehensive strategies for commissioning, finance, workforce, IT, communication, estates and patient and public involvement
- enabled Practice Based commissioning groups to introduce at least four new primary care based services that are currently hospital based
- agreed plans for the re-provision of GP premises in Stansted, Harlow and Epping
- ensure health is considered as part of planning proposals for housing developments and the second runway at Stansted airport.
We have kept all these promises.

We also said we would:

- plan the introduction of a community based learning disability service for children and young people
- reduce elective referrals to acute hospitals to a level below the current monthly average
- extend the primary mental health service
- roll out the chlamydia screening programme for at least 15% of the local population aged under 25.

We have kept all these promises.

There is more we need to do to meet these commitments. They form part of our strategy detailed in chapter 3, where we describe our plans in detail for meeting these commitments as well as the other goals we have identified in this strategic plan.

**Practice based commissioning**

Practice Based Commissioning (PBC) is a key lever for change and development of services in west Essex and our PBC groups will be instrumental in the delivery of this strategy.

In the last year (200-08) we have put in place new governance arrangements that have strengthened PBC’s ability to make a difference. This has included the introduction of an innovation fund allowing PBC groups to test out new ideas and service innovation without the need for unwieldy bureaucracy. This has helped produce a number of initiatives (described in earlier chapters of this plan). However, this is not enough; we need to do more to support the PBC groups to take a lead in driving forward the strategy.
Over the coming months we will:

- support the PBC groups to develop their own management capacity, using incentive funds available for PBC
- through allowing PBC to reinvest up to 100% of savings, support the development of new cost-effective services in primary and community care to enable the shift of services from secondary care
- allow practices more freedom to invest savings at practice level to extend the range of services on offer to their own patients
- assist in the monitoring of secondary and primary care performance especially with validation of activity reporting
- enable PBC to engage and drive the commissioning of secondary care services for the population
- enable PBC to engage and drive the commissioning of health development
- support PBC groups, through timely, accurate and evidence based information, to ensure cost effective prescribing.

To do this we will provide PBC groups with financial, commissioning and information expertise to support practices and PBC groups to engage in the commissioning process. Each commissioning group will have a dedicated senior manager whose sole responsibility will be to coordinate support for the group.

As well as taking a lead role in driving commissioning strategy, we will encourage practices to extend the scope of services they provide. We will achieve this through a market management and procurement strategy that will support the development of, and attract, new providers where plurality of provision is needed to drive up quality or provide choice.

The Professional Executive Committee will take a lead role on behalf of the Board in examining PBC proposals and setting the agenda for practice based commissioning groups.
Working with partners

We will work closely with the County Council and our three district councils in Epping Forest, Harlow and Uttlesford.

There are many common health issues (such as housing growth) across west Essex. However, each of the localities has unique health needs.

The local councils are critical to successful health development and to ensure planning in each of the districts creates a healthy environment and that planning applications take into account health needs and health services.

Our public health and locality teams will work closely with district council Local Strategic Partnerships. We will also work with the county council through the joint director of public health; the Children and Young People’s partnerships (sub groups of the LSPs); the Drug Action Team; Education; Transport and both the Children and Adult Safeguarding Boards.

We will also continue to strengthen our joint work with social services and education.

In the case of social services we will work to strengthen joint team working in care of the elderly, long-term conditions, mental health and children’s services, ensuring co-location of teams wherever possible, and as we develop new models for provider services, establishing joint management arrangements building on the success of those established in learning disabilities and mental health. We will also reinforce the use of the single assessment process, and support the development of individual client/patient budgets.

With education we will develop further the direct relationship we have established with local schools focussing particularly on primary and secondary schools in the more deprived parts of West Essex where we can have a major impact on health inequalities through schools.

We will work jointly to co-ordinate the work of community services, influencing contracts and working with all health providers (GP practices, pharmacists, community nurses, acute hospitals etc.) in addition to other services such as education and housing to focus on improving the health of the population. We intend to establish a new model for our provider services which should facilitate improved joint working.
In partnership, we will develop strategies to improve health-based assessment of needs and address key areas of our strategy to include:

- diminishing risk factors, such as reducing obesity and smoking
- improving disease prevention programmes such as schemes to encourage active and healthy lifestyles
- encouraging early detection of disease through increasing uptake of screening programmes
- improving access to and treatment of diseases in primary and secondary care.

This will reduce population risk factors by ensuring the public has adequate and appropriate information about health and disease prevention to help them make informed choices to understand and manage their health. We will use social marketing techniques to ensure that we are getting our message across.

The three Local Strategic Partnerships (LSPs) in west Essex plan to drive forward the public health agenda and deliver the Local Area Agreement priorities. Key areas to be addressed by the LSPs are:

- educational attainment levels
- public transport that is available and acceptable within Epping Forest and Uttlesford
- alternative forms of transport such as cycling and walking that will minimise road congestion and tackling the rising obesity problem among the population
- preventative programmes such as tackling obesity, smoking, poor sexual health practice and emotional health and well-being
- reducing the level of smoking, particularly within the male population of Harlow and Waltham Abbey.
Public health, school nursing and health visiting teams will continue to work closely with schools and colleges in west Essex. They will be involved in planning young people’s services through the CYPSP and LSP.

The voluntary sector will also provide some services commissioned by us and, crucially, provide other services that supplement those of the statutory sector. This will be particularly important, for example, in supporting hard to reach groups where statutory services are less effective or in supporting carers or patient self help where the voluntary sector can be uniquely effective. We will ensure voluntary organisations are supported to compete to provide a wider range of services and we will recognise them as important partners of the PCT at all levels.

**Civil Contingencies Act Responsibilities**

As part of our responsibilities under the Civil Contingencies Act, 2004, we are required to have plans and procedures in place to ensure we are able to provide appropriate protection and care for our local population in the event of an emergency or major incident. We will continue to develop our emergency planning arrangements over the next five years and will do this in partnership with all other relevant agencies.

The third sector is critical to our performance. They will influence policy and strategy, both in specific areas of work and in general strategic development. We will engage voluntary groups with a special interest (e.g. Alzheimer’s Society or the Diabetic Association) in designing services we commission.
Involving local people

Our most important partners are local people, our service users and carers who know first hand what the services we commission are like and have direct knowledge of what is needed locally. We will always consult local people, working closely with LINks, on any proposed changes to service.

As described in chapter 2, service users will always be involved in planning new or permanent changes to services at an early stage, seeking advice from LINks and other patient groups, on how best to do this on a service-by-service basis. The only exception to this will be in an emergency when temporary changes may occur.

We will engage individual service users in monitoring the quality of services we commission in a range of ways such as encouraging feedback and monitoring complaints, group work with people receiving services or through both national and local surveys.

We will ensure there is appropriate user representation at strategic levels throughout the organisation’s business. Appreciating that the NHS is complex we will develop training and induction sessions for lay representatives to allow them to take a full and active part in meetings.

We will continue to work with our established user consultative forums and assist the Older People’s Advisory Group to become established across the west Essex area.
In-year monitoring

In-year monitoring of the strategic plan will be through the production and review of our annual operational plan.

The operational plan will include all aspects of the strategic plan that require action in-year. Detailed actions, together with time-scales, named lead director and manager for each initiative will be included.

The operational plan will also include our assurance framework. Each initiative will be risk scored and, where appropriate, high risk schemes will be added to our risk register, and monitored through the appropriate group.

Quarterly reports on progress toward our strategic aims will be presented to the Board, with performance monitoring reports presented to every board meeting. The performance monitoring report includes all metrics required for monitoring our progress against our strategic goals, Healthcare Commission indicators, World Class Commissioning scorecard indicators and LAA targets.

Financial planning (financial plan summary)

Our strategy is underpinned by an assumed level of funding over the next five years. The first two years of the strategy is covered by the current Comprehensive Spending Review (CSR) which is delivering a year-on-year increase to our recurring baseline funding of 5.2% (year 1) and 5.1% (year 2).

Our distance from target allocation (the amount of funding we receive versus the amount that is deemed to be required for the weighted population) will, over the first two years of the strategy, bring the PCT to within 1.6% above target which approximates to £6.5m actual funding. The final three years of the strategy assumes that growth resource will be at the lower end of the scale in order to move the PCT further towards target.
This financial model has been constructed using International Financial Reporting Standards.

Table 1 shows this assumed funding and expenditure over the five-year period of the strategy.

<table>
<thead>
<tr>
<th>Resources</th>
<th>09/10</th>
<th>10/11</th>
<th>11/12</th>
<th>12/13</th>
<th>13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent baseline</td>
<td>390,481</td>
<td>408,252</td>
<td>424,582</td>
<td>441,566</td>
<td>459,228</td>
</tr>
<tr>
<td>Non-recurrent funding</td>
<td>15,932</td>
<td>15,250</td>
<td>15,860</td>
<td>16,494</td>
<td>17,154</td>
</tr>
<tr>
<td>Lodgements</td>
<td>3,000</td>
<td>(500)</td>
<td>(750)</td>
<td>(750)</td>
<td>(600)</td>
</tr>
<tr>
<td><strong>Total resource</strong></td>
<td><strong>409,413</strong></td>
<td><strong>425,312</strong></td>
<td><strong>442,094</strong></td>
<td><strong>459,808</strong></td>
<td><strong>478,380</strong></td>
</tr>
</tbody>
</table>

**Applications**

<table>
<thead>
<tr>
<th>GP contracts</th>
<th>33,572</th>
<th>34,242</th>
<th>34,925</th>
<th>35,622</th>
<th>36,333</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP prescribing</td>
<td>51,634</td>
<td>54,338</td>
<td>57,077</td>
<td>59,957</td>
<td>62,989</td>
</tr>
<tr>
<td>Dental contracts</td>
<td>9,722</td>
<td>10,264</td>
<td>10,520</td>
<td>10,730</td>
<td>10,945</td>
</tr>
<tr>
<td>PCT provider arm</td>
<td>28,838</td>
<td>29,686</td>
<td>30,613</td>
<td>31,653</td>
<td>32,705</td>
</tr>
<tr>
<td>Primary and community</td>
<td>8,106</td>
<td>14,266</td>
<td>18,946</td>
<td>24,019</td>
<td>28,598</td>
</tr>
<tr>
<td>Mental health</td>
<td>32,955</td>
<td>35,126</td>
<td>36,873</td>
<td>38,464</td>
<td>40,114</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>9,433</td>
<td>9,631</td>
<td>9,833</td>
<td>10,040</td>
<td>10,251</td>
</tr>
<tr>
<td>Continuing care/FNCC</td>
<td>8,225</td>
<td>8,431</td>
<td>8,641</td>
<td>8,857</td>
<td>9,079</td>
</tr>
<tr>
<td>Acute care contracts</td>
<td>158,817</td>
<td>158,773</td>
<td>161,046</td>
<td>163,651</td>
<td>167,074</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>9,009</td>
<td>9,461</td>
<td>9,950</td>
<td>10,471</td>
<td>11,003</td>
</tr>
<tr>
<td>Other secondary care</td>
<td>2,791</td>
<td>3,022</td>
<td>3,115</td>
<td>3,210</td>
<td>3,610</td>
</tr>
<tr>
<td>Specialist contracts</td>
<td>32,145</td>
<td>32,889</td>
<td>33,658</td>
<td>34,435</td>
<td>35,215</td>
</tr>
<tr>
<td>Social marketing spend</td>
<td>60</td>
<td>62</td>
<td>63</td>
<td>65</td>
<td>66</td>
</tr>
<tr>
<td>Management</td>
<td>22,055</td>
<td>22,992</td>
<td>23,653</td>
<td>24,333</td>
<td>24,999</td>
</tr>
<tr>
<td>Contingency</td>
<td>2,050</td>
<td>2,130</td>
<td>3,215</td>
<td>4,300</td>
<td>5,400</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>409,413</strong></td>
<td><strong>425,312</strong></td>
<td><strong>442,094</strong></td>
<td><strong>459,808</strong></td>
<td><strong>478,380</strong></td>
</tr>
</tbody>
</table>
Growth assumptions

The financial model used to deliver this strategy in the first two years is predicated on a growth level of 5.2% and 5.1% respectively. For the final three years of the strategy the value is less certain (particularly given the current economic climate), but for the purposes of this model the assumed growth level is 4%.

If these assumptions are correct, we are forecast to receive over £92m extra over the next five years with which to maintain the current services, address pay and price increases and invest in new services to deliver the National agenda (as set out in the Darzi Next Stage Review), our own five-year service strategy and the NHS East of England pledges.

Inflation assumptions

In this financial model, contract activity pay and price increases have been shown at a level of 2.2% (09/10) and thereafter 2.1%. Pay awards for our staff and provider arm staff have been assumed at 2.5%. Increases to prescribing costs have been predicted to be 5% and GP and dental contractors are assumed to show an inflationary pressure of 2%.

Intelligence for estimates regarding pay and prices inflation have been taken from monitor guidance issued to NHS and Foundation Trusts.

Demographics

There is an assumption within the strategy that the population of west Essex is going to increase in the medium term due to planned housing growth and that the population itself is an aging one.

We are therefore on an upward age/cost curve and financial pressures will result from both of these changes.

The baseline population figures have been taken from the latest Office for National Statistics data. Projections for population growth have also been up-rated to account for Potential Housing Growth and Impact on Population Projections published by the East of England Regional Assembly. The financial model has built in a level of demand growth commensurate with the change in population numbers and its demographics.
Activity assumptions

As well as changes in activity brought about by a changing population, we are committed to deliver the best care possible for our patients in the best setting. This will result in a shift of activity from the traditional acute hospital setting to a more person centred community setting if appropriate to do so. The strategy also details our drive to prevent ill health and avoid unnecessary hospital admissions.

The financial model assumes that over the five years, over £6m of activity will move from the acute hospital setting and be re-provided within a primary care setting at an estimated cost reduction of £0.6m. The shift is modelled using HRGs identified by the NHS Institute as areas of activity that that are both suitable and capable of being moved out of a secondary care setting. This is assumed to be a 25% reduction in baseline activity for those relevant HRGs. This frees up resources to invest in other services we have highlighted as being essential to deliver.

The model also assumes a prudent approach to the 18-week waiting list target activity, assuming higher levels of activity that previously to maintain the length of wait at 18 weeks and the underlying increase in referrals.
Key initiatives

Key investments have been identified in line with national targets, the Darzi Next Stage Review and NHS East of England pledges. These investments have been prioritised and profiled to deliver the strategy in the most effective and efficient way. Table 2 shows the cumulative level of investment for each of our top priorities over the next five years.

<table>
<thead>
<tr>
<th>Five-year spend on strategy initiatives</th>
<th>09/10 £000's</th>
<th>10/11 £000's</th>
<th>11/12 £000's</th>
<th>12/13 £000's</th>
<th>13/14 £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying healthy</td>
<td>220</td>
<td>1,801</td>
<td>2,619</td>
<td>4,157</td>
<td>4,254</td>
</tr>
<tr>
<td>Improving mental health services</td>
<td>220</td>
<td>1,336</td>
<td>1,393</td>
<td>1,457</td>
<td>1,530</td>
</tr>
<tr>
<td>Improve maternity and newborn services</td>
<td>300</td>
<td>850</td>
<td>910</td>
<td>970</td>
<td>1,031</td>
</tr>
<tr>
<td>Improve children's health</td>
<td>335</td>
<td>1,138</td>
<td>1,392</td>
<td>1,421</td>
<td>1,451</td>
</tr>
<tr>
<td>Improve planned care</td>
<td>1,109</td>
<td>2,368</td>
<td>3,760</td>
<td>4,155</td>
<td>4,227</td>
</tr>
<tr>
<td>Planned care</td>
<td>200</td>
<td>950</td>
<td>1,059</td>
<td>1,418</td>
<td>1,678</td>
</tr>
<tr>
<td>Acute care</td>
<td>0</td>
<td>80</td>
<td>100</td>
<td>110</td>
<td>120</td>
</tr>
<tr>
<td>Long term conditions care</td>
<td>280</td>
<td>565</td>
<td>722</td>
<td>884</td>
<td>1,095</td>
</tr>
<tr>
<td>End of life care</td>
<td>25</td>
<td>317</td>
<td>323</td>
<td>329</td>
<td>336</td>
</tr>
<tr>
<td>Patient experience</td>
<td>50</td>
<td>51</td>
<td>52</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td><strong>2,739</strong></td>
<td><strong>9,455</strong></td>
<td><strong>12,330</strong></td>
<td><strong>14,955</strong></td>
<td><strong>15,775</strong></td>
</tr>
</tbody>
</table>
Other applications of funds

At present, activity that attracts a tariff price also has an adjustment to account for different market forces within particular areas (MFF adjustment). Part of the extra resources we will receive has been allocated to an increase in MFF due to increased demand and price. It is estimated this will cost about £2.3m over the period.

As is usual with any financial plan and in line with historic experience, a certain level of non-inflationary cost pressures have been built in to the model to address any unexpected increases to expenditure during each year. In 2009-10 the value of the cost pressures is £1m thereafter rising by £0.5m per annum.

This strategy carries with it a significant agenda to deliver to world class standards. A need for significant investment in our infrastructure of circa £1.5m has been identified and this has been added to the model for 2009-10.

Lodgement of surpluses

At the beginning of the strategy period, NHS West Essex had £3.0m of historic surplus lodged with the Strategic Health Authority. There is a requirement within the East of England economy that a certain level of lodgements should be maintained and has consequently been provided for. As can be seen in the model, to deliver our prioritised initiatives we will need to draw down £3.0m in 2009-10 from that initial lodgement but we are able to repay that amounts back into the fund during the following years to build the surplus back up to £2.6m.

Contingency

During the period covered by the latest CSR a contingency of 0.5% of our baseline has been factored in, continuing the practice we have followed since inception. The final three years of the strategy present a more uncertain picture and so the built-in contingency has been risk-adjusted for the possibility of the growth funding percentage being less than the assumed 4%.
Disinvestments

We acknowledge investments are, on the whole, delivered using increased funding. However good financial management combined with the need to deliver value for money and evidence-based care, necessitates a continual programme of service review to disinvest in less efficacious services. This frees up resources to help deliver our vision of healthcare within this strategy. A combination of efficiencies and disinvestment will be essential should we not receive the level of growth funding assumed within this model.

Each year we allocate expenditure across a range of health groups (programme budgeting). NHS West Essex has engaged Price Waterhouse Coopers (PWC) to report on ways in which this programme budgeting information can be used to inform commissioning decisions. It is expected this toolkit will highlight the health areas in which we would appear to have under invested, given the health needs of the population. This, together with identified areas of over investment, should enable us to target our funds in the most effective and efficient way. Below is an initial list of disinvestments identified for 2009-10.
### Disinvestments

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary to primary care shift</td>
<td>750</td>
</tr>
<tr>
<td>Reviewing LES's</td>
<td>50</td>
</tr>
<tr>
<td>Extended hours LES</td>
<td>120</td>
</tr>
<tr>
<td>Sydenham House closing</td>
<td>1,057</td>
</tr>
<tr>
<td><strong>Total disinvestments</strong></td>
<td><strong>1,977</strong></td>
</tr>
</tbody>
</table>

### Demand management

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holly House Oral Surgery (DwSI)</td>
<td>200</td>
</tr>
<tr>
<td>Urgent care</td>
<td>200</td>
</tr>
<tr>
<td>Lymphodaema nurse impact</td>
<td>50</td>
</tr>
<tr>
<td>Stroke Unit further savings</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total demand management savings</strong></td>
<td><strong>650</strong></td>
</tr>
</tbody>
</table>

### Productivity savings

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates</td>
<td>100</td>
</tr>
<tr>
<td>Better Care Better Value</td>
<td>200</td>
</tr>
<tr>
<td>Surgical Thresholds</td>
<td>500</td>
</tr>
<tr>
<td><strong>Total productivity savings</strong></td>
<td><strong>800</strong></td>
</tr>
</tbody>
</table>

### Overall total

| **Overall total**                                     | **£3,427**    |
Productivity

We continue to monitor ourselves against the better care better value indicators and have embarked on service changes to increase productivity, for example the A&E/Walk-in Centre scheme and benchmarking of primary care services. We will undertake further work in areas of productivity informed by PWC as highlighted above. Disinvesting to re-invest to increase productivity is a strong driver in our strategy.

Capital investments

Delivering better care in a primary and community setting, allowing increased access and enhanced facilities will require a programme of investment in rebuilding and refurbishment of the our current building stock and that of third party buildings which we lease.

It is planned that by 2011 Ongar War Memorial Hospital will be rebuilt at a capital cost of about £6.5m. It is anticipated this will be funded from the Community Hospitals Capital Fund held centrally. A review of the Saffron Walden Community Hospital site is being undertaken to help address the capacity problem with the local GP surgeries. This will also facilitate the expansion of certain services on the site to save local residents from having to travel out of the area.

It is planned that clinic-GP premises in Stansted, Harlow, North Weald, Dunmow and Waltham Abbey will also undergo a programme of refurbishment or replacement. It is assumed that as we do not own these buildings we will continue to work with 3rd party developers to finance the capital costs of the reprovission. The revenue consequences have been factored into the planned initiatives within the model.

The financial model has been prepared using International Financial Reporting Standards as we (along with all other public sector bodies) will be moving to these standards from 2009-10. There is an implication that Private Finance Initiatives (PFI) properties will have to be included on our balance sheet. Should this happen, there will be a likely revenue impact of about £0.5m per annum in respect of the St Margaret’s Hospital PFI scheme. This has been factored into the plan.
Cash flow

Based on the planned revenue and capital forecasts, the Trust, moving forward from its current balance sheet position, is not forecasting any cash shortfalls. The cash flow position will need to be kept under constant review in line with all assumptions employed within the current forecasts.

Financial risks

As with any future long-term plan there is a risk one or more of the assumptions will prove to be inaccurate. In this model there is an assumed level of growth that for the first two years has a relative certainty about it but the final three years of the plan carries greater risk. Should the level of growth be 0.5% less than predicted we will receive over £6.5m less than the model shows. This could impact to a certain extent on the level of investment we can engage in but would be covered by the larger contingency built in to the current model. However should the level of funding be a full percentage point lower, our growth would be £13m less and not be entirely covered by contingencies. Should the growth be less than assumed, our investment/disinvestment plans will need to be timed to deliver the strategy during the period.

The levels of inflation in the model are based on recent assumptions. However with the current economic climate there is a risk these levels could increase causing a pressure elsewhere within the model. While there is a risk inflation might increase, the impact of recessionary pressures is likely to curtail the growth of inflation.

The third major area of risk is around the demand assumptions. These are predicted on an increase in population due to significant planned housing development in the region in the medium term. The recent economic downturn might affect these plans which could result in a lower than expected housing growth.

Where planned investments in new/refurbished buildings rely on the use of 3rd party capital we realise the need to have contingency plans in place should the economic downturn reduce the amount of that capital available to us.

Summary

The assumptions modelled with this strategy will be continually reviewed and refreshed in the light of emerging risks and opportunities. This will ensure the financial strategy remains aligned to the organisation’s service plans.
Risk management

Risk management is the identification and management of situations that can either reduce the ability of, or prevent, us achieving our aims and objectives. It is not ever possible to be risk free, however effective risk management minimises both the risks of these things occurring and their potential impact.

Within the PCT risk management is achieved through:

- annual identification and evaluation of risks through the development of the operational plan
- risk assessments and incident reporting
- reviewing our strategic plan and progress against targets
- developing and implementing actions that minimise risk occurrence and impact
- monitoring risk management processes and actions taken to minimise risk by the relevant committees.

Risk register

The Board manages risks through the use of accident and incident reporting, and through the monitoring of operational and strategic performance. This is used to identify and manage trends and patterns that highlight where things are not as they should be.

The risk register records the nature of what our risk exposures are, and the mechanisms used to manage them alongside details of what, if anything, needs to be done to improve or maintain control of those risks. The executive directors use it to manage risk exposures and monitor any actions implemented, which provides assurance (confidence) to the Board about what is being done to minimise risk exposure and its impact.
Operational plan

We publish an annual operational plan that outlines our key strategic aims, objectives, national and local targets for the year ahead. Each objective has a lead director and manager who are responsible for ensuring delivery. They will develop an action plan should this deviate from planned activity during the year. They score the objective against the impact on the organisation should it not be achieved. This could be in terms of damage to reputation, financial or punitive measures that would be applied by an external body.

While the Board reviews the overall plan twice a year, the plan is monitored monthly by the integrated governance committee with red risks reviewed and investigated by the audit committee who highlight any remedial action to the Board.

The operational plan also acts as the organisations assurance framework.
Strategic risks

Within this strategy there are a significant number of actions and aims to be achieved within the next five years. These will be fed into our operational planning process and monitored through our established committee structure. However there are a number of external risk factors that have been identified which could significantly impact on our achievement.

These are set out below.

*Financial*

See above financial plan summary.

*Workforce*

We have identified through a gap analysis those areas where investment is needed to develop the skills base. These are procurement, marketing, financial evaluation, public engagement and organisational development. The aim is to utilise external support while developing the in-house workforce.

The key risk is a scarcity of good staff in these areas against a background of a number of organisations seeking to employ. This has already caused an increase in pay grades for certain staff to try and encourage people to apply to or stay within an organisation.

We will seek to ensure it is widely regarded as an employer of choice to overcome this risk.

In early 2009, we will produce a comprehensive Development Plan that will address the organisational challenges to becoming a World Class Commissioning organisation. This will include robust plans for developing and building the workforce.
Population growth

The west Essex area is marked for rapid housing growth and expansion. This will have a significant impact on the services required. However the current financial climate has seen many developments shelved for an indefinite period and some financial backers no longer willing to invest.

While this is likely to be a temporary delay we still need to plan for expansion at a time of uncertainty.

Private to NHS repatriation

With the NHS becoming ever more efficient and waiting times reducing, there are a number of people who previously would have utilised private health care plans or were self funding who are now turning to the NHS. This is a new area of need and is being scoped for potential impact.

Market stimulation

The world class commissioning agenda clearly indicates the stimulation of our local health market is essential to driving up the quality of services. We will have to manage this carefully to ensure we do not lose the local side of health care but also that the less attractive services are not deprived of the same focus as those with a higher profile.

We will also need to support smaller providers, particularly from the third sector, who are not used to operating in a more commercial environment, to compete for contracts. This is important as these organisations often have valuable skills and local knowledge.

Change of government or health policy

A change at national level may have an impact on the strategic direction the NHS is currently following, therefore we need to be effective at horizon scanning, anticipating policy change to maintain flexibility in service delivery. Likewise when national policy dictates immediate action or implementation, such as with the GP-led health centres, then we need to be able to quickly resources, (staff and money), to achieve this.
Organisational requirements and enablers (organisational development (OD) plan summary)

We will undergo significant transformation in the next five years. We aim to become a high-achieving organisation that recruits and retains high-performing staff, is seen as innovative, and has an enviable reputation as a world class commissioner. The Organisational Development (OD) strategy will support the development of the desired behaviours, attitudes and culture that will enable us to deliver this aim.

An organisational development group was established in October 2006. The group has overseen the successful implementation of actions which have resulted in the Trust growing in maturity and reputation and as an organisation which staff take pride in working for.

An organisational development strategy has been developed which builds on, and further develops, this work. The strategy includes actions that reflect the need for developing a range of skills and organisational competencies to deliver the world class commissioning agenda.

As well as world class commissioners, the west Essex economy needs high performing providers. We will work with other organisations across the health economy to support the development of a talent management approach. In taking this approach it will support the development of high performing providers able to deliver high quality, safe and effective services.

We will lead the development of a sub-economy workforce strategy through the Essex County Workforce Group, which will ensure the economy as a whole has the right staff with the right skills to deliver a world class service. This will also build on the clinical engagement and partnership working already in place. Delivering our strategic plan presents a number of challenges for workforce planning.

Shifting services into the community and increasing specialist nursing services to support the management of long-term conditions are just two of the areas that will require detailed planning to ensure providers have enough of the right staff with the right skills able to work out in our communities.

Successful and effective organisations take a holistic and systemic approach to organisational development, recognising that a committed and motivated workforce is the key to delivering high performance.
We recognise the importance of investing in the development of staff to promote a shared vision and a culture of excellence and will be well placed to perform as a world class commissioner.

Over the last year we have focused on supporting teams to become effective and efficient through team building, utilising tools such as Myers Briggs and coaching. We have also linked with the East of England Strategic Health Authority on the development of senior managers through management development programmes such as aspiring directors. Regular management away days are held to develop generic skills.

A key priority over the past year was the embedding of the appraisal system to ensure staff are given the opportunity for feedback and review of their developmental needs. We will continue to build on these developments with more focused development on the key skills required for world class commissioning and systematic development of our talent.

A new structure was developed and implemented in 2007 which reflected the need to develop close links with the local and county councils and practice-based commissioning groups.

With the move to become a world-class commissioner the current structures need to be strengthened and built on, whilst retaining the positive aspects of partnership working and devolved responsibility. A major, in depth analysis of the organisations capability and capacity is underway to inform our World Class Commissioning Development Plan. This plan will outline the resources required and actions to be taken to ensure the PCT develops into a world-class commissioning organisation.

The approach will be to develop the existing workforce through talent management, succession planning and developmental programmes. In commissioning, market analysis, public engagement, procurement, marketing and PR skills and expertise we will increase capacity both on a temporary and long-term basis and use external specialist experts to enable us to meet our requirements whilst developing current staff.

Our focus is on developing as a world class commissioner, which has meant corporate systems and processes need to be reviewed to ensure they are sufficiently robust for a high performing commissioning organisation.
The business planning process has been strengthened by the implementation of a project management approach across the Trust supported by development of a performance management culture with all staff accountable for the delivery of their objectives and a problem oriented approach to overcoming barriers.

The aim will be to empower staff and ensure responsibilities are appropriately delegated, that bureaucracy is limited and staff feel able to make decisions and solve problems. A comprehensive development plan will be developed and in place in the early part of 2009.

The Board style is of visible leadership with a ‘walk the floor’ approach. Staff are encouraged to express their views and participate in making the organisation a fun place to work. Staff engagement and feedback has been encouraged through Have Your Say staff focus groups and regular monthly team briefings.

To encourage innovation, team working and high quality services from internal staff and external providers we will be launching its Recognition Awards, with the ceremony becoming a key event in the calendar for the NHS in west Essex.

We will seek to recruit and retain staff who are motivated, want to work for a high-performing organisation and will recognise and reward those who are committed to the values of the Trust.
Estates developments

Our Strategy for Healthcare describes our aim of providing services as close as possible to people’s homes and to move more health services into community settings. This sets a challenge for the gradual redevelopment of facilities to ensure they are modern, accessible and fit to provide integrated community services with a very broad range of functions.

We also anticipate increasing integration within premises of community services and general practice, dentistry and pharmacy depending upon local circumstances (this does not imply the merger of organisations).

In line with our responsibilities to work with our partners to improve the quality of life of west Essex residents, we will work on opening up health facilities to the community to support activity that encourages good health. Since most facilities are in the middle of local communities and often include both large group areas and individual rooms they are ideal for such use.

We are committed to enhancing the patient experience by ensuring the quality of buildings is high and that they are accessible to people with disabilities.

We are committed to reducing our carbon footprint therefore all new developments will take account guidance on carbon efficiency.

NHS West Essex will pursue a strategy of supporting steady replacement of contractor premises as opportunity and financial capability allow.

A continuous programme of redevelopment working with primary care contractors, planning authorities and developers will ensure that facilities are modernised, accessible and capable of providing the increased range of community services the strategy identifies.

Below we have outlined our programme of key developments over the next five years. These developments are required for a combination of the following reasons:

- the need to replace poor facilities
- the need provide high quality community facilities to support shifting services into the community
- growth in demand
- planned housing growth.
Stansted and the surrounding areas

By 2010, we plan to provide new and improved primary health care facilities for the local community in Stansted and the surrounding catchment areas. These areas currently receive good primary and community health care services. However they are provided from sites that do not meet the standards of modern health facilities and offer poor access for less mobile patients.

The new development will provide facilities for services that have had to relocate such as:

- a full range of general practice services
- district nursing
- Chiropody
- NHS dentistry (currently there is no NHS dentist in Stansted)
- capacity for other services.

The centre will allow GPs, practice and community staff to work side by side delivering a more integrated service and experience for patients in a better environment.

Harlow Growth Area Funding (GAF)

Harlow District Council attracted enabling monies to regenerate specific areas in Harlow. Three schemes involve the replacement of three current health centres.
Lister House, Staple Tye

The current GP practice serves a population of 17,000, in accommodation about one third of the size required to adequately cater for this list size. The building has no potential for growth, does not meet disabled access requirements and has no patient parking space.

The new health facility will:

- provide state-of-the-art modern health facility for Staple Tye
- provide sufficient capacity to accommodate the existing population (17,000 and planned population 3,000)
- improve local access to health services by increasing capacity and offering opportunities for further service development
- encourage integration of services and increased multidisciplinary working
- allow sufficient capacity to develop new models of care that deliver care closer to home.

This development has a proposed operational timeframe of April 2010.

Osler House - Potter Street

The current GP practice serves a population of 3,300. The building has limited potential for growth, does not meet DDA requirements internally and has no parking space.

The new health facility will offer:

- modern health facility for Potter Street
- sufficient capacity to accommodate the existing population (3,300) and planned population (2,000)
- improved local access to health services by increasing capacity and offering opportunities for further service development
- encourage integration of services and increased multidisciplinary working
- allow sufficient capacity to develop new models of care that deliver care closer to home.

Vacating the existing premises is required to facilitate the regeneration of Prentice Place. As a consequence the Osler House development must proceed if the planned development goes ahead. Proposed operational timeframe is April 2011.
Jenner House - Old Harlow

The current GP practice serves a population of 8,709. The new development is required to meet planned population growth.

The new health facility will offer:

- a state-of-the-art modern health facility for Old Harlow
- sufficient capacity to accommodate the existing population and additional planned population (12,000)
- improved local access to health services by increasing capacity and offering opportunities for further service development
- encourage integration of services and increased multidisciplinary working
- allowing sufficient capacity to develop new models of care that deliver care closer to home.

The proposed operational timeframe is April 2012

North Weald - Epping Forest

This development will replace a branch surgery that is no longer adequate either in capacity or quality. It will also provide additional capacity to cater for the planned housing growth in the area. The development is due to be operational in 2010.
Ongar War Memorial Hospital

After a successful public consultation the Board has agreed to a rebuild of this site to ensure a full range of community-based services is available to the local community.

The new facility will provide facilities for two local GP practices that are currently in highly unsuitable premises, a full range of community nursing and health visiting, physiotherapy, speech and language therapy, podiatry, a leg ulcer service and phlebectomy.

There will also be capacity to house other services, such as diagnostics and out-patient clinics.

The current in-patient provision is replaced with beds at the Epping Forest Unit at St Margaret's Hospital. The new facility will be operational in 2011.

Ninefields - Waltham Abbey

The estate is served by a GP practice that is operating out of two converted flats. These premises are completely unsuitable and efforts have been made over some time to identify appropriately located land for a new development.

We are planning the new facility to have capacity to house additional services. We will work closely with the local authority and voluntary sector to ensure other community services can be incorporated as the Ninefields estate is not well served for community services, particularly for young people.
Saffron Walden Community Hospital site

In line with our strategy this site is of strategic importance. The inpatient services have been redeveloped to ensure they comply with guidance on single-sex accommodation. In the longer term the number of community beds is likely to be expanded. The site will retain its community clinic.

We intend to redevelop the vacant land on the hospital site to enable the provision of replacement GP facilities for some practices in Saffron Walden. The development plan may also include an urgent care centre and extended GP services. It is planned that the new facilities will be operational by 2014.

We have prioritised these developments using the method described in chapter 3. All these developments will be required over the next few years. However, the prioritisation will help with decisions of re-phasing or re-scaling of developments if changes to funding, planned growth in the population or demand occur.

<table>
<thead>
<tr>
<th>Development</th>
<th>Priority score (overall impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stansted</td>
<td>113</td>
</tr>
<tr>
<td>Lister House - Harlow</td>
<td>106</td>
</tr>
<tr>
<td>Osler House - Harlow</td>
<td>118</td>
</tr>
<tr>
<td>Jenner - Harlow</td>
<td>125</td>
</tr>
<tr>
<td>North Weald</td>
<td>97</td>
</tr>
<tr>
<td>Ongar</td>
<td>Committed already</td>
</tr>
<tr>
<td>Ninefields - Waltham Abbey</td>
<td>128</td>
</tr>
<tr>
<td>Saffron Walden</td>
<td>107</td>
</tr>
</tbody>
</table>
Market management and procurement

To deliver our strategic initiatives we will need to work closely with providers to ensure they have the capacity and capability to deliver the services needed. We will also need to ensure that we promote choice of provider for hospital services and, as far as is possible and appropriate, for community, primary care and mental health services. We will look to commission services from a range of providers including NHS providers, voluntary sector and independent not-for-profit and for profit organisations.

Priorities for provider market development

We have seen from the analysis in chapter 2, that there are a number of issues that need to be addressed to ensure we are obtaining value for money and high quality convenient and accessible services.
Hospital Services:

- Princess Alexandra Hospital is popular with local people but still has some way to go in terms of quality (see chapter 2). Its Integrated Business Plan predicts growth in activity from Hertfordshire and from housing growth with west Essex, along with a modest shift of services into the community. As lead commissioner we would want to ensure the viability of PAH and will achieve this through jointly developing our strategies for services provided by PAH, with Hertfordshire PCTs and the PCT. We will ensure the quality of services continues to improve through robust contracting and performance management, including introducing additional patient experience and other key performance indicators linked to incentive payments (CQUIN). We will also look to extend financial incentive payments alongside the penalties that already exist.

- Although 61% of our population choose PAH for their hospital treatment, significant numbers also use our other main providers, including Addenbrookes to the north of the area, Mid Essex to the east and Whipps Cross to the south. We will work closely with the lead commissioners for these hospitals to ensure that strong contractual regimes are in place.

- Due to our geographical location patients have historically had and continue to have a choice of eight main providers plus London providers. This is due to transport links into London and the commuter population. Consequently we already have a mature and developed market for acute care.

- Local people tell us they want to have a local choice of provider, as described in chapter 3. Working with practice-based commissioners, we will look at what services can be provided nearer to our population that will give a local choice for people. In particular we will look at specialities appropriate to provision in a community setting and also urgent care services. When redesigning pathways in the community we will, in some cases work with existing providers to relocate their services into community settings, for example some outpatient services. In others, where significant redesign is required, or where the quality of service needs to improve, we will commission and procure the services competitively.
Community and mental health services

- In west Essex there is a de facto monopoly for both community and mental health services. It is expected our provider arm will soon be an independent organisation and we will need to ensure that our effective preferred provider status is appropriately tested over the next period. We will publish, in early 2009, a timetable of those services that we will be market testing to ensure value for money and that we are looking to redesign and deliver in a different way. Our focus will be to look at services that support people with long term conditions and services that support older people to avoid admission to hospital.

- Similarly we would wish to test the quality and efficiency of mental health service provision. Due to the nature of mental health services, we will be limited as to the degree to which we will be able to use competition. However we will use robust contracting and contract monitoring to drive improvement. We will also look at the potential to introduce plurality in appropriate areas.

- When testing the market for services in the community and also with some mental health services, we will place particular emphasis on ensuring that third sector and voluntary organisations are encouraged to bid for services that we plan to procure through a competitive tender.
Primary care

- The priority for general practice is to improve access and convenience and to increase the scope of services. This will require current providers to change the way they work. A majority of practices have already committed to providing extended hours. We will be monitoring whether this, together with the GP-led health centre in Loughton, increases patient satisfaction with access and responsiveness of GP services. We will expect current providers to respond to their patients’ views on access and improve where necessary. If there are areas where there is little or no improvement, we will introduce additional services to drive up quality. This could include introducing an extended access model of service similar to the GP-led health centres. We will also explore how we can increase choice of primary care provider where there is little choice currently.

- Over 2009-10, we will be reviewing all PMS contracts to ensure value for money. We will also be reviewing the use of recycled MPIG funds as these are released. We will use benchmarked quality and patient experience indicators when undertaking these reviews. Our aim will be to ensure all patients have access to an enhanced level of service quality and access.

- The development of new health facilities across west Essex will allow co-location of services and the shift of services into the community. Services will be provided by a range of providers, including GP practices. We will work with PBC groups to develop our plans for these facilities to ensure that the right services are included.

- Work is already underway to commission significant additional primary care dental capacity. We will continue to introduce new providers as well as work with existing providers to increase capacity. We will also be introducing a Balanced Scorecard as part of their contracts to ensure quality and to reverse the trend of increase referrals to secondary care.
Procurement

To ensure open and transparent procurement of services and relationships with providers, we will be publishing a Commercial Strategy and a Procurement Framework early in 2009.

The strategy will outline:

- overall principles that we will apply in our dealings and relationships with providers
- the outcomes for patients that we wish to achieve through management of the market, for example, improved choice and driving up quality, convenience and access
- the approach we will take to ensure services are value for money and contestable, ie testing the market, benchmarking and introducing competition.

The Procurement Framework will outline our preferred procurement routes and the circumstances under which we will use each route, the framework will cover:

- when we will tender and what methods of tendering we will use
- when we will use ‘any willing provider’ procurements
- when we will use primary care contracts (Locally Enhanced Services)
- in what circumstances we may decide not to have a competitive procurement process
- the process for each procurement route
- the approach toward contracting including negotiating and contract monitoring.
Contract management and monitoring

In 2007-08, we introduced a number of innovations to our main acute contract including a range of KPIs including patient experience and quality indicators. We will continue to strengthen our contract management arrangements and extend these to all providers. In particular we will:

- as far as is possible and practical, use Department of Health model contracts
- extending KPIs to encompass more patient experience measures, shifting the emphasis more towards quality and linking this with performance payments
- develop clinical validation of service delivery and coding
- work with the local health economy to identify opportunities for aligning incentives with quality and outcome measures.
### APPENDIX 1—Summary of goals and initiatives

<table>
<thead>
<tr>
<th>Goals</th>
<th>Initiatives</th>
<th>Strategic Aims and Pledges</th>
<th>Priority</th>
<th>Financial Impact at Yr 5 (£000's)</th>
<th>Target By 2014</th>
<th>Current Performance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying Healthy</td>
<td>• improve the health of people who live in West Essex that have the lowest life expectancy as determined by gender specific MSOAs, to reduce the gap between the lowest and highest to no more than ten years, and ensure the highest life expectancy does not fall below 85 years</td>
<td>Pledge 8 Aim 2</td>
<td>Top</td>
<td>included within CVD and smoking figures</td>
<td>Reduced gap in life expectancy to &lt; 10 years between the lowest and the highest life expectancy not falling below 85 years</td>
<td>Current Gap 13.75 years</td>
</tr>
<tr>
<td>• Reduce the number of deaths caused by cardiovascular disease by 40% from 1997 baseline</td>
<td>• Vascular risk assessment for all those who would benefit.</td>
<td>Pledge 5 Aims 2 &amp; 6</td>
<td>Top</td>
<td>2,849</td>
<td>Reduce mortality from CVD to 59 per 100,000</td>
<td>Current rate 67.13 per 100,000</td>
</tr>
<tr>
<td>• Reduce the number of deaths caused by cancer by 40% from 1997 baseline</td>
<td>• Improve uptake of cancer screening</td>
<td>Pledge 5 Aims 2 &amp; 6</td>
<td>High</td>
<td>included in Cancer Strategy – planned care</td>
<td>Reduce mortality from Cancer to 99 per 100,000</td>
<td>Current rate: 109.29 per 100,000</td>
</tr>
<tr>
<td>• Halt the rise in childhood obesity and then seek to reduce it</td>
<td>• Targeted programmes for children and their families (MEND and mini-MEND)</td>
<td>Pledge 11 Aims 2 &amp; 6</td>
<td>Medium</td>
<td>157</td>
<td>Reduce percentage of obese children in Y6 to 16.5% or less</td>
<td>Current percentage 17.6%</td>
</tr>
<tr>
<td>• Reduce obesity amongst adults</td>
<td>• Weight loss programmes (exercise and diet) working with partners in LSPs</td>
<td>Aims 2 &amp; 6</td>
<td>Medium</td>
<td>540</td>
<td>Increase percentage of adults participating in activity**</td>
<td>Current: Epping 22.3% Harlow 21.6% Uttlesford 26.3%</td>
</tr>
<tr>
<td>• Improving sexual health</td>
<td>• Working with LSP reduce teenage</td>
<td>Pledge 5</td>
<td>Medium</td>
<td>Within</td>
<td>2011 rate of 20.22</td>
<td>Awaiting baseline</td>
</tr>
</tbody>
</table>
## VISION

- Ensure at least 25% of young people between the age of 15 and 24 have been screened for Chlamydia by the end of March 2009 rising to 35% in 2011
  - Pregnancy
    - Extending outlets for chlamydia screening and developing call/recall in primary care.
  - Provider: CQUN
  - Aims: 2 & 6
  - Target: 1,000 girls aged 15-17 years, 35% of young people screened
  - Line: Current rate 7%

- Reduce the prevalence of smoking by achieving at least 50 quitters per 1,000 smokers by 2011
  - Working with partners to:
    - Target services at most deprived areas
    - Provide Baseline prevalence of children and young people and reduce by 1% pa
  - Pledge: 10
  - Aims: 2 & 6
  - Target: 119
  - 50 Quitters per 1,000 smokers (at least 1,000 quitters in 2010/11)
  - Current rate 44 quitters per 1,000 smokers

- Halt the rise in alcohol related hospital admissions by 2010 and seek to reduce it by 1% per year thereafter
  - Screening in primary care (GPs) of ‘at risk’ groups
  - Implement strategy to reduce alcohol related assaults
  - Aims: 2 & 6
  - Low financial impact
  - Baseline established and target set
  - No baseline available

### Mental Health inc LD

- Work to de-stigmatising mental illness, and promote wider acceptance and understanding of mental health problems.
  - Introduction of carer’s strategy
  - Information programme
  - Pledge: 1, 8 & 9
  - Aims: 1, 3, 5 & 6
  - Medium: 308
  - Monitor non-compliance with contract KPIs
  - KPIs in all contracts

- Improve the lives of those suffering from mental illness
  - Implement mental health strategy
  - Pledge: 1, 7 & 9
  - Aims: 1, 3, 5 & 6
  - Improved patient experience
  - Establish patient experience baseline to be established

- Ensure that patients wait no longer than 18 weeks from referral to treatment commencement
  - Agree referral to treatment target for all MH services
  - Pledge: 1 & 2
  - Aim: 5
  - RTT standard to be established
  - CRHT: 100% seen within 4 hours EIP: max 14 days by Sept 09
  - Awaiting guidance

- Improve access to psychological therapies
  - Implement programme to achieve 24 high intensity and 15 low intensity therapists by 2010
  - Aims: 1, 3 & 6
  - Top: 470
  - 24 high intensity 15 low intensity therapists by 2013
  - 4 WTE counsellors and psychologists in current models of care

- Help people who suffer dementia to be cared for at home and to
  - Strategy in development – to include
  - Pledge: 1, 7 & 9
  - Top: 753
  - Targets to be once strategy is
  - Baseline to be established once
## VISION

<table>
<thead>
<tr>
<th>Ensure that their dementia is identified at an early stage.</th>
<th>New pathway</th>
<th>Early diagnosis</th>
<th>Carer support</th>
<th>Aims 1, 3, 5 &amp; 6</th>
<th>Completed</th>
<th>Strategy is complete</th>
</tr>
</thead>
</table>

## TODAY

<table>
<thead>
<tr>
<th>Maternity and newborn</th>
<th>Enhanced services in primary care</th>
<th>Pledge 1 &amp; 9</th>
<th>Aims 1, 3, 5 &amp; 6</th>
<th>Low</th>
<th>Financial Impact</th>
<th>Within budget</th>
<th>Improved service user satisfaction</th>
<th>Baseline self assessment Jan 09</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maternity and newborn</th>
<th>One to one midwife support in established labour</th>
<th>Pledge 1, 9 &amp; 11</th>
<th>Aims 1, 3, 5 &amp; 6</th>
<th>Low</th>
<th>Medium</th>
<th>Financial Impact</th>
<th>Within budget</th>
<th>90% of women soon before 12th week of pregnancy</th>
<th>Current 75%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maternity and newborn</th>
<th>At least one midwife visit post discharge</th>
<th>Pledge 1, 9 &amp; 11</th>
<th>Aims 1, 3, 5 &amp; 6</th>
<th>Low</th>
<th>Medium</th>
<th>Financial Impact</th>
<th>Within budget</th>
<th>3 cycles available to those meeting NICE criteria</th>
<th>1 cycle</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maternity and newborn</th>
<th>3 cycles of IVF</th>
<th>Pledge 1, 9 &amp; 11</th>
<th>Aims 1, 3, 5 &amp; 6</th>
<th>Low</th>
<th>Medium</th>
<th>Financial Impact</th>
<th>Within budget</th>
<th>66% breastfeeding</th>
<th>27.1% breastfeeding</th>
</tr>
</thead>
</table>

### Children’s Services

<table>
<thead>
<tr>
<th>Child health promotion programme</th>
<th>Introduce single generic assessment of need supported by specialist services where needed e.g. parenting, CAMHS, lifestyle</th>
<th>Pledge 1, 7, 8, 9, 10, 11, Aims 1, 2 &amp; 3</th>
<th>Low</th>
<th>Financial Impact</th>
<th>achieved by new ways of working</th>
<th>Programme in place</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Children’s Services</th>
<th>Increasing immunisation uptake including MMR</th>
<th>Pledge 1, 7 &amp; 9, 11, Aims 2</th>
<th>Low</th>
<th>Financial Impact</th>
<th>54</th>
<th>MMR rate at Age 2: 95% Age 5: 95%</th>
<th>Current MMR rate: Age 2: 82.5% Age 5: 85.2% (1st dose) 75.2% (2nd dose)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Children’s Services</th>
<th>Increasing parenting programmes</th>
<th>Pledge 1, 7 &amp; 9, Aims 1, 3, 5 &amp; 6</th>
<th>Low</th>
<th>Financial Impact</th>
<th>106</th>
<th>To evidence increase investment in short breaks</th>
<th>£100,000 per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>TODAY</td>
<td>FUTURE</td>
<td>DELIVERY</td>
<td>APPENDICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>--------</td>
<td>----------</td>
<td>------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Strengthening CAMHS – investing in doubling provision by 2013.</td>
<td>• Double investment in CAMHS over life of strategy</td>
<td>Pledge 1, 7 &amp; 9</td>
<td>Medium</td>
<td>1,199</td>
<td>Level 4 achieved for all relevant vital sign indicators.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aims 1, 3 &amp; 5</td>
<td></td>
<td></td>
<td>Current performance: Full range of services: 2 appropriate accommodation; 4 24 hour cover; 4 Full range early interventions: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We will ensure that looked after children are able to access services as easily as the rest of us.</td>
<td>• Specific and targeted health promotion programme, including health checks.</td>
<td>Pledge 1, 7 &amp; 9</td>
<td>Within budget</td>
<td>User survey improved on baseline. Target to be determined</td>
<td>Baseline survey underway</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aim 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Planned Care**

<p>| • Improving access to and the scope of primary and community care | • Extended opening hours in most practices | Pledge 1, 3 &amp; 9 | Top | 1,616 | Increased patient satisfaction aggregate score of 90%+ |
| | • 8 to 9 CP services available across west Essex | | | | Current 84% |
| | • Broader range of pharmacy services | | | | |
| | • Eight new health facilities planned over 5 year. | | | | |
| • Ensuring that primary NHS dental services are available to all those that need them | • Increase services to ensure that at least 60% of population have seen a NHS dentist in previous 24 months | Pledge 1, 4 &amp; 9 | Low | 478 | Minimum 60% of population having visited an NHS dentist in previous 24 months |
| | • Target oral health promotion programme at worst 50% MSOAs | | | | Current 46% |
| • Ensure that people waiting for treatments within a community setting wait no longer than 18 weeks form referral to treatment. | • Referral to treatment times agreed for all non-consultant led services. Eight weeks and less for many including physiotherapy | Pledge 1 &amp; 2 | Top | 300 | All services listed meeting referral to treatment target |
| | | Aim 5 | | | See appendix c |
| • Maintain and improve access to hospital services | • Implement cancer reform strategy | Aim 2 &amp; 5 | High | 568 | Meet all national cancer targets |
| | • Increasing radiotherapy capacity | | | | Meeting all current standards |
| | • Cancer centre at PAH | | | | |
| | • Develop local renal services | | | | |
| | • Improve the ability of patients choose a hospital and be able to | | | | Current usage |</p>
<table>
<thead>
<tr>
<th>Vision</th>
<th>Today</th>
<th>Future</th>
<th>Delivery</th>
<th>Appendices</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Acute (Urgent) Care</strong></th>
<th>book an appointment at the time of referral.</th>
<th>March 09</th>
<th>58%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that as far as is possible and safe, care is provided as close as possible to people’s homes.</td>
<td>Ensure that 25% of outpatient appointments are provided in a community settings including the majority of specialties e.g. ophthalmology or dermatology.</td>
<td>Pledge 1, 5 &amp; 7, Aim 1, 3, 4, 5 &amp; 6</td>
<td>Low financial impact</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute (Urgent) Care</th>
<th>book an appointment at the time of referral.</th>
<th>March 09</th>
<th>58%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute (Urgent) Care</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Long Term Conditions</strong></th>
<th>book an appointment at the time of referral.</th>
<th>March 09</th>
<th>58%</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will improve the lives of those suffering a long term condition through:</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
<tr>
<td>o supporting them to maintain their independence,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o ensuring that the services are personalised, holistic and,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o provided in a community setting or in their own home wherever possible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 3 years, review all main pathways starting with Diabetes, COPD and heart disease, including case management</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
<tr>
<td>Increase self-help and patient education programmes</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
<tr>
<td>Individual care plans for all</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
<tr>
<td>Pilot individual budgets</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
<tr>
<td>Introduce a carers strategy</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>End of Life Care</strong></th>
<th>book an appointment at the time of referral.</th>
<th>March 09</th>
<th>58%</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will ensure that, wherever possible, the care people receive at the end of their lives meets their specific needs; that they have choice over where and how they receive care and are supported to</td>
<td>Increase proportion of deaths that occur outside hospital to 70%</td>
<td>Pledge 1, 5, 7 &amp; 9, Aim 1, 3, 4, 5 &amp; 6</td>
<td>High</td>
</tr>
<tr>
<td>o increase the number of attendances at A&amp;E and unnecessary emergency admissions to hospital to the best performing 25% of comparable PCTs.</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
<tr>
<td>Improve access to urgent care services</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
<tr>
<td>book an appointment at the time of referral.</td>
<td>book an appointment at the time of referral.</td>
<td>March 09</td>
<td>58%</td>
</tr>
</tbody>
</table>

NHS West Essex - Strategic Plan 2009-14
### Patient Experience
- Continuously improve patient experience across all the services we commission.
- Introduce new methods of collecting patient views – ‘Patient tracker’
- Include patient experience into all contracts with penalties

<table>
<thead>
<tr>
<th>Pledge</th>
<th>Impact</th>
<th>Target</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low financial impact</td>
<td>54</td>
<td>Improve the aggregate satisfaction score by 1% pa</td>
</tr>
<tr>
<td>6</td>
<td>High</td>
<td>Within budgets</td>
<td>Hospital Morality rate of &lt; 100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By 2012 MRSA = or &lt; 0.35 per 10,000 population</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>C-Diff = or &lt; 3.55 per 10,000 population</td>
</tr>
</tbody>
</table>

### Patient Safety
- Make patient safety a priority for all our services and ensure that they are the best in England
- continue to reduce incidence of health acquired infections
- continue route cause analysis
- focus on ‘whole pathway’ risks
- reduce hospital mortality rates
- reduce medicines management associated risk

<table>
<thead>
<tr>
<th>Pledge</th>
<th>Impact</th>
<th>Baseline</th>
</tr>
</thead>
</table>

*Based on most recent available data.

** The percentage of the adult (age 16 and over) population in a local area who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week).

*** Unless public health data indicates that a greater variation is to be expected in a particular location, for example due to the age of the registered patients.
APPENDIX 2—Framework of health needs of west Essex  

West Essex Primary Care Trust\(^1\) covers three local authority areas, Epping Forest, Harlow and Uttlesford plus the extra ward of Steeple Bumpstead in Braintree\(^2\).

Epping Forest district is in the south east of Essex\(^3\) and is a mixture of rural and urban areas. It stretches northward from its boundary with Greater London into the heart of rural Essex. Covering 131 square miles, it is called Epping Forest because of the forest which occupies a large part of it. The key population centres are the commuter towns of Loughton (the largest town in the district), Chigwell and Buckhurst Hill, as well as the market towns of Epping, Ongar, and Waltham Abbey which lies in the Lea Valley.

Harlow is a small district on the west of Essex, bordering Hertfordshire. It is one of a number of ‘new towns’ built in the 1950s to provide social housing to people living in London. Covering 12 square miles, the town was designed by architect Sir Frederick Gibberd and built on a theme of neighbourhoods around the town centre. Each of the original seven neighbourhoods has necessary amenities - shops, schools, church, health centre and district council neighbourhood offices. The aim across the town was to have large areas of green open spaces - most of which have been preserved.

Uttlesford district is in north-west Essex and covers an area of about 250 square miles. Uttlesford is considered a predominantly rural area but has major road networks running through it which allows easy access to London. Its just off the M11, making transport links into Cambridge to the north easy and also has Stansted Airport in its boundaries. The main residential areas of Saffron Walden, Great Dunmow and Thaxted are all historic market towns awash with a wealth of beautiful and distinctive architecture.

---

\(^1\) Throughout this document West Essex PCT is used to refer to the area covered by all of this PCT including the ward in Braintree, while west Essex refers to the area covered by the three districts of Epping Forest DC, Harlow DC and Uttlesford DC.

\(^2\) When comparing information at a district level the ward of Bumpstead is not included unless stated.

\(^3\) Throughout this document Essex is used to refer to the county of Essex, which includes the unitary authorities of Southend-on-Sea and Thurrock. Where information only applies to the Essex County Council locality, the term ECC is used.
1. Population Demographics

1.1 Key challenges

*Population Growth and an aging population*

The population projections for west Essex suggest increases to up to 11% by 2021, with about a 63% rise in the number of people aged 85+ years and a 33% increase in 65+ year olds. The majority increase in the aging population will be in Uttlesford and Epping Forest localities, which presents challenges as these are localities with large rural areas and poor access to services.

Population increases due to housing developments will mean changes to the make up of the population, with more families with young children expected. An aging population will mean an increase in patients with long term conditions such as diabetes and dementia. These long-term conditions are important co-morbidities that impact on the ability to treat acute episodes of ill-health.

The PCT will need to ensure the provision (and possibly re-provision) of community services across West Essex that are appropriate for the demographic need.

*Pockets of deprivation*

Overall west Essex is not considered to be deprived but it covers some of the most deprived areas in the country within in Staple Tye in Harlow, as well as some of the least deprived in Uttlesford. Often the areas of high deprivation experience significant health inequalities. Areas of high deprivation which require targeted work include large parts of Harlow, the north east area of Waltham Abbey and small parts of Loughton and the Limes Farm area.

1.2 Population size

West Essex PCT currently has a resident population of 274,891 and a registered population of 283,123. This equates to over 8,000 extra people who are registered with the PCT and not resident in the area.
1.3 Structure of the population

West Essex has a different population structure to that of England as a whole; it has slightly more older aged people, and fewer 15-34 year olds which may reflect how this group in the population move to other more affordable areas (Figure 1.2). The number of females is higher for most age groups from 15 years and particularly so in the older age groups (which is largely due to consistent patterns of longer life expectancy in females).
Figure 1.2: Population pyramid for West Essex compared to England using mid-year 2006 population estimates, 2007
1.5 Projected Population Changes

West Essex is one of a number of ‘growth areas’ identified for regeneration and growth. Figure 1.3 shows west Essex is expected to have a minimum of 27,500 new dwellings built by 2021. The majority of which will be in the Harlow District Council area. There is also large-scale housing planned north of Harlow in East Hertfordshire. This growth will have an impact on the health of the population, with people from this area accessing services in Harlow and also people from Harlow accessing any new facilities developed as part of the new housing schemes.

Population forecasts developed for the East of England Regional Assembly (EERA) by the Population and Housing Research Group at Anglia Ruskin University (Dec 2006) taking into account the Secretary of State’s proposed changes to the Regional Spatial Strategy forecast an increase in the districts population cover by West Essex PCT of nearly 11% between 2006 and 2021 to a population of 297,800.

As shown in Figure 1.4, these forecasts differ slightly from the ONS population projections. There are complex methodological reasons for this but, simply, the ONS projections assume continuation of recent trends in births, deaths and migration but do not take into account any future policy changes.

Figure 1.3: Essex allocations for minimum dwelling provision 2001-2021

<table>
<thead>
<tr>
<th>Location</th>
<th>Total to build</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maidon</td>
<td>2,400</td>
</tr>
<tr>
<td>Brentwood</td>
<td>3,500</td>
</tr>
<tr>
<td>Epping Forest</td>
<td>3,500</td>
</tr>
<tr>
<td>Castle Point</td>
<td>4,000</td>
</tr>
<tr>
<td>Rochford</td>
<td>4,600</td>
</tr>
<tr>
<td>Southend</td>
<td>6,000</td>
</tr>
<tr>
<td>Braintree</td>
<td>7,700</td>
</tr>
<tr>
<td>Uttlesford</td>
<td>8,000</td>
</tr>
<tr>
<td>Tendring</td>
<td>8,500</td>
</tr>
<tr>
<td>Basildon</td>
<td>10,700</td>
</tr>
<tr>
<td>Chelmsford</td>
<td>16,000</td>
</tr>
<tr>
<td>Harlow</td>
<td>16,000</td>
</tr>
<tr>
<td>Colchester</td>
<td>17,100</td>
</tr>
<tr>
<td>Thurrock</td>
<td>18,500</td>
</tr>
<tr>
<td>TOTAL</td>
<td>126,500</td>
</tr>
</tbody>
</table>

Source: Secretary of State’s proposed changes to the Regional Spatial Strategy, policy H1 (Dec 2006)
ONS data shows the population of West Essex PCT is projected to grow to over 298,800 people by 2021, a 8.8% increase from 2006.

Figure 1.4: West Essex growth in population
While new housing will lead to considerable population growth, population ageing will also be an important demographic trend over coming years. In general, people are living longer and therefore there are increasing numbers and proportions of older people. Population ageing in is predicted to occur at a slightly slower rate then the east of England, but there are some significant differences in expected population structures between areas, with Epping Forest and Uttlesford experiencing most of the increase in the older population.

Figure 1.5: Population changes in west Essex

<table>
<thead>
<tr>
<th>Age group</th>
<th>EERA forecasts (2006-2021)</th>
<th>ONS Projections (2006-2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td>u5 population</td>
<td>increase by over 6%</td>
<td>increase by nearly 10%</td>
</tr>
<tr>
<td>5-14 year olds</td>
<td>decrease by nearly 2%</td>
<td>decrease by around 8%</td>
</tr>
<tr>
<td>Working age popn</td>
<td>increase by around 7.5%</td>
<td>increase by nearly 4%</td>
</tr>
<tr>
<td>Aged 65+</td>
<td>increase by 33%</td>
<td>increase by 30%</td>
</tr>
<tr>
<td>Aged 85+</td>
<td>increase by nearly 60%</td>
<td>increase by 63%</td>
</tr>
<tr>
<td>Total population</td>
<td>increase by over 11%</td>
<td>increase by over 8.8%</td>
</tr>
</tbody>
</table>

Older women outnumber older men, as death rates are greater among men than among women. It is expected the over-representation of women in older age groups will decrease in the long-term due to the improvement in death rates among older men.

The greater number of women than men is most pronounced among the very old, as women tend to live longer than men, and with deaths of men in the world wars having an impact. Using the ONS projections, among those aged 85+, it is estimated the proportion of women will decrease from 68% in 2006 to 62% in 2021.
Figures 1.6 and 1.7: Projected changes in the population for males and females by age for West Essex PCT
1.7 Ethnic Breakdown

According to the 2001 Census, west Essex has 20,488 residents from minority ethnic groups. There are 11,214 residents from ethnic groups other than white and 9,274 from white minority groups. People from all minority ethnic groups made up 7.63% of west Essex residents - across England, 13% of people belonged to these groups.

A higher concentration of residents from ethnic groups can be seen at the southern end of Epping Forest district inside the M25. People from ethnic groups other than white made up 4.17% of west Essex residents. Over double as many people across England were from these groups (9.1%). White minority groups contained 3.45% of the west Essex population slightly below the England level of 3.93%. The largest ethnic group in Harlow other then white is Chinese with 0.9%, in Epping Forest it is Indian with 1.7% and in Uttlesford it is other ethnic groups with 0.3%.

Figure 1.7: Essex concentrations of minority ethnic groups

Legend

- Concentration of ethnic groups other than "White British"
  - Up to 3%
  - 3% to 5.5% (Essex avg)
  - 5.5% to 8.5% (East avg)
  - 8.5% to 13% (England avg)
  - More than 13%

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Data: Census 2001, National Statistics.

Essex County Council, PPP
October 2007
1.9 Growth in diversity

It should be noted the census information dates back to 2001. ONS has produced experimental statistics on ethnicity, although it is not clear the extent to which new growth is reflected. The following chart shows districts in Essex have become more diverse with the areas closest to London and those containing the largest towns tending to have the highest concentrations of people from minority ethnic groups. Epping Forest and Harlow are two of the areas which have the highest proportion of people from all minority ethnic groups in Essex.

Figure 1.8: Essex ethnic groups by district/borough 2005
1.11 Economic migration

The advent of economic migration associated with the expansion of the European Union has led to significant inward migration from the ‘A8 countries’ into Essex. A cumulative total of 1,875 migrants registered to work for employers in the district in west Essex between May 04 and Jun 07, these figures do not included those self-employed nor those not registered with the worker registration scheme for whatever reasons. Migrants in west Essex tend to be young adults aged 18-34 and the majority are Polish migrants.

1.12 Travelling families

The travelling community includes Romany gypsies, Irish travellers and new travellers. Most live in caravans on sites that are either local authority managed or private. A small proportion lives in caravans on unauthorised sites. Gypsies and travellers have long featured in west Essex. There are four registered sites throughout the districts. These sites have 69 residential pitches and capacity for 112 caravans as of January 2008. West Essex had 273 caravans in January 2005 and three years later this figure decreased to 263 caravans in January 2008. Life expectancy in the gypsy/traveller population tends to be below that of the general population with the literature highlighting high smoking prevalence and levels of coronary heart disease.

1.13 Deprivation

There is now good evidence to suggest deprivation and social exclusion can impact on a number of aspects of life including health; employment and the economy; crime; education and skills; housing and the environment.

One of the common measures used is the Index of Multiple Deprivation (IMD). The higher the IMD score, the more deprived an area is said to be. Using the IMD 2007 score, the 354 local authorities in England are then ranked from 1 (most deprived) to 354 (least deprived). The districts in west Essex are ranked as follows Harlow is 121, Epping Forest 229 and Uttlesford 347. How they compare to other areas in Essex can be seen in Figure 1.9.

The IMD 2007 provides deprivation indices at sub-district level (super output area, SOA). The use of the SOAs means that pockets of deprivation can be targeted more effectively with services and it also highlights the small areas of deprivation that can be masked by being situated in a relatively affluent area. West Essex has some of the most affluent and some of the most deprived areas in the country. Many of the most deprived areas also experience the lowest levels of life expectancy.

---

5 Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia
6 Worker Registration Scheme, Home Office
7 Department of Communities and Local Government
Figure 1.9: Essex IMD 2007 scores

Source: English Indices of Deprivation 2007, Communities and Local Government.
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2. Life Expectancy and Mortality

Mortality is a direct measure of health care need reflecting the overall disease burden on the population, both the incidence of disease and the ability to treat it. Rates may be improved by reducing the population’s risk (e.g. encouraging healthier lifestyles and reducing exposure to smoking), by earlier detection of disease and by more effective treatment. Life expectancy is correlated to mortality in that it is the number of years the average person is expected to live considering the mortality rates of the area.

2.1 Key challenges

<table>
<thead>
<tr>
<th>Increasing Inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are persistent and significant inequalities within west Essex. There are increasing inequalities in death rates in people aged under 75. These inequalities are much larger for males and show few signs of reducing. Both genders have experienced an overall reduction over time in death rates due to circulatory disease, but this has not happened in men from the most-deprived areas of West Essex PCT.</td>
</tr>
</tbody>
</table>

The average life expectancy of west Essex is 80 years, with the highest life expectancy by middle super output area (MSOA) of 84.7 years and a lowest of 75.4 years.

<table>
<thead>
<tr>
<th>Harlow Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harlow men have the lowest life expectancy across all of the three localities in west Essex, and the second lowest across Essex. There is a 5.7 years difference in life expectancy between men and women in Harlow. The area in Harlow with the lowest life expectancy for males is around Bush Fair.</td>
</tr>
</tbody>
</table>

Harlow men have the highest mortality rate, out of the three localities, for most of the major causes, with particularly high rates in Bronchitis, emphysema and other COPD mortality for all ages, circulatory disease mortality in under-75s and suicide and undetermined injury mortality for all ages.
2.2 Life Expectancy

Life expectancy is a measure of overall life chances and can indicate areas of poor health. Life expectancy is influenced by economic and social determinants and access to health care. Key issues in west Essex are as follows:

- The average life expectancy is 80 years.
- Life expectancy is better than the national average with 77.8 year for men and 82.2 year for women compared to 77.3 and 81.6 years respectively nationally, but there are differences between each locality and men and women.
- Harlow men have the lowest life expectancy of all the localities and genders in west Essex. There is a 5.7 years difference in life expectancy between Harlow men and Harlow women with 77.3 years and 83.0 years respectively.
- Life expectancy for women in Harlow is increasing faster than for men and than the national rates.
- For men, life expectancy in Harlow and Epping Forest is not increasing as fast as nationally;
- The longest life expectancy for all people by MSOA is 84.7 years and the shortest is 75.4 years, a difference of 9.3 years.
- The MSOA in Harlow with the lowest life expectancy for males is around the Bush Fair area with 74.8 years.
- The MSOA in west Essex with the lowest life expectancy for males is around the Waltham Abbey North East area with 73.3 years.
Figure 2.1: District level Life Expectancy

Life expectancy at birth

The health of the population has been improving steadily. However, despite this general improvement, the gap in the main causes of death between those in advantaged and disadvantaged groups widened in the latter part of the 20th century. Those in disadvantaged groups are more likely to die earlier and to be in poorer health compared with the rest of the population.

The reasons for these health inequalities are complex. There are links with people’s social and demographic circumstances such as their educational attainment, occupation, income, type of housing, sex, ethnicity and where they live. These factors also relate to lifestyle behaviours such as smoking, drinking, diet and risk taking (Focus on Social Inequalities, 2004).

Looking at life expectancy by deprivation quintiles in west Essex we can see the most deprived quintile has the lowest life expectancy, which is significantly lower than the other quintiles. There is no significant difference amongst the least deprived four quintiles (Figure 2.2).

Figure 2.2: Life Expectancy in Years by deprivation quintiles (MSOAs grouped by IMD 2004 score) for west Essex, 2004-2006
2.4 All-cause mortality

All-cause mortality by age group is the number of deaths in a given age group in relation to the population in that age group (usually expressed per 100,000). In this case we are looking at all ages and at under 75 year olds, which is considered premature mortality.

All ages

The all-cause mortality rate for all ages has shown a steady improvement in males for in the areas cover by west Essex. Females have also shown some small improvement but not at such a rate as males, and their rate is appearing to level off in recent years. The trend line for Harlow males is consistently similar to the trend line for England period and above the regional and Essex County Council (ECC) averages.

Figure 2.3: All cause all age mortality rate
When examining all cause mortality at MSOA, we can see there is variation across west Essex with the highest mortality rates in Harlow and Waltham Abbey.

*Under 75-year-olds*

The all-cause mortality for under-75s has seen a steady improvement in males over the last ten years but Harlow has been consistently above the national average. Improvements for females have been variable with a slight improvement overall. Again, MSOA analysis shows even greater variation with the highest mortality rates being found around Harlow and Waltham Abbey.

Figure 2.4: All causes mortality rate for under 75-year-olds
Mortality rates have largely improved steadily over the last ten years, however, improvement has tended to be faster for males. Female mortality rates are, without exception, lower than those for males. Circulatory diseases (including stroke and CHD) remain the most common cause of death at 35% of the total. Cancer is a close second at 29%. Cause of death is similar for both males and females except that males have a higher percent of cancer deaths and females a higher percent due to other causes.

Figure 2.5: Causes of death for all people in west Essex in 2006
2.5 Mortality by different causes

The following tables provide a summary of the data on mortality with further detail set out in the Appendix 1. Key points to note are:

- Deaths from circulatory disease in under-75s are lower than national rates in all localities expect for Epping Forest males and females, which in recent years have been increasing. There is over a six-fold difference in death rates between MSOAs within west Essex with the lowest in Church Langley, Harlow and the highest in Waltham Abbey town, this difference is significant.

- Cancer mortality rates overall are similar to or lower than national rates for females compared to national rates, in males all localities are also lower expect for Epping Forest where it has recently increased to above the national rate for both genders. Particular trends to note on cancer mortality are:
  - Lung cancer mortality is increasing in females.
  - Breast cancer mortality in women was increasing but now all three localities are below the national rate.
  - Prostate cancer mortality is increasing in Uttlesford.
  - In Uttlesford cancer mortality for women had been increasing but has recently shown signs of decreasing again.
  - There is a two-fold difference in premature cancer death rates between MSOAs in west Essex. With the lowest in the rural patch east/south east of Saffron Walden and the highest in the north area of Great Dunmow, both of these are in the Uttlesford locality.

- Mortality from respiratory diseases causes a higher proportion of deaths in Harlow (17.3%) than in either Epping Forest (14.6%) or Uttlesford (16.5%). A large proportion of respiratory disease mortality is linked to smoking.

- Both Harlow and Uttlesford have had high and increasing suicide rates in men in the last few years, though they now show signs of decreasing. Recently there have been increasing suicide mortality in females for all localities.

- Men have higher death rates than women for a range of causes amenable to health care (clustered together as a single indicator) and they are falling at a slower rate then females. Death rates from these causes are lower in all localities in west Essex than nationally.
3. Long-term Conditions

3.1 Key Challenges

*Older People and Long-term conditions*

With a growing and ageing population we are likely to see any increase in the number of people being diagnosed and living with long term conditions. For example a 44% increase in number of diabetics by 2025. An increase in long term conditions will exacerbate if current lifestyle patterns persist, for example increasing obesity. All of these factors could result in increased hospital admissions and longer length of stay when the long term condition is a co-morbidity factor impacting on the treatment of an acute period of illness.

3.2 Diabetes

Estimated prevalence of diabetes in West Essex PCT is 4.2% - below the national average of 4.5% but similar to the regional average of 4.3%. Of the three localities in west Essex, Epping Forest has the highest prevalence of 4.5%. Diabetes is forecasted to increase with an aging population and if trends with obesity persist.

Figure 3.1: PBS diabetes projections - 2010 to 2025 (in 5 year bands)
3.3 Coronary Heart Disease

Estimated prevalence of coronary heart disease in West Essex PCT in 2008 for over-16s is 5.4% which is just below the national average of 5.6%. Of the three localities in west Essex Harlow has the highest prevalence with 5.8%, Epping Forest 5.1% and Uttlesford 4.4%. In all localities men have a higher prevalence than females and in the future the prevalence is expected to increase across the board.

Figure 3.2: Estimated prevalence of coronary heart disease by sex and area
3.3 Hypertension

Estimated prevalence of hypertension in West Essex PCT in 2008 for over-16s is 31.5% for 2008 - just above the national average of 30.3%. Of the three localities, Uttlesford has the highest prevalence with 30.6%, Epping Forest 29.7% and Harlow 30.2%.

In all localities men have a higher prevalence then females and in the future the prevalence is inspected to increase across the board. Health Survey for England data was used to estimate the prevalence of hypertension so the fact Uttlesford has a higher prevalence can not be solely down to more people being diagnosed in primary care services.

Figure 3.3: Estimated prevalence of hypertension by sex and area
Cancer

This section shows the incidence of all cancers (excluding non-malignant melanoma) in all age population for West Essex localities expressed as 3 year rolling averages followed by a breakdown to show the incidence of individual cancers in each locality for 2001-2005.


Figure 3.4: Incidence of cancer in West Essex all age population expressed as 3 year rolling average DSR per 100,000 population
There is a marked similarity in the incidence of the top five cancers in people from the three West Essex PCT localities. Urological and prostate tumours occur at the highest incidence in all localities whilst tumours of the digestive tract are second highest in Epping Forest and Uttlesford and third highest in Harlow. More information can be seen in Figure 3.5 and Appendix 2.

For tumours of male genitalia the ICD10 codes include those for prostate tumours which may explain the relatively high position relative to other tumours. However, some uncertainty was expressed when the data was queried with the Cancer Registry and the situation is under review.

Figure 3.5: Incidence of cancer by type in West Essex all age population for 2001-2005 expressed DSR per 100,000 population
3.4 Chronic Obstructive Pulmonary Disease (COPD)

Estimated prevalence of COPD in West Essex PCT in 2008 for over 16 year olds is 3.0% which is below the national average of 3.6%. Of the three localities Harlow has the highest prevalence with 3.3%, Epping Forest 2.6% and Uttlesford 2.3%. In all localities men have a higher prevalence then females and in the future the prevalence is expected to increase across the board but with a bigger increase in men.

Figure 3.6: Estimated prevalence of COPD by sex and area
3.5 Mental Health

Mental health problems cover a wide range of problems which affect someone’s ability to get on with their daily life. Although the majority of people recover from mental health problems, long term problems can lead to considerable disruption and difficulty in people’s lives. However, with help, many people can lead active lives. One in four people will have some sort of mental health problem in their life and about 1 in 20 of the adult population will suffer from clinical depression.

In West Essex, there is a higher prevalence rate for mixed anxiety and depression compared to the national average (9.9% for West Essex and 8.8% for England). More specifically, anti-depressant prescription data highlights that Uttlesford has a higher rate compared to Harlow and Epping Forest. However, both Uttlesford and Harlow have a higher prescription rate than the West Essex average. There are higher suicide rates in males in both Harlow and Uttlesford.

3.6 Dementia

The number of people estimated to have dementia will increase over the coming years with most of the increase in the 85+ age group. The per cent of these people with dementia that are females will decrease over time, which is linked to the population projections which suggests that more males will be living longer in the future.

Figure 3.7: Dementia projections aged 65 in quinary age bands
3.7 Chronic Kidney Disease

Estimated prevalence of Chronic Kidney Disease (CKD) stages 3-5 for West Essex PCT is 9.1% which is just below the regional average of 9.2%, with nearly 19,500 people estimated to have chronic kidney disease. Of the three localities, Epping Forest has the highest prevalence of chronic kidney disease is 9.5%. The age group with the highest number of is the 75-84 year olds. Figure 3.8 show there is considerable difference between the estimated prevalence of chronic kidney disease and those actually diagnosed with the disease.

Figure 3.8: CKD stage 3-5 prevalence estimates at different geographic areas
4. Lifestyles

4.1 Key Challenges
The key lifestyle challenges in west Essex are:

- the rising levels of obesity in both adults and children and the long term implications this has for the chronic diseases and the provision of health care.
- the continuing high prevalence of smoking in certain areas of the patch particularly in Harlow, parts of Waltham Abbey and Loughton.
- the lack of a downward trend in teenage conceptions across all the districts in west Essex, but particularly in Harlow; and
- the increasing problem of alcohol misuse in the population.
4.2 Obesity and Physical activity

In England two-thirds of adults and a third of children are either overweight or obese, and without action this could rise to almost nine in ten adults and two-thirds of children by 2050s. We have targets to halt the raise in obesity in both child and adults and start to work to reverse it.

Child measurement data in 2007 showed 1 in 11 reception children and 1 in 6 Year 6 children were obese, with particular problems in Harlow and Epping Forest (Figure 4.2).

Figure 4.1: Table of childhood obesity by year and locality 2006/07

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<th>Reception Year</th>
<th>Year 6</th>
<th>All years</th>
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<td>9.22 (1 in 11)</td>
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<td>Harlow</td>
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<td>Uttlesford</td>
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<td>West Essex</td>
<td>9.35 (1 in 11)</td>
<td>17.5 (1 in 6)</td>
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Figure 4.2: Maps of childhood obesity by MSOA by reception year and year 6
It is estimated adult obesity in west Essex is around 24%, which equates to approximately 52,169 Obese Adults. 2007-08 QOF data indicates there are 20,001 identified obese adults, 8.8% of over-16s, however only an estimated 36% of the registered population have had their BMI measured (based on data collected in Quarter 1 2008/09, which is likely to account for the low number identified thus far. Estimates of the level of obesity in adults suggest that Harlow has the highest prevalence of obesity within west Essex with 26.8% which is the highest in Essex and just above the regional average of 26.6%. Both Epping Forest and Ut- tlesford are estimated to have prevalence’s well below the regional and national averages with 22.9% and 22.6% respectively.

Figure 4.3: Chart of estimated obesity levels
One of the key lifestyle challenges is to halt the raise in obesity in both adults and children. The main costs of obesity are as a result of Hypertension, Coronary Heart Disease and Type 2 diabetes. There has been a 40% reduction in CHD mortality in 10 years with about half of this is due to lifestyle change. Obesity has been shown to be increasing, with an expected one-third of adults being obese by 2020 (Choosing Health 2004). This has implications for the projected future costs for these long-term conditions. More than 4 in 5 people with diabetes (type II) are overweight (Diabetes UK). A 10% weight reduction has been shown to reverse the progression of Type 2 diabetes in 50% cases, reduce obesity related mortality by 40% and significantly reduce morbidities associated with obesity. About 5% of total NHS resources and up to 10% of hospital inpatient resources are used for the care of people with diabetes (Diabetes NSF).

4.3 Smoking

Smoking is the UK’s single greatest cause of preventable illness and early death, half of all smokers will be killed by their habit with most dying from the three main diseases: cancer, COPD and CHD.

With the high mortality rates for these conditions in some of the areas of west Essex, smoking as a risk factor which contributes to these high rates is of a concern. Nationally, the prevalence of smoking in the adult population is estimated at 24%. New experimental statistics have estimated that Harlow has a smoking prevalence of around 30%, higher than regional averages and the second highest in East of England. The other localities in west Essex are below the regional average. Several areas across west Essex have been estimated as having a smoking prevalence above 30%, particularly around parts of Loughton, Waltham Abbey, the south west corner of Harlow, and the Netteswell area of Harlow.

Work locally on the use of stop smoking services has shown that not enough men are accessing the services from the more deprived groups and those that do access the service are less likely to quit. Initiatives are being set up to try and provide services to meet the needs of this population.
Figure 4.4: Experimental local authority level smoking prevalence estimates for East of England 2005
Figure 4.5: MSOA smoking estimates

Estimated prevalence of smoking

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(Equal intervals)

Source: National Statistics website: www.statistics.gov.uk
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4.4 Sexual Health and Teenage Conceptions

Sexual health problems are a significant cause of premature ill health and death, for example: unwanted pregnancies, pelvic inflammatory disease, infertility problems, and sexually transmissible infections. There are marked inequalities in those who suffer from sexual health problems linked to social class, culture and ethnicity and to attitudes towards gay, lesbian and bisexual people.

Sexual health is exceptional in that it is one of the few health areas that affects the majority of the population and is relevant throughout the greater part of people’s lives. Locally west Essex has significant challenges in the area of sexual health.

The most common sexually transmitted infection in young people is genital chlamydia. West Essex PCT has the second highest rate of chlamydia infections of all PCTs in Essex and at a locality level Harlow had the highest out of all the local authority areas, well above the national average. Recent work locally on the use of the chlamydia screening service has shown we are not getting enough men screened and are not reaching enough 20 to 24-year-olds for chlamydia screening.

Figure 4.6: Trends in Chlamydia rates in west Essex for 2006 by local authority area
The majority of new cases of HIV have been acquired heterosexually overseas, mostly amongst Black-African populations. For those acquiring the infection in the UK the most common route of transmission is still sex between men, with approximately two thirds acquiring the infection this way. However, two-thirds of these new diagnoses are amongst heterosexuals with more than four Black African heterosexuals being newly diagnosed for each white heterosexual. In West Essex PCT the number of HIV positive patients has almost tripled from 60 in 2002 to 154 in 2006.

Harlow has always had a high teenage pregnancy rate; baseline figures from the teenage pregnancy strategy show in 1998 the rate was 48.8 per 1,000, compared to an Essex and national average of 36.9 and 46.6 respectively. The National Teenage Pregnancy strategy set targets for local authorities to decrease these figures by 50% by 2010. Harlow’s rate was 49.6 per 1,000 in 2004-2006 (three-year rolling average), the fourth highest in the east of England and an increase on the baseline. Wards in Harlow which have very high teenage conception rate are Staple Tye, Toddbrook, Nettleswell and Sumners and Kingsmoor.

The teenage conception rate for Epping Forest and Uttlesford are below the national and regional rates but have both started to show increases. At the ward level the area of Waltham Abbey Paternoster has the third highest ward rate in the whole of west Essex. The percentage of pregnancies leading to abortion has also been lower in Harlow then in other areas in west Essex (Harlow 52%, Epping Forest 72% and Uttlesford 59% under 18 conceptions leading to abortion, 2004-6), but above the national percent of 47%.
Figure 4.7: Teenage conception trend charts
4.5 Substance misuse

Alcohol misuse

Alcohol misuse has become a serious and worsening public health problem in the UK. The misuse of alcohol, chronically, heavy drinking or binge drinking all poses a threat to health such as high blood pressure, mental ill-health and liver disease and to society through crime and anti-social behaviour. Up to 18% of adults in west Essex are reported to be engaging in hazardous drinking (regular drinking each week between 22-50 units for men and 15-35 for women). Furthermore, 15% of adults are engaging in binge drinking.

Consequently, the number of alcohol-attributable hospital admissions in west Essex has been increasing yearly since 2003, which has major complications in terms of cost to the health service and lost working days through alcohol related absence. Interestingly while West Essex as a whole is lower than the east of England and national averages, Harlow men have a significantly higher rate of alcohol related mortality from specific conditions.
Drugs Misuse

The 2004-05 problem drug using (PDU) estimates produced by the University of Glasgow’s Centre for Drug Misuse Research suggested Essex has an estimated PDU population of 2889 (opiate and crack users). If the estimated prevalence rate for Essex is applied to west Essex, the three localities anticipate to have an estimated PDU population of; 172, 269 and 154 respectively (estimated total equal to 1% of total West Essex PCT population).

Until May 2008 the two main drug and alcohol service providers (ADAS and CDAT) for drug misuse in west Essex had 329 numbers in treatment. In general, numbers of PDU’s in treatment is increasing but recent work undertaken Dr Richard Holland and Dave Knock indicates a huge number of patients across Essex admitted to hospital with a drug-related medical condition could not be matched to individuals listed in the NDTMS (National Drug Treatment Monitoring System) database who are in contact with the drug treatment agencies. This indicates those who are admitted to hospital with a drug related medical condition could potentially benefit from a referral to a drug treatment agency.

Figure 4.9: Hospital admission for alcohol-related harm
5. Health Protection

5.1 Key Challenges

Access to Services

Immunisations and screening services are two areas where there is good provision but low uptake rates in certain areas across west Essex. Epping Forest has low rates of MMR vaccinations and Harlow has low cervical screening rates. Not only is it a matter of geographical barriers to services we also need to consider whether the services are appropriate to the populations accessing them are they in the right place, are they open at the most convenient times, and is the population aware of what is available to them.

5.2 Childhood Immunisation rates

Within West Essex PCT the per cent of children having the relevant vaccinations by the time they are 12 months old are similar to the regional average but below the 95% target (Figure 5.1). By the time the children are 24 months old the per cent being vaccination increases slightly to about the 95% mark except for the MMR vaccination which is around 84%.

At a locality level Epping Forest consistently has lower immunisation rates in children then the rest of west Essex.
Figure 5.1: Uptake of childhood immunisations in West Essex PCT at 12 months
Figure 5.2: Uptake of childhood immunisations in West Essex PCT at 24 months
5.2 Influenza and Pneumococcal immunisation rates

*Influenza Immunisation*

Every year, a flu immunisation programme is run targeting those who are at high risk of being affected by influenza which includes all those aged 65 years and over.

Uptake as at the end of January 2008 for over 65-year-olds in west Essex was 72.45% an increase on 2006-07 where West Essex PCT achieved an overall Influenza uptake rate of 71.6%, above the 70% target. Uptake by locality was - Epping Forest 69.0%, Harlow 75.24% and Uttlesford 74.96%.

*Pneumococcal Immunisation*

This has been recommended for all people aged 65 and over, in addition to those at high risk under-65.

There is no formal uptake target for pneumococcal vaccination for those aged 65 and over. Uptake at the end of 2007/08 was 69.11%. Uptake by locality was Epping Forest 62.86%, Harlow 72.17% and Uttlesford 75.75%.
5.3 Cervical Screening Rates

The national standard is that 80% of women should be screened every 5 years. In West Essex coverage (79.4%) is below the national standard but just above the national average (79.2%). However there is variation amongst age groups; younger women are least likely to attend for screening. In 2006-07 nationally only 68% of women aged 25-29 years attended for screening and this is likely to be the same picture locally. This is concerning as abnormalities are normally highest in this age group.
Coverage is considerably lower than would be expected in a population such as west Essex and ranks tenth out of 14 in the east of England. The most recent data for 2007-08 is for quarter 3 and gives West Essex PCT a coverage rate of 78.9%. There is considerable variation between practices in coverage of screening. Latest results by practice show that 17 (43%) practices are achieving 80% coverage or above (Figure 5.5).

Figure 5.5: Coverage of cervical screening by locality, as at 31/12/07 (Q3 2007/08)
Appendix 1: SUMMARY OF MORTALITY INDICATORS BY LOCALITY

(□ = decrease, ▲ = increase, ♂= males, ♀= females)

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Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge

Figure A1.1: Epping Forest
### Figure A1.2: Harlow

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<td>Above</td>
</tr>
<tr>
<td>All age (lung) ♂</td>
<td></td>
<td>Slightly</td>
<td>Above</td>
</tr>
<tr>
<td>All age (lung) ♂</td>
<td>then increased but now</td>
<td>Below</td>
<td>Above</td>
</tr>
<tr>
<td>All age (lung) ♂</td>
<td>up</td>
<td></td>
<td>Just below</td>
</tr>
<tr>
<td>All age (prostate)♂</td>
<td>overall after a slight increase</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td><strong>RESPIRATORY DISEASE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age ♂</td>
<td>now appearing to level off</td>
<td>Above</td>
<td>Above</td>
</tr>
<tr>
<td>All age ♂</td>
<td>showing signs of up again</td>
<td>Above</td>
<td>Above</td>
</tr>
<tr>
<td><strong>SUICIDE AND UNDETERMINED INJURY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age ♂</td>
<td>now signs of decreasing</td>
<td>Above</td>
<td>Above</td>
</tr>
<tr>
<td>All age ♂</td>
<td>slightly now recently</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td><strong>CAUSES AMENABLE TO HEALTH CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age ♂</td>
<td>then up</td>
<td>Below</td>
<td>Above</td>
</tr>
<tr>
<td>All age ♂</td>
<td>slightly now decreasing</td>
<td>Below</td>
<td>Above</td>
</tr>
</tbody>
</table>

Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge
### Figure A1.3: Uttlesford

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td><strong>ALL CAUSES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age ♂️</td>
<td>↓ now appearing to increase</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>All age ♂️</td>
<td>↓ small</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>&lt;75 ♂️</td>
<td>↓ but appearing to increasing</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>&lt;75 ♂️</td>
<td>↑</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td><strong>CIRCULATORY DISEASES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age (all) ♂️</td>
<td>↓</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>All age (all) ♂️</td>
<td>↓</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>&lt;75 (all) ♂️</td>
<td>↓</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>&lt;75 (all) ♂️</td>
<td>↓</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>CHD &lt;75 ♂️</td>
<td>↓ now decreasing</td>
<td>Below</td>
<td>Just below</td>
</tr>
<tr>
<td><strong>CANCER</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age (all) ♂️</td>
<td>↓ now increasing again</td>
<td>Below</td>
<td>Above</td>
</tr>
<tr>
<td>All age (all) ♂️</td>
<td>↑ to start but now ↓</td>
<td>Below</td>
<td>Above</td>
</tr>
<tr>
<td>&lt;75 (all) ♂️</td>
<td>↑ slight increase again</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>&lt;75 (all) ♂️</td>
<td>↑ to start but now ↓</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>All age (lung) ♂️</td>
<td>↑ appearing to level off</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>All age (lung) ♂️</td>
<td>↑ initially now huge increase</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>All age (breast) ♂️</td>
<td>↑ to start but now ↓</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>All age (prostate) ♂️</td>
<td>↑ now appearing to increase</td>
<td>Above</td>
<td>Above</td>
</tr>
<tr>
<td><strong>RESPIRATORY DISEASE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age ♂️</td>
<td>↓ now appearing to level off</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>All age ♂️</td>
<td>↑</td>
<td>Below</td>
<td>In line</td>
</tr>
<tr>
<td><strong>SUICIDE AND UNDETERMINED INJURY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age ♂️</td>
<td>↑ now signs of decreasing</td>
<td>Below</td>
<td>Below</td>
</tr>
<tr>
<td>All age ♂️</td>
<td>↑ now increasing again</td>
<td>Above</td>
<td>Above</td>
</tr>
<tr>
<td><strong>CAUSES AMENABLE TO HEALTH CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All age ♂️</td>
<td>↓</td>
<td>Below</td>
<td>Just below</td>
</tr>
<tr>
<td>All age ♂️</td>
<td>↑</td>
<td>Below</td>
<td>Below</td>
</tr>
</tbody>
</table>

Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge
Figure A2.1: All age DSR cancer incidence 2001-2005 for Harlow
Figure A2.2: All age DSR cancer incidence 2001-2005 for Epping Forest
Figure A2.3: All age DSR cancer incidence 2001- 2005 in Uttlesford
APPENDIX 3—Services covered by the East of England Pledge 2

For all services listed below, by April 2010 a patient will wait no longer than 18 weeks from referral to treatment and in many cases the maximum wait will be much shorter.

<table>
<thead>
<tr>
<th>Service</th>
<th>Current Max wait @ Dec-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric physiotherapy</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Paediatric Occupational therapy</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Paediatric speech and language therapy (special needs)</td>
<td>27 weeks</td>
</tr>
<tr>
<td>Paediatric speech and language therapy (General)</td>
<td>17 weeks</td>
</tr>
<tr>
<td>Paediatric dietetics</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Paediatric health visitor counselling</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Direct access musculoskeletal physiotherapy</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Community physiotherapy (Epping and Harlow)</td>
<td>5 weeks</td>
</tr>
<tr>
<td>Community [hysiotherapy (Utlesford)</td>
<td>14 weeks</td>
</tr>
<tr>
<td>Patient appliances</td>
<td>9 weeks</td>
</tr>
<tr>
<td>Podiatric surgery</td>
<td>51 weeks</td>
</tr>
<tr>
<td>Bio-mechanics (specialist podiatry)</td>
<td>20 weeks</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Adult speech and language therapy</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Domiciliary occupational therapy</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Community dentistry</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Continence service</td>
<td>9 weeks</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>7 weeks</td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>3 weeks</td>
</tr>
<tr>
<td>Multiple Sclerosis specialist nurse</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Parkinson's Disease specialist nurse</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Dietetics</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Wheelchair services</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Community podiatry</td>
<td>16 weeks</td>
</tr>
<tr>
<td>Day therapy</td>
<td>N/A</td>
</tr>
<tr>
<td>Williams Day Unit</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Orchard Day Unit</td>
<td>3 weeks</td>
</tr>
</tbody>
</table>