A meeting of the **OVERVIEW AND SCRUTINY PANEL (SERVICE DELIVERY)** will be held in the **COUNCIL CHAMBER, PATHFINDER HOUSE, ST MARY'S STREET, HUNTINGDON, PE29 3TN** on **TUESDAY, 7 OCTOBER 2008** at **7:00 PM** and you are requested to attend for the transaction of the following business:-

Contact (01480)

APOLOGIES

1. MINUTES (Pages 1 - 4)

To approve as a correct record the Minutes of the meeting of the Panel held on 2nd September 2008. **Miss H Ali 388006**

2 Minutes.

2. MEMBERS' INTERESTS

To receive from Members declarations as to personal and/or prejudicial interests and the nature of those interests in relation to any Agenda Item. Please see Notes 1 and 2 overleaf.

2 Minutes.

3. LOCAL GOVERNMENT ACT 2000: FORWARD PLAN (Pages 5 - 12)

A copy of the current Forward Plan, which was published on 12th September 2008, is attached. Members are invited to note the Plan and to comment as appropriate on any items contained therein. **R Reeves 388003**

15 Minutes.

4. FLEXIBLE WORKING STRATEGY

To receive a presentation by the Head of Information Management on the progress made to date in respect of the Flexible Working Strategy. **M Hinton 388196**

20 Minutes.

5. CAMBRIDGESHIRE AND PETERBOROUGH JOINT MUNICIPAL WASTE STRATEGY (Pages 13 - 18)

To consider a report by the Head of Operations on the Cambridgeshire and Peterborough Joint Municipal Waste Strategy. **R Ward 388635**

15 Minutes.

6. ENHANCED CLEANSING SERVICES (Pages 19 - 28)

To consider a report on the Cabinet's decisions in response to the Panel's recommendations on the Enhanced Cleansing Services report. **Miss H Ali 388006**

15 Minutes.

7. ALCOHOL DISORDER ZONES (Pages 29 - 32)

To consider a report by the Head of Administration on Alcohol Disorder Zones. **R Reeves 388003**

15 Minutes.

8. IMPROVING LOCAL ACCOUNTABILITY CONSULTATION CHANGES TO OVERVIEW AND SCRUTINY POWERS (Pages 33 - 40)

To consider a report by the Head of Administration seeking the Panel's views on the changes proposed for Overview and Scrutiny powers. **R Reeves 388003**

15 Minutes.

9. STRATEGIC HEALTH AUTHORITY: STRATEGIC VISION DOCUMENT (Pages 41 - 172)

To receive and note the Strategic Health Authority's Strategic Vision Document. **A Roberts 388004**

15 Minutes.

10. OVERVIEW AND SCRUTINY PANEL (SERVICE DELIVERY) - STUDIES (Pages 173 - 182)

To consider a report by the Head of Administration on the Panel's programme of studies. **Miss H Ali 388006**

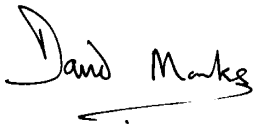
15 Minutes.

11. SCRUTINY

To scrutinise decisions since the last meeting as set out in Decision Digest **(TO FOLLOW)** and to raise any other matters for scrutiny that fall within the remit of the Panel.

10 Minutes.

Dated this 25 day of September 2008



Chief Executive

Notes

1. *A personal interest exists where a decision on a matter would affect to a greater extent than other people in the District –*

   (a) the well-being, financial position, employment or business of the Councillor, their family or any person with whom they had a close association;

   (b) a body employing those persons, any firm in which they are a partner and any company of which they are directors;

   (c) any corporate body in which those persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000; or

   (d) the Councillor's registerable financial and other interests.

2. *A personal interest becomes a prejudicial interest where a member of the public (who has knowledge of the circumstances) would reasonably regard the Member's personal interest as being so significant that it is likely to prejudice the Councillor's judgement of the public interest.*

Please contact Miss H Ali, Democratic Services Officer, Tel No: (01480) 388006 / e-mail: Habbiba.Ali@huntsdc.gov.uk if you have a general query on any Agenda Item, wish to tender your apologies for absence from the meeting, or would like information on any decision taken by the Panel.

Specific enquiries with regard to items on the Agenda should be directed towards the Contact Officer.

Members of the public are welcome to attend this meeting as observers except during consideration of confidential or exempt items of business.

Agenda and enclosures can be viewed on the District Council's website – www.huntingdonshire.gov.uk *(under Councils and Democracy).*

If you would like a translation of Agenda/Minutes/Reports or would like a large text version or an audio version please contact the Democratic Services Manager and we will try to accommodate your needs.

Emergency Procedure

In the event of the fire alarm being sounded and on the instruction of the Meeting Administrator, all attendees are requested to vacate the building via the closest emergency exit and to make their way to the car park adjacent to the Methodist Church on the High Street (opposite Prima's Italian Restaurant).

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HUNTINGDONSHIRE DISTRICT COUNCIL

MINUTES of the meeting of the OVERVIEW AND SCRUTINY PANEL (SERVICE DELIVERY) held in the Council Chamber, Pathfinder House, St Mary's Street, Huntingdon, PE29 3TN on Tuesday, 2 September 2008.

PRESENT: Councillor S J Criswell – Chairman.

Councillors J D Ablewhite, Mrs M Banerjee, Mrs K E Cooper, J E Garner, P Godley, Mrs P A Jordan, J M Sadler, M F Shellens and J S Watt.

APOLOGIES: Apologies for absence from the meeting were submitted on behalf of Councillors E R Butler, Mrs J A Dew, P G Mitchell, Ms M J Thomas and P K Ursell.

24. MINUTES

The Minutes of the meeting of the Panel held on 1st July 2008 were approved as a correct record and signed by the Chairman.

25. MEMBERS' INTERESTS

No declarations were received.

26. LOCAL GOVERNMENT ACT 2000: FORWARD PLAN

The Panel considered the current Forward Plan of Key Decisions (a copy of which is appended in the Minute Book) which had been prepared by the Leader of the Council for the period 1st September to 31st December 2008. In so doing, Members were reminded that the Sub-Regional Housing Strategy item would be considered at the Panel's October meeting. In addition, the Panel were informed that they would receive a copy of the report on Community Engagement when it became available.

27. ENVIRONMENTAL IMPROVEMENTS TO ST IVES TOWN CENTRE

(Councillor P L E Bucknell, Executive Councillor for Planning Strategy and Transport, was in attendance for this item).

The Panel considered a report by the Head of Environmental Management (a copy of which is appended in the Minute Book) proposing that public consultation was undertaken on a range of options for Phase 2 of the environmental improvements to the Market Hill and Bridge Street areas of St Ives.

By way of background, Members were advised that the options had been subject to scrutiny by an Advisory Group comprising County, District and Town Councillors together with Panel representatives and

representatives from local consultative groups such as the Town Partnership, the Access Group and the Civic Society. The Panel also was reminded that its role in the process was to ensure that the Environmental Improvements Protocol previously approved by the Cabinet had been adhered to.

In noting the public consultation proposed on the options identified, the Panel expressed the view that extensive publicity for the consultation process should be undertaken. In that light, it was reported that a number of methods of engaging with the public would be employed during the consultation process. Discussion then ensued on bus services operating within the town centre. In so doing, the Panel were advised that access for buses would not be affected by any of the proposed options.

Having expressed satisfaction that the Environmental Improvements Protocol had been adhered to, the Panel

RESOLVED

that the Cabinet be recommended

(a) to note the progress of the scheme and consultation to date;

(b) to approve the principle of the scheme and to take the necessary public consultation to identify the preferred option; and

(c) to receive feedback at a future meeting.

28. CUSTOMER SERVICE QUARTERLY PERFORMANCE REPORT: APRIL - JUNE 2008

(Councillor L M Simpson, Executive Councillor for Customer Services and Information Technology, was in attendance for this item).

Consideration was given to the Customer Service Quarterly Performance Report for the period April to June 2008 (a copy of which is appended in the Minute Book). In introducing the report, the Customer Service Manager reported that, following the formation of a new Customer Services Team in February 2008, quarterly performance reports would now be produced that covered all services within the Team.

Having noted the performance of individual services in the period covered, the Panel received clarification on a number of activities referred to within the report. In so doing, the Panel requested that additional information relating to the number of unanswered telephone calls received by the Call Centre, together with the number of enquiries in areas that were not the responsibility of the District Council, be incorporated into future performance reports.

29. ADOPTION OF LOCAL STANDARDS FOR THE PROVISION OF CORE SPORTS FACILITIES IN HUNTINGDONSHIRE

(Councillor Mrs D C Reynolds, Executive Councillor for Housing and Public Health was in attendance for this item).

With the assistance of a report by the Head of Environmental and Community Health Services (a copy of which is appended in the Minute Book) the Panel were acquainted with a proposal to adopt local standards for the provision of core sports facilities in Huntingdonshire. The standards would help to achieve an appropriate range of sports facilities to meet future need.

It was reported that, in light of the preparations for the forthcoming Olympics, the adoption of local standards was timely. In response to concerns raised by the Chairman, the Panel were assured that the adoption of standards would not result in the creation of new facilities that would compete with existing Council facilities. In addition, the Council would not be responsible for future operating and maintenance costs of new facilities.

The Panel was informed that whilst the proposal was for five specified types of sports facilities, an emerging Leisure Facilities Strategy would incorporate other facilities. In recognising that the adoption of local standards was being encouraged by Sport England, the Panel

RESOLVED

that the Cabinet be recommended to adopt the local standards for the provision of core sports facilities in Huntingdonshire as outlined within Table 1 of the report now submitted.

30. CHEWING GUM LITTER REDUCTION TRIAL

The Panel received and noted a report by the Head of Operations (a copy of which is appended in the Minute Book) on the outcome of the chewing gum litter reduction trial, which took place between August 2007 to August 2008. The report also contained details of a proposal to extend the scheme to St Neots.

The Panel noted that the removal of chewing gum from pavements in town centres cost the Council £17,000 per year. In response to a question by a Member regarding the level of savings achieved since the introduction of the scheme, it was reported that as the scheme was still in its early stages, the level of savings achieved had not yet been identified. Having suggested that details of the scheme be forwarded on to Parish Councils, the Panel

RESOLVED

(a) that the outcome of the chewing gum litter reduction trial in the period August 2007 to August 2008 be noted;

(b) that the intention to extend the scheme to St Neots be noted; and

(c) that Parish Councils be provided with details of the scheme.

31. OVERVIEW AND SCRUTINY PANEL (SERVICE DELIVERY) - STUDIES

The Panel considered a report by the Head of Administration (a copy of which is appended in the Minute Book) which contained details of actions taken in response to recent discussions and decisions.

Further to Minute No. 08/20, Members were advised that the Cabinet would consider the Panel's report on Enhanced Cleansing Services at their meeting on 4th September 2008. Having been reminded of previous requests made by the Cabinet for Panel Members to present the Panel's reports, Councillor J D Ablewhite was nominated to attend the Cabinet meeting.

Councillor M F Shellens reported that he was still pursuing his investigations into the new A14 proposals and the impact that they would have on air quality and noise pollution.

32. SCRUTINY

The 86th Edition of the Decision Digest was received and noted.

Chairman

FORWARD PLAN OF KEY DECISIONS

Prepared by **Councillor I C Bates**
Date of Publication: **12 September 2008**
For Period: **1 October 2008 to 31 January 2009**

Membership of the Cabinet is as follows:-

Councillor I C Bates	- Leader of the Council	4 Church End Hilton Huntingdon PE28 9NJ Tel: 01480 830250 E-mail: Ian.Bates@huntsdc.gov.uk
Councillor L M Simpson	- Deputy Leader of the Council and Executive Councillor for Customer Services and Information Technology	45 Devoke Close Stukeley Meadows Huntingdon Cambs PE29 6XE Tel: 01480 388946 E-mail: Mike.Simpson@huntsdc.gov.uk
Councillor P L E Bucknell	- Executive Councillor for Planning Strategy and Transport	Compass House Pathfinder Way Warboys PE28 2RD Tel: 01487 824222 E-mail: Peter.Bucknell@huntsdc.gov.uk
Councillor K J Churchill	- Special Advisor to the Cabinet	51 Gordon Road Little Paxton St Neots PE19 6NJ Tel: 01480 352040 E-mail: Ken.Churchill@huntsdc.gov.uk
Councillor D B Dew	- Executive Councillor for Leisure	4 Weir Road Hemingford Grey Huntingdon PE28 9EH Tel: 01480 469814 E-mail: Douglas.Dew@huntsdc.gov.uk
Councillor C R Hyams	- Executive Councillor for Operational and Countryside Services	22 Bluegate Godmanchester Huntingdon Cambs PE29 2EZ Tel: 01480 388968 E-mail: Colin.Hyams@huntsdc.gov.uk

Councillor A Hansard	- Executive Councillor for Resources and Policy	78 Potton Road Eynesbury St Neots PE19 2NN Tel: 01480 388942 E-mail: Andrew.Hansard@huntsdc.gov.uk
Councillor Mrs D C Reynolds	- Executive Councillor for Housing and Public Health	17 Virginia Way St Ives PE27 6SQ Tel: 01480 388935 E-mail: Deborah.Reynolds@huntsdc.gov.uk
Councillor T V Rogers	- Executive Councillor for Finance and Environment	Honeysuckle Cottage 34 Meadow Lane Earith Huntingdon PE28 3QE Tel: 01487 840477 E-mail: Terence.Rogers@huntsdc.gov.uk

Any person who wishes to make representations to the decision maker about a decision which is to be made may do so by contacting Mrs Helen Taylor, Senior Democratic Services Officer on 01480 388008 or E-mail: Helen.Taylor@huntsdc.gov.uk not less than 14 days prior to the date when the decision is to be made.

The documents available may be obtained by contacting the relevant officer shown in this plan who will be responsible for preparing the final report to be submitted to the decision maker on the matter in relation to which the decision is to be made. Similarly any enquiries as to the subject or matter to be tabled for decision or on the availability of supporting information or documentation should be directed to the relevant officer.

Roy Reeves
Head of Administration

Notes:- (i) Additions/significant changes from the previous Forward are annotated ***
(ii) For information about how representations about the above decisions may be made please see the Council's Petitions Procedure at http://www.huntsdc.gov.uk/NR/rdonlyres/3F6CFE28-C5F0-4BA0-9BF2-76EBAE06C89D/0/Petitionsleaflet.pdf or telephone 01480 388006

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Consultation	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
Community Engagement	Cabinet	16 Oct 2008	Previous Report to Cabinet	Dr S Lammin, Head of Environmental and Community Health Services Tel No. (01480) 388280 or email. Sue.Lammin@huntsdc.gov.uk		A Hansard	Service Delivery

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Consultation	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
Customer Service Development in St. Ives and St. Neots	Cabinet	16 Oct 2008	None.	Julia Barber, Head of Revenue Services Tel No. 01480 388105 or email - Julia.Barber@huntsdc.gov.uk		L M Simpson	Service Delivery
Joint Municipal Waste Strategy	Cabinet	6 Nov 2008	Consultation Documents	Robert Ward, Head of Operations Tel No. (01480) 388635) or email - Robert.Ward@huntsdc.gov.uk	Wide Public Consultation	C R Hyams	Service Delivery
Sub-Regional Housing Strategy	Cabinet	6 Nov 2008	None.	Steve Plant, Head of Housing Services Tel No. 01480 388240 or email - Steve.Plant@huntsdc.gov.uk	To be carried out with stakeholders July/August	Mrs D C Reynolds	Service Delivery
Insurance Liability Test Case - Zurich Municipal/MMI	Cabinet	6 Nov 2008	None	Vicki Stevens, Solicitor Tel No. (01480) 388023 or email - Vicki.Stevens@huntsdc.gov.uk		T V Rogers	Service Support
Proposals for Riverside Park	Cabinet	6 Nov 2008	Draft Proposals for Riverside Park	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve following consultation with other key stakeholders	P L E Bucknell & Others	Service Support
Development Control Policies Preferred Options	Cabinet	6 Nov 2008	Issues and Options Report and Summary of Representations	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve for Consultation	P L E Bucknell	Service Support

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Consultation	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
To adopt Urban Design Framework for South of High Street, Ramsey	Cabinet	6 Nov 2008	Draft Consultation Document	Richard Probyn, Planning Policy Manager Tel No 01480 388430 or e-mail - Richard.Probyn@huntsdc.gov.uk	Approve changes for adoption having followed consultation with the public and statutory bodies	P L E Bucknell	Service Support
To adopt Somersham Conservation Area Boundary Changes and Character Statement	Cabinet	6 Nov 2008	Draft Consultation Document	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve changes for adoption having followed consultation with the public and statutory bodies	P L E Bucknell	Service Support
Draft MTP	Cabinet	20 Nov 2008	Financial Strategy, Previous Year's Budget Report and Various Annexes	Steve Couper, Head of Financial Services Tel No. 01480 388103 - or email Steve.Couper@huntsdc.gov.uk	Overview and Scrutiny (CSF)	T V Rogers	Corporate Strategic Framework
Decent Homes Grant***	Cabinet	20 Nov 2008	Letters for Go-East dated 10 Apr 2008 and 6 Jun 2008. Previous Cabinet Reports Dated 12 Jan 2006, 29 Jun 2006 and 22 Nov 2007	Steve Plant, Head of Housing Services Tel (01480) 388240 or email - Steve.Plant@huntsdc.gov.uk		Mrs D C Reynolds and T V Rogers	Service Delivery
Great Fen Governance	Cabinet	20 Nov 2008	None.	Malcolm Sharp, Director of Operational Services Tel No. 01480 388301 or email - Malcolm.Sharp@huntsdc.gov.uk		P L E Bucknell	Service Support
Gypsy and Travellers Issues and Options Report	Cabinet	20 Nov 2008	Local Development Scheme	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve for Consultation	P L E Bucknell	Service Support

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Consultation	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
To adopt Urban Design Framework for land at The Whaddons, Mayfield Drive, Huntingdon***	Cabinet	20 Nov 2008	Draft Consultation Document	Richard Probyn, Planning Policy Manager Tel No 01480 388430 or e-mail - Richard.Probyn@huntsdc.gov.uk	Approve changes for adoption having followed consultation with the public and statutory bodies	P L E Bucknell	Service Support
To adopt Godmanchester Conservation Area Boundary Changes and Character Statement	Cabinet	20 Nov 2008	Draft Consultation Document	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve changes for adoption having followed consultation with the public and statutory bodies	P L E Bucknell	Service Support
To adopt Kimbolton Conservation Area Boundary Changes and Character Statement	Cabinet	20 Nov 2008	Draft Consultation Document	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve changes for adoption having followed consultation with the public and statutory bodies	P L E Bucknell	Service Support
To adopt Houghton and Wyton Conservation Area Boundary Changes and Character Statement	Cabinet	20 Nov 2008	Draft Consultation Document	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve changes for adoption having followed consultation with the public and statutory bodies	P L E Bucknell	Service Support

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Consultation	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
Older Persons Housing Strategy Update***	Cabinet	18 Dec 2008	Housing Strategy 2006-11. Ageing Well, Housing, Health and Social Care Strategy for Older People. Lifetime Homes, Lifetime Neighbourhoods, A National Strategy for Housing in an Ageing Society, CLG, DWP, and DH, March 2008	Jo Emmerton, Housing Strategy Manager Tel No. (01480) 38823 or email - Jo.Emmerton@huntsdc.gov.uk		Mrs D C Reynolds	Service Delivery
Amendments to Disabled Facilities Grant Legislation***	Cabinet	18 Dec 2008	The Disabled Facilities Grants (Maximum Amounts and Additional Purposes) (England) Order 2008 (S12008/1189). The Housing Renewal Grants (Amendment) (England) Regulations 2008 (S12008/1190). Housing Strategy 2006-11. Housing Grants Construction and Regeneration Act 1996	Jo Emmerton, Housing Strategy Manager Tel (01480) 388203 or email - Jo.Emmerton@huntsdc.gov.uk		Mrs D C Reynolds	Service Delivery
Parish Plans and Local Plan Policy	Cabinet	18 Dec 2008	Previous Report to Cabinet in Dec 2003	Richard Probyn, Planning Policy Manager Tel No. (01480) 388430 or email. Richard.Probyn@huntsdc.gov.uk	Adopt process of incorporating relevant Parish Plan Policies into Planning Policies	P L E Bucknell	Service Support
ICT Strategy***	Cabinet	18 Dec 2008	ICT Strategy	Andrew Howes, IMD Operations Manager Tel No. 01480 388190 or email - Andrew.Howes@huntsdc.gov.uk		L M Simpson	Service Delivery

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Consultation	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
Web Strategy***	Cabinet	18 Dec 2008	Web Strategy	John Taylor, IMD Development Manager Tel No. (01480) 388119 or email - John.Taylor@huntsdc.gov.uk		L M Simpson	Service Delivery
Great Fen Master Plan Progress***	Cabinet	8 Jan 2009	None.	Malcolm Sharp, Director of Operational Services Tel No (01480) 388301 or email - Malcolm.Sharp@huntsdc.gov.uk		P L E Bucknell	Service Support
Response to Highway Agency Pre-Consultation on side road Orders - A14 Improvements***	Cabinet	8 Jan 2009	Consultation Documents	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk		P L Bucknell	Service Support
Draft Planning Contributions Supplementary Planning Document	Cabinet	29 Jan 2009	Huntingdonshire Development Plans	Richard Probyn, Planning Policy Manager Tel No. 01480 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve for Consultation	P L E Bucknell	Service Support
Huntingdon West Area Action Plan Preferred Options	Cabinet	29 Jan 2009	Issues and Options Report and Summary of Representations	Richard Probyn, Planning Policy Manager Tel No. (01480) 388430 or email - Richard.Probyn@huntsdc.gov.uk	Approve for Consultation	P L E Bucknell	Service Support

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OVERVIEW & SCRUTINY PANEL (SERVICE DELIVERY) **7TH OCTOBER 2008**

CABINET **6TH NOVEMBER 2008**

CAMBRIDGESHIRE & PETERBOROUGH JOINT MUNICIPAL WASTE STRATEGY
(Report by the Head of Operations)

1. PURPOSE OF REPORT

1.1 To approve adoption of the revised Joint Municipal Waste Management Strategy.

2. INTRODUCTION AND BACKGROUND INFORMATION

2.1 The Joint Waste Partnership of Cambridgeshire County Council, Peterborough City Council and the 5 district councils submitted its Joint Municipal Waste Strategy to Defra in 2002. Huntingdonshire District Council adopted this strategy in 2002. Defra guidance on Municipal Waste Strategies states that strategies should be reviewed and revised every five years so that they reflect national, regional and local policies, legislation and targets. This review has now been completed. The revised document, a copy of which has been placed in the Members Room, combines the original principles established in 2002 and incorporates new themes that have emerged over the last five years. The revised and updated strategy has nine key themes all of which have associated objectives and actions.

2.2 Following its adoption in 2002, it was agreed that the strategy would be reviewed after 5 years. Recycling Plans, which were appended to the 2002 Strategy, were reviewed in 2005 and revised plans have been available on the RECAP (Recycling in Cambridgeshire and Peterborough) website since then.

2.3 The partner authorities have been working towards voluntary targets agreed within the strategy for combined recycling and composting as follows:-

45 - 50% by 2010/11
50 - 55% by 2015/16
55 – 60% by 2020/21

2.4 Together, the partnership members have achieved a very high overall recycling and composting rate, with an average of 50.5% for 2007/08 across the partnership area. As a result of this joint working, Cambridgeshire has been the highest performing shire county in the country for the last four years and is likely to be again in 07/08. Huntingdonshire's recycling rate for 2007/08 was 55.93%, amongst the highest in the country. This excellent

performance throughout the partnership area means that the 2010/11 target has been achieved 3 years ahead of time.

2.5 As a high performing authority/partnership, we are not now required by DEFRA to produce a new strategy however the partnership agreed that as a review is regarded as Best Practice it should be carried out. The new updated strategy incorporates up to date and relevant targets with a clear action plan to deliver them.

2.6 The revised document combines the original principles of the 2002 document with new themes that have emerged since the original document was written. An extensive public consultation has been carried out to ensure that the document addresses current and future need.

The nine key themes of the strategy are outlined below.

- Underlying Strategic Principles for the Waste Strategy
- Joint Working,
- Climate Change;
- Protection of the Environment;
- Waste Prevention & Reuse;
- Recycling & Composting;
- Management of Residual Waste;
- Wider Waste Role; and
- Stakeholder Engagement

Attached at Appendix A are the eighteen actions which are designed to deliver the strategy objectives

2.7 The strategy covers arrangements for the sustainable management of Municipal Solid Waste (MSW) controlled by the RECAP partners and is the framework for addressing waste prevention, reuse, recycling and recovery in line with the waste hierarchy. It also covers collection, treatment and disposal of MSW. The strategy is a forward thinking document which clearly identifies the links between waste management and climate change. It continues to direct the way forward for waste management within the area and reconciles the twin aspirations of customer satisfaction whilst achieving the national and European waste diversion targets.

3. FINANCIAL IMPLICATIONS

3.1 As a high performing authority that has made significant investment in waste management and recycling services in recent years, there are no financial implications associated with the adoption of the new strategy.

4. RECOMMENDATIONS

4.1 Cabinet are requested to

a) approve the adoption of the revised and updated Joint Municipal Waste Management Strategy.

BACKGROUND INFORMATION

Strategy for dealing with Joint Municipal Solid Waste 2002 – 20022 in Cambridgeshire and Peterborough.

Contact Officer: Robert Ward, Head of Operations
☎ 01480 388635

APPENDIX A

REVIEW OF JOINT MUNICIPAL WASTE MANAGEMENT STRATEGY

FOR CAMBRIDGESHIRE AND PETERBOROUGH – ACTION PLAN

Action No.	
1.	**JMWMS*:*** Maintain the relevance and responsiveness of the JMWMS:
2.	**RECAP Governance*:*** The Partnership Team will implement and review a robust mechanism for effective decision making, communication and change management throughout the partnership.
3.	**New Communities*:*** Provide effective and efficient provision of waste services to new and re-locating Council Tax payers entering the JSA as a result of the Growth Agenda.
4.	**Service Modification*:*** Identify service modifications required to meet Strategy and statutory targets.
5.	**Joint Procurement:** Investigate and pursue opportunities for joint procurement (via joint contracts and jointly procured contracts) for bring sites, Materials Recovery Facilities, bulking and transfer stations or joint kerbside collection contracts, where feasible.
6.	**Climate Change*:*** RECAP will work to place itself in a position to reduce its climate change impacts from waste management activities and to monitor impact on climate change.
7.	**Enviro-Crime:** Develop and implement consistent and co-ordinated policies in the partnership.
8.	**Waste Prevention:** Decrease the amount of total household waste per dwelling to 1,272 kg by 2019/20.
9.	**Third Sector Reuse:** Increase opportunities for reuse in the partnership area.
10.	**Marketing and Communication:** In 2009 the Marketing Group will develop a communication strategy to be implemented over the following 10 years, which will aim at increasing the diversion from landfill.
11.	**Trade Waste Recycling:** Develop and implement a Trade Waste Strategy, by the end of 2008.
12.	**Dry and Organic Recycling*:*** To develop the existing comprehensive recycling service within the JSA, in order to achieve the RECAP JMWMS targets.
13.	**Key Indicators:** Ensure the effective delivery of the Strategy to achieve statutory targets.
14.	**Legislative Responsibilities:** To ensure the compliance with all waste legislation and treatment regulations.
15.	**Procurement of Residual Waste Treatment Facilities:** To provide sustainable waste treatment facilities to ensure the diversion of waste captured in the residual waste stream.
16.	**Wider Waste Role:** Play a wider role in tackling non-municipal waste.

17.	**Funding*:*** The partnership team will continually monitor and seek external funding opportunities (such as WRAP and DEFRA) to implement initiatives that further achieve the RECAP's objectives, and these opportunities will demonstrate best practice and raise RECAP's profile.
18.	**Development of Waste Targets within LAAs*:*** RECAP will seek to influence the inclusion of waste targets within the local area agreements annual refresh process.

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OVERVIEW AND SCRUTINY PANEL (SERVICE DELIVERY) **7TH OCTOBER 2008**

ENHANCED CLEANSING SERVICES
(Report by the Head of Administration)

1. INTRODUCTION

1.1 The purpose of this report is to acquaint the Panel with the Cabinet's response to the Panel's report on Enhanced Cleansing Services for the District's market towns.

2. BACKGROUND

2.1 At its meeting on 1st July 2008, the Panel made a series of recommendations designed to enhance Sunday cleansing services in all the market towns in the District. The Cabinet considered the Panel's report at their meeting on 4th September 2008.

2.2 A copy of the report considered by the Cabinet is appended hereto.

3. CABINET DECISION

3.1 The Cabinet noted the recommendations contained within the report but before making a decision, requested further information on the introduction of Sunday cleansing services, in particular, the operational issues associated with the scope of the areas to be cleaned and the delivery of the service. Particular reference was made to the extent of the areas identified and the need to target specific streets.

3.2 The Cabinet also registered their concerns that additional cleansing services on a Sunday were likely to cause some early morning noise and commented that this would be seen as being detrimental to some residents living within the vicinity.

3.3 In addition, a request was made for a financial proposal to be prepared for consideration as part of the Council's Medium Term Plan in the future.

3.4 The Cabinet did, however, concur with the Panel's recommendations to seek financial contributions from the Town Councils towards the cost of implementing the proposal and for the use of Alcohol Disorder Zones to be investigated. A report on the latter appears elsewhere on the Agenda.

4. CONCLUSION

4.1 The Cabinet has noted the recommendations outlined in the Panel's report and has asked for additional information. Further progress on this matter will be reported on at the meeting. The Panel is requested to consider what action to take.

BACKGROUND INFORMATION

Reports and Decisions of the meeting of the Cabinet held on 4th September 2008.
Reports and Meetings of the Overview and Scrutiny Panel (Service Delivery) on 2nd September 2008.

Contact Officer: **Miss H Ali, Democratic Services Officer**
☎ **01480 388006**

ENHANCED CLEANSING SERVICES PROPOSAL FOR MARKET TOWNS
(Report by the Overview and Scrutiny Panel (Service Delivery))

1. INTRODUCTION

1.1 At its meeting on 1st July 2008, the Overview and Scrutiny Panel (Service Delivery) considered a report containing details and costs of providing additional cleansing services in the District's town centres on Sundays. The report is attached as an Appendix hereto.

2. BACKGROUND

2.1 In October 2006, the Panel established a Working Group comprising Councillors J D Ablewhite, R W J Eaton and J W Davies to consider whether there was a need to introduce a cleaning service in towns on Sundays to deal with the effects of the Saturday night time economy in terms of litter. In view of the rise of the Sunday economy the Working Group was asked to take into account tourism and Sunday trading.

2.2 Following discussion, the Working Group suggested that a trial of new cleansing arrangements on Sundays should be undertaken in St Ives. This proposal was considered by the Panel at its meeting on 8th January 2008, when a detailed explanation of various options and their financial implications was available. However, the Panel were of the view that a similar situation existed in other areas and, therefore, requested additional information, including the financial implications, on providing a cleansing service on Sundays in the market towns across the District.

3. DELIBERATIONS

3.1 Members of the Panel, at their meeting on 1st July 2008, reiterated their concerns about the cleanliness of the District's town centres on Sundays, particularly as Sunday trade and tourism are increasing both at a local and national level. Reference was made to the effect of litter on the objectives in these respects identified in Growing Success, the Council's Corporate Plan, and, more specifically, the Local Economy Strategy.

3.2 The Panel has taken into account a representation made by Holywell-cum-Needingworth Parish Council, who have registered concerns that the District Council cleaning regime is focused primarily on town centres and that cleansing services for villages are predominantly funded by Parish Councils. Nevertheless, the Panel were of the view that as users of the towns, parishioners would benefit from the proposed cleansing services.

3.3 The Panel has discussed the option of establishing Alcohol Disorder Zones within the District. This is a Government measure designed to identify establishments deemed responsible for the problems in an area. Those establishments identified are liable to pay for the necessary cost of services required to return an area back to an acceptable state. The Panel has expressed the view that investigation of the potential benefits of introducing

Alcohol Disorder Zones should be undertaken, with a view to adopting this as a long term measure to address the problems associated with litter in Towns.

3.4 In terms of the operational costs of introducing a Sunday cleansing service, the Panel has concluded that the annual cost of £52,400 demonstrates good value for money, particularly, in light of the anticipated benefits that would be achieved. The Panel have, however, expressed their view that as savings are required to be identified by the Council to meet the costs of the proposal, financial contributions should be sought from the Town Councils. Cleansing on Sundays would be more feasible and there would be a greater likelihood that a service would be introduced if such contributions were forthcoming.

4. CONCLUSION AND RECOMMENDATIONS

4.1 The Panel has identified that there is a need to introduce Sunday cleansing services in the market towns across the District, which has arisen out of the growing Saturday night time economy and the adverse effect of the resulting litter on Sunday trade and tourism. In recognising the financial constraints already placed upon the Council, the Panel therefore

RECOMMEND the Cabinet to

(a) introduce cleansing services on Sundays in the market towns across the District as set out in the Appendix;

(b) seek financial contributions from Town Councils towards the costs of implementing this proposal;

(c) subject to the outcome of (b) above, include a bid for funding for the proposal in the Medium Term Plan; and

(d) investigate the introduction of Alcohol Disorder Zones in the District in the long term.

BACKGROUND INFORMATION

Minutes and Reports of the Overview and Scrutiny Panel (Service Delivery)

Contact Officer: Miss Habbiba Ali, Democratic Services Officer
01480 388006

APPENDIX

OVERVIEW AND SCRUTINY PANEL (SERVICE DELIVERY) 1ST JULY 2008

ENHANCED CLEANSING SERVICES – PROPOSALS – MARKET TOWNS
(Report by the Head of Operations)

1. INTRODUCTION

1.1 The Overview and Scrutiny Panel considered a report on 8th January 2008, Enhanced Cleansing Service - Pilot Study and resolved that a further report be submitted to a future meeting giving full details and costs of providing a full cleansing service to the main town centres on Sundays. The Panel requested that the proposals as outlined at option 2 of the report, be adopted for the purpose of preparing the report

1.2 This report provides members with revised proposals based on the above.

2. ENHANCED SUNDAY CLEANSING PROPOSALS

2.1 The proposed enhanced Sunday cleansing services will be provided by 8 employees and one Supervising Inspector working from 06.00 to 10.00. The areas detailed in the town centres below will be cleansed using a combination of mechanical sweepers, litterpicking and the emptying of litterbins situated on roads detailed below, using the resources listed for each area.

St Ives Compact mechanical sweeper, plus a response team of 3 undertaking litter picking and emptying of litter bins.

St Ives	
The Waits	The Broadway
Crown Street	Merryland
Bridge Street	The Quay
The Pavement	Market Hill
White Hart Lane	Sheep Market
Market Road	Station Road
Cattle Market Car Park	

Huntingdon Compact mechanical sweeper, plus a response team of 3 undertaking litter picking and emptying of litter bins.

Huntingdon	
High Street	Ferrars Road
George Street	Royal Oak Passage
Market Hill	Princes Street
Literary Walk	St Marys Street
Hartford Road	St Benedicts Court
Chequers Court	St Germain Walk
Trinity Place	Chequers Way
Brewery Yard	St Germain Street Car Park
Brewery Yard	

St Neots Compact mechanical sweeper, plus a response team of 3 undertaking litter picking and emptying of litter bins.

St Neots	
St Neots Road	High Street
Cambridge Street	Huntingdon Street
Tebbutts Road	New Street
Church Street	Brook Street
South Street	St Marys Street
Priory Lane	Tan Yard
Bec Road	The Priory
Priory Lane Car Park	Waitrose Tan Yard Car Park
Market Square West	Market Square South

Ramsey & Godmanchester Response team of 2 undertaking litter picking and emptying of litter bins

	Godmanchester	
	Causeway	Post Street
	Old Court Hall	Cambridge Street

	Ramsey	
	Great Whyte	Little Whyte
	High Street	New Road
	Mews Close Car Park	

Appendix 1 to this report provides maps of the actual areas that will be cleansed under these proposals.

3. OPERATING COSTS

	Per week	**Per annum**
Employee costs including supervision and management	**£790**	**£41,000**
Vehicle and Plant operating costs	**£220**	**£11,400**
Total Cost	**£1,010**	**£52,400**

Financial Context

No provision has been made for enhanced cleaning services in the Council's financial plan. The existing plan can be summarized as:

1) A deficit had already been planned for years 2008/9 through to 2014/5 by which time revenue reserves would be reduced to what is considered to be a minimal level.
2) The existing medium term financial plan is based on Council Tax rises of 5% every year for the next 10 years.
3) The existing medium term financial plan requires further savings to be identified of £0.5m for 2009/10 rising to £1.0m and £2.0m in each of the following two years.
4) All new expenditure will add to the requirement to make savings in other areas.

4. OPTIONS FOR DELIVERING THE ENHANCED SERVICE

4.1 As indicated at para 3 above, there is at present, no funding identified to provide this increased level of service and if Members were minded to recommend to Cabinet that the proposals be introduced, it would be necessary to prepare a bid for funding as part of the medium term financial plan later in the year which would be considered on its merits when assessed against other competing priorities.

5. SUMMARY

5.1 As indicated in the report considered by the Panel on 8th January 2008 our existing street cleansing services currently deliver a frequency based cleansing service higher than the EPA and COPLAR requirements. We are currently performing well in relation to the national performance indicators (which measures litter, detritus, graffiti and flyposting) being in the upper quartile of performance nationally.

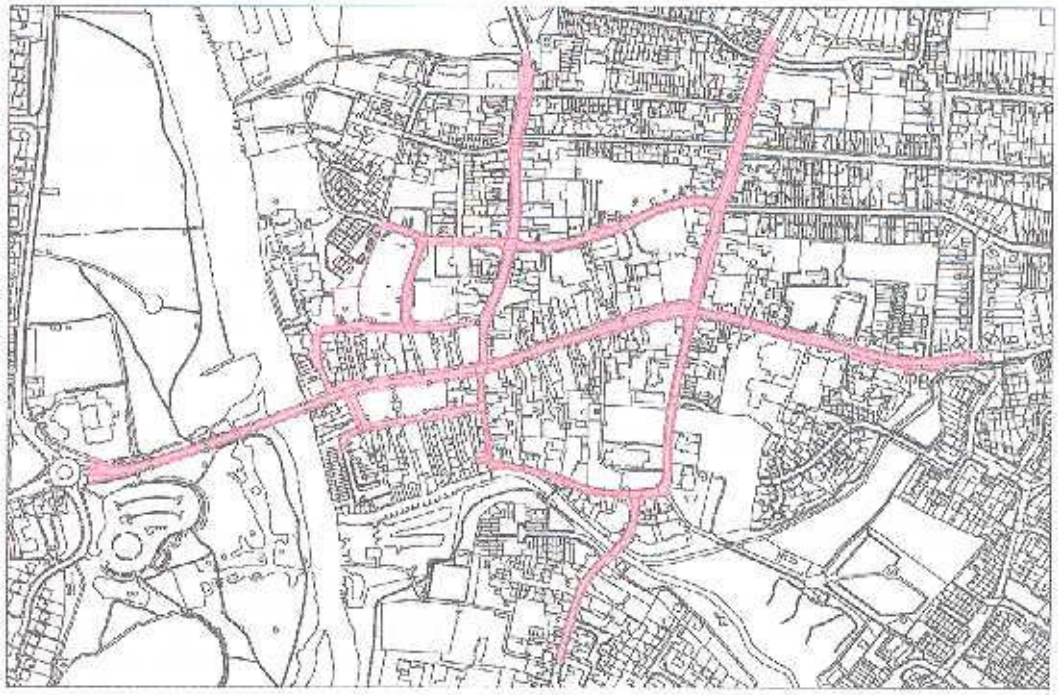
5.2 The enhanced Sunday cleansing services proposed in this report would improve the Town Centre appearance *in the mornings*, but the standard will deteriorate during the day as there will be no full time presence to maintain the standard throughout the day. Litter dropped during the day will be recovered on the Monday morning by scheduled cleansing regimes.

6. MATTERS FOR CONSIDERATION

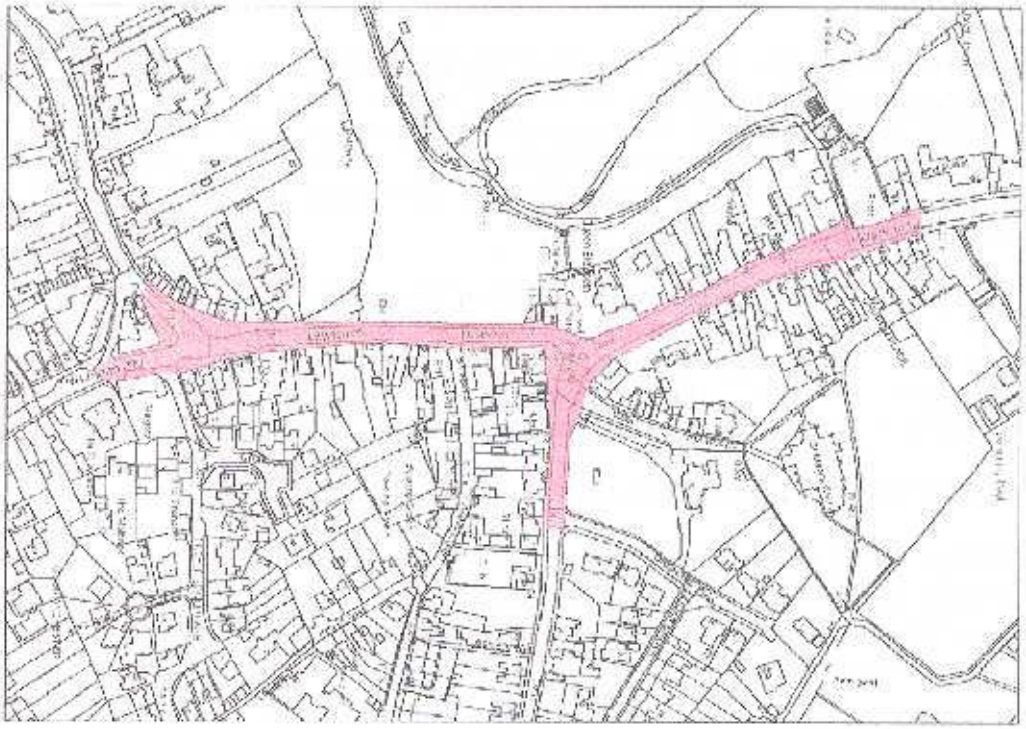
6.1 If the Panel supports improved cleaning services for one or more of the towns they may consider a recommendation to Cabinet that additional funding be provided or that the cleaning service be enhanced by savings from other services.

Contact Officer: **Robert Ward**
Head of Operations
☎ 01480 388635

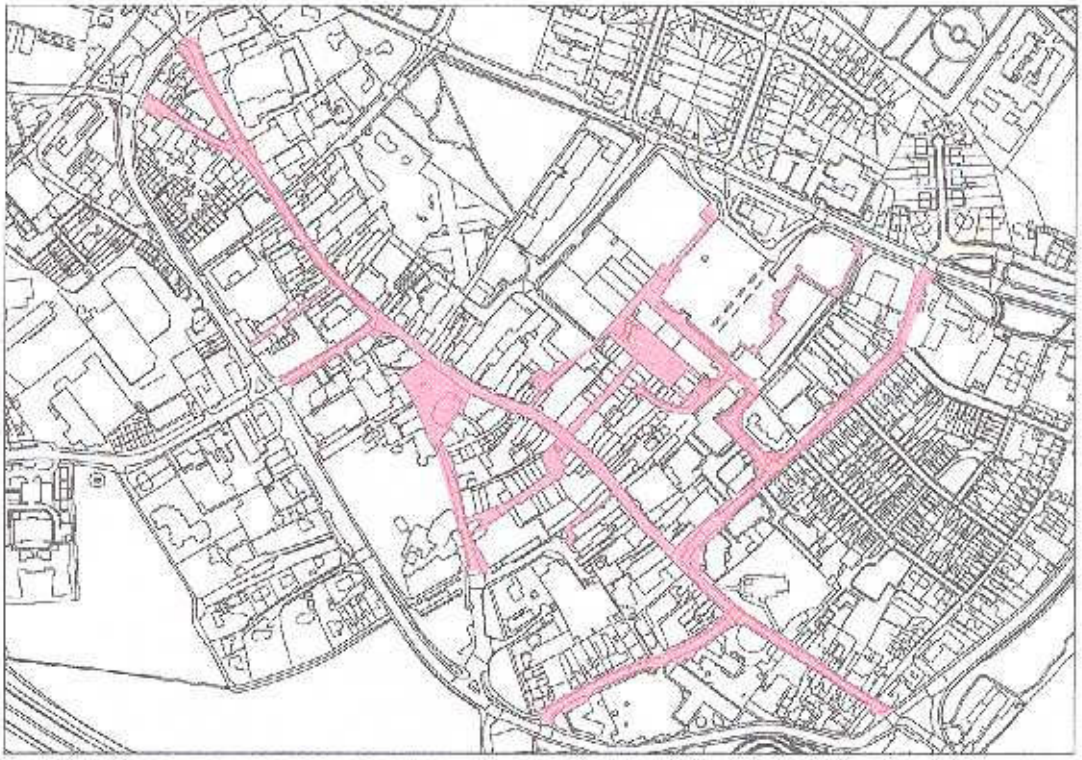
St Neots



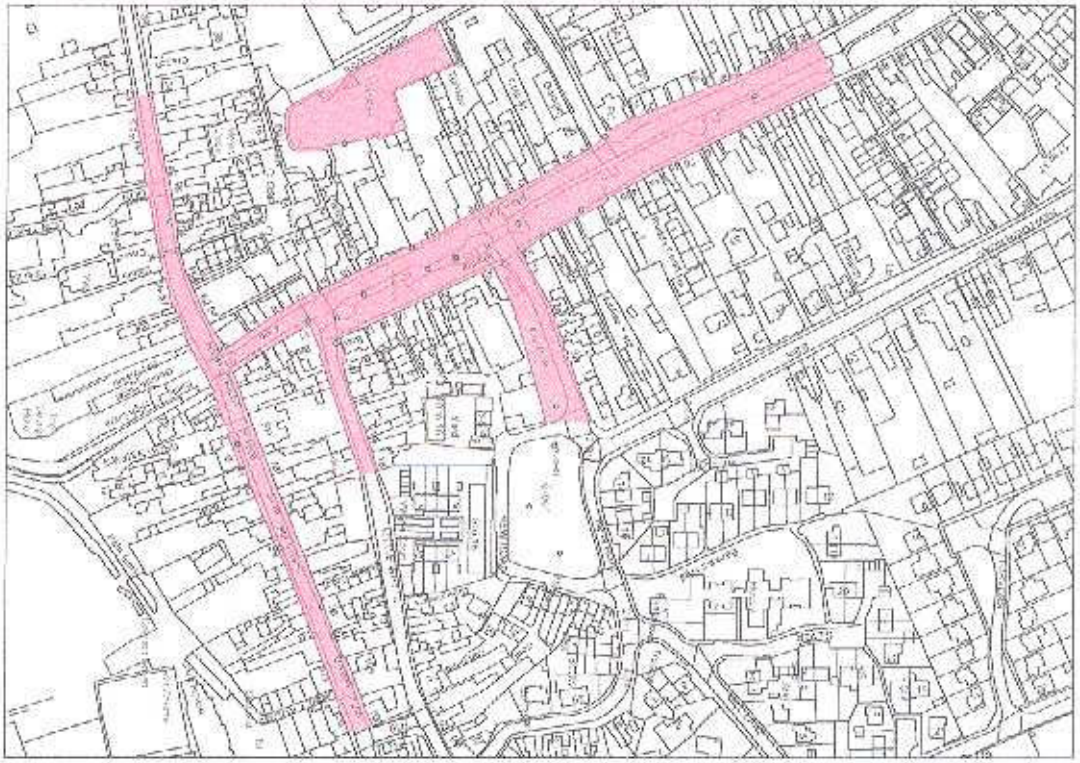
Godmanchester



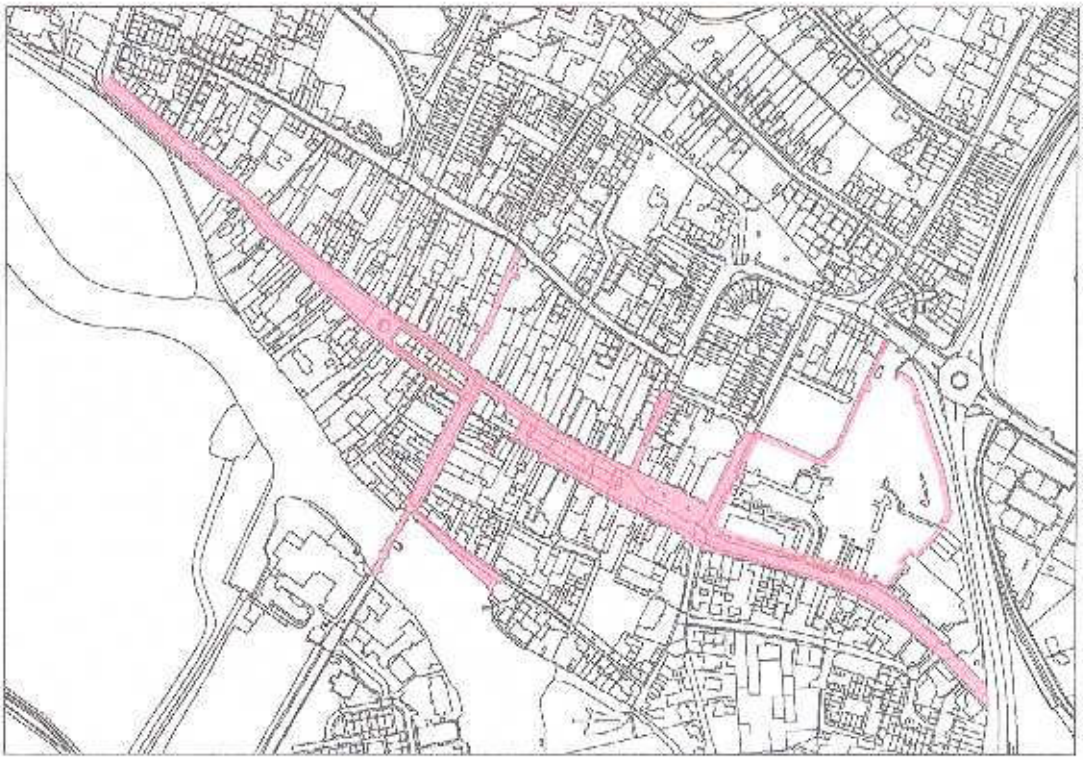
Huntingdon



Ramsey



St Ives



OVERVIEW & SCRUTINY PANEL (SERVICE DELIVERY) — **7TH OCTOBER 2008**
CABINET — **16TH OCTOBER 2008**
LICENSING COMMITTEE — **21ST OCTOBER 2008**

ALCOHOL DISORDER ZONES
(Report by Head of Administration)

1. Introduction

1.1 The Cabinet has recently asked for further information on Alcohol Disorder Zones (ADZs), arising from a report submitted by the Overview and Scrutiny Panel (Service Delivery) on the introduction of an enhanced cleansing service on Sundays in the market towns in the District to counteract the after-effects of the night time economy in town centres. The Panel had recommended an investigation of the introduction of ADZs in the District in the long term.

1.2 The purpose of this report is to explain the circumstances in which ADZs can be introduced.

2. The Legislation

2.1 ADZs were introduced by the Violent Crime Reduction Act 2006 in response to problems in city and town centres as a result of excessive alcohol consumption. It was unrelated to but reflected growing concern about the implications of the Licensing Act 2003 on longer opening hours for licensed premises. The accompanying regulations only came into effect in June 2008 with guidance issued by the Home Office shortly beforehand.

2.2 The designation of an area as an ADZ is defined as a non-executive function. It is therefore a responsibility of Council as opposed to Cabinet. As ADZs are related exclusively to alcohol consumption, as will be explained later in this report, it seems appropriate for this to fall within the terms of reference of the Licensing Committee.

3. Implications of an ADZ

3.1 The designation of an area as an ADZ is a last resort. It is a course of action to be embarked upon by an authority, either of its own volition or at the request of the police, when all other measures possible under the various legislation to control the adverse effects of alcohol consumption has failed to resolve a problem.

3.2 Both authorities (and other agencies) have enforcement powers to deal with contravention of the legislation in individual premises, in public spaces and by members of the public. ADZs are appropriate where problems relating to alcohol consumption cannot easily be attributed to individual licensed premises and registered clubs. Where all other remedies have been attempted without success, an authority and the police can contemplate designating the area concerned as an ADZ.

3.3 It is important to note, especially in the context of the discussions at the Scrutiny Panel and Cabinet meetings, that ADZs are intended only to address high levels of alcohol related nuisance and annoyance to members of the public or disorder that is not attributable to a single premises. The decision to proceed has to be evidence based and demonstrate that the problems cannot be dealt with by other means. Evidence must include police incident, crime and custody data and CCTV incident logs but can be backed up by NHS Emergency Department data, licensing authority evidence, bus and taxi incident forms and feedback from the public. The latter in themselves are not sufficient.

3.4 If the authority is considering proceeding with an ADZ, there is an extensive consultation process that involves public notice in the press and to various bodies and licence holders inviting representations on the proposals. The response to any representations also must be published. If the authority intends to proceed, it must compile an action plan setting out preventative measures with voluntary charges to licence holders within the area designated. If those measures do not work within 8 weeks, the authority can proceed to designate an ADZ. This involves another round of public consultation. If an ADZ is designated, it must be reviewed every 3 months with public notice of any decision to continue, amend or lift a designation.

4. Measures and Charges

4.1 The measures that can be taken to address any alcohol related nuisance and annoyance are restricted to activities by Trading Standards Officers relating to the sale of alcohol to children, by Environmental Health Officers relating to noise nuisance from licensed premises, by Licensing Officers of the licensing authority and by police constables and community safety officers. A baseline level of service has to be calculated for a period preceding designation and an enhanced level after designation.

4.2 Costs can be recovered from licensed premises and registered clubs selling alcohol within the designated area for the delivery of the enhanced services plus the administrative cost of the ADZ process. In calculating individual charges, these must be scored on rateable values and hours of opening of premises with a facility for discounts and exemptions to be granted. Failure to pay the charge demanded by the licensing authority for the enhanced services can lead to the suspension of licences and certificates.

5. Conclusion

5.1 The measures described are appropriate only when all other measures have failed to deal with nuisance and annoyance to members of the public relating to alcohol consumption. They cannot be applied to other problems associated with late night entertainment such as hot food outlets or litter. They are therefore inappropriate in the case of an enhanced cleansing regime in town centres which was the subject of the investigation by the Overview and Scrutiny Panel (Service Delivery).

5.2 The situation in the town centres in the District will continue to be monitored in association with partner organisations and if it is felt that an ADZ would be appropriate, this will be brought to the attention of the Licensing Committee.

6. Recommendation

It is therefore

Recommended

that the position with regard to the new powers to designate alcohol disorder zones be noted.

Background Papers:

Violent Crime Reduction Act 2006
The Local Authorities (Alcohol Disorder Zones) Regulations 2008
Home Office Guidance on the Designation of Alcohol Disorder Zones.
Report by the Overview and Scrutiny Panel (Service Delivery) on Enhanced Cleansing Services Proposal for Market Towns.

Contact Person:

Roy Reeves, Head of Administration
Tel: (01480) 388014

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OVERVIEW & SCRUTINY PANEL (SERVICE DELIVERY) **7TH OCTOBER 2008**

OVERVIEW & SCRUTINY PANEL (SERVICE SUPPORT) **14TH OCTOBER 2008**

CABINET **16TH OCTOBER 2008**

IMPROVING LOCAL ACCOUNTABILITY CONSULTATION CHANGES TO OVERVIEW AND SCRUTINY POWERS

(Report by Head of Administration)

1. Introduction

1.1 At the Panels' meetings in February, a report was considered on changes to overview and scrutiny introduced by the Local Government and Public Involvement in Health Act 2007 and a consultation paper on the Councillor 'call for action' and local petitions. The Panels were advised that further information would be submitted to them on the implementation of the legislation as this became available.

1.2 The Department for Communities and Local Government (CLG) has now issued a further consultation paper on the changes, in the light of the publication of the recent White Paper 'Communities in Control'. The consultation asks a number of questions, in response to which suggested answers are contained in the attached annex. The Panels' and Cabinet's views are sought on the changes proposed and the attached response.

2. Communities in Control White Paper

2.1 The White Paper builds on the changes introduced in the 2007 Act and contains the following proposals for overview and scrutiny –

- Encouraging more creative involvement of the public, for example by holding deliberative events
- Moving meetings into the community and considering webcasting
- Greater public involvement in suggesting and selecting topics for review
- Making information more readily available and accessible on websites and at council offices
- Further enhancing the powers of overview and scrutiny committees to require information from partners on a broader range of issues
- If necessary providing councils in two tier areas with a power to combine resources in 'area' scrutiny committees
- Requiring some dedicated scrutiny resource in county and unitary councils.

2.2 Further proposals of relevance to overview and scrutiny are –

- Increasing the visibility of officers of local public bodies so that they are open to public scrutiny and questioning by local communities
- A new right to petition to hold local officers to account
- A new duty on Councils to respond to all petitions, including electronic petitions, relating to local authority functions or other public services where the Council shares delivery responsibilities.

3. Improving Local Accountability Consultation

3.1 CLG are planning a series of consultation papers to implement changes introduced by the 2007 Act and the White Paper. In addition to the improving

local accountability paper, the others are the making and enforcement of byelaws, a revised code of conduct for Members, on-line petitioning for mayors, time off entitlements for membership of Councils and other voluntary organisations, and a review of the code of recommended practice on local government publicity.

3.2 The particular issues on which views are sought in the current paper are –

- Developing and strengthening overview and scrutiny by implementing the provisions of the 2007 Act to enhance scrutiny powers in relation to Local Area Agreement partners and the delivery against targets and in particular regulations in respect of –
    - Overview and scrutiny committees requiring information from partner authorities
    - Publication of scrutiny reports, recommendations and responses
    - Establishment of joint county and district overview and scrutiny committees
    - Enhancing the powers of district overview and scrutiny committees
- How best to take forward the proposals in the White Paper to raise the profile of overview and scrutiny
- Increasing the visibility and accountability of local public officers
- Facilitating the work of councillors by enabling them to use information and communications technology to participate in meetings and vote remotely.

4. Other Proposals

4.1 Members may recall that the report in February also referred to the changes introduced in the Police and Justice Act 2006 which required every authority to have a crime and disorder committee to scrutinise the discharge of crime and disorder functions by other responsible authorities. Implementation of the proposals has been delayed pending the Flanagan report on policing and the publication of a Green Paper on the Police.

5. Conclusion

5.1 The Government is committed to raising the profile of overview and scrutiny as part of a series of measures to encourage greater community involvement in local decision making. Several of the initiatives have already been either tried or implemented by the Council but Members will be aware of the difficulty in engaging with the public other than in cases where a high profile issue has raised local concern.

5.2 The Panels and Cabinet will be updated as the anticipated regulations and guidance are issued.

6. Recommendation

6.1 Suggested responses to the questions posed in the consultation paper are made in the attached annex and it is

RECOMMENDED

that the Panels and Cabinet consider and endorse the responses for submission to CLG as part of the implementation process of the 2007 Act and the White Paper.

Background Papers:

Crime and Justice Act 2006
Local Government and Public Involvement in Health Act 2007
Communities in Control White Paper
Improving Local Accountability White Paper
Report to Overview & Scrutiny Panels in February 2008 on Local Petitions and Calls for Action

Contact Officer

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IMPROVING LOCAL ACCOUNTABILITY CONSULTATION
CHANGES TO OVERVIEW AND SCRUTINY POWERS

Questions Raised and Suggested Answers

Question 1

This deals with the arrangements for overview and scrutiny committees to require information from partner authorities. This enables a district council committee to seek information from the county council as lead authority or any partner in an LAA that relates to a target connected with the district's area and functions. CLG propose limited regulation on the release and withholding of information. Release refers to information that relates to LAA targets and withholding concerns data protection, commercial confidentiality and information already in the public domain. No time limits are proposed for responses to requests nor how requests can be kept to manageable proportions which will be matters of local discretion. Comments are invited on the proposals.

Suggested Response

While local discretion and flexibility is welcomed, it is important that some mechanism is in place to ensure that partners do co-operate in providing information to the detail required and in a timely manner. Since Freedom of Information requests are time limited to 20 working days with an appeal to the Information Commissioner where a public authority fails to comply, it would not be unreasonable for the same sanctions to be applied in this case.

Question 2

The 2007 Act specifies the arrangements for the withholding of exempt and confidential information when overview and scrutiny reports are published and an authority responds. This does not include an executive and the question raised is whether there is agreement to the extension of the same principle to local authority executives.

Suggested Response

Agreed

Question 3

The 2007 Act enables the establishment of joint county and district overview and scrutiny committees. The consultation paper invites comments on the extension of existing overview and scrutiny powers to joint committees, while recognising the need for co-ordination to ensure that duplication does not arise in terms of the scrutiny of partners by a number of overview and scrutiny committees.

Members will be aware that joint scrutiny already exists in Cambridgeshire. In terms of health scrutiny, district councillors are co-opted to the relevant County scrutiny committee and a joint accountability committee has been formed to scrutinise the LAA board, Cambridgeshire Together. A separate report deals with those joint arrangements elsewhere on the agenda.

Suggested Response

The extension of scrutiny powers to joint committees is welcomed. The joint committee however should not be able to direct the work of scrutiny committees in individual authorities nor be able to exercise any veto over legitimate lines of enquiry into the achievement of LAA targets or the performance of partners. It should be a matter for local discretion as part of the agreed terms of reference between the local authorities concerned as to how the joint committee might co-ordinate scrutiny activities, respond to proposals by individual authorities for an area based study or suggest that a study is undertaken by an individual authority's scrutiny committee.

Question 4

Regulations are proposed to implement the provisions in the 2007 Act to give district scrutiny committees in two tier areas similar powers to lead councils, i.e. county councils. As such, they can make reports and recommendations to the county council on local improvement targets and the county must respond within 2 months. Other authorities will be required to have regard to such reports and recommendations. While it will be for a district committee to determine its programme of work, it should have regard to scrutiny work planned by the lead council and any joint committee. To minimise potential duplication, the requirements for a county council to respond and partner authorities to have regard to a report and recommendations will only apply to matters where a joint committee has not already reported. Comments are invited.

Suggested Response

The proposals to extend similar powers to district scrutiny committees are supported. While the need to avoid duplication is recognised, a timescale should be applied to the restriction preventing a district committee from scrutinising a subject already considered by a joint committee of say 2 years.

Question 5

This only applies to authorities of less than 85,000 population.

Question 6

CLG are proposing to introduce a power for county and district councils to combine scrutiny resources in area scrutiny committees if they wish to do so. Comments are invited on what issues should be considered as part of any new power.

Suggested response

While there is a role for an area committee in considering issues of county wide significance and in scrutinising LAA targets and performance, it should not circumvent the ability of district committees to scrutinise individual subjects relevant to that authority's area within the general power of promoting economic, social and environmental well-being. An area committee's co-ordinating responsibility should be limited to an advisory capacity only.

The primary role of an area committee should be to hold to account an LAA Board but it will be powerless to do so unless it has the ability to call in decisions of the Board. If an area committee cannot do so and it is impractical for scrutiny committees of individual authorities to exercise this function, a Board cannot be effectively held to account.

Question 7

CLG propose that county, unitary and borough councils are required to make provision for a dedicated scrutiny resource to support the overview and scrutiny

function. A similar requirement is not extended to district councils, presumably because of the resource implications for smaller authorities.

Suggested response

No comment.

Question 8

CLG want to introduce an appeals mechanism if petitioners are not satisfied with an authority's response to a petition. As overview and scrutiny committees are independent of the executive, CLG propose that they act as the appeals body with a remedy of triggering a debate at full council if they consider the response to be not sufficiently adequate. Comments are invited about the practicality of this approach.

Suggested response

The approach is unnecessarily bureaucratic. Authorities will have existing mechanisms for dealing with petitions. In the case of Huntingdonshire, petitions containing over 50 signatures are already presented to Council and those with over 10 signatures to a scrutiny panel. It should be a matter for the discretion of individual authorities to decide upon the most appropriate method to deal with a petition, as long as there is an assurance that this will be considered in a member forum.

Question 9

The White Paper seeks to achieve a consistency of approach in public services to formalise arrangements to require chairmen and chief executives to attend a public hearing in the community at regular intervals every three or four months to explain their actions and listen to the views and concerns of local people. The requirement to attend such meetings should form part of the job descriptions of the chairman and chief executive and the question raised is whether those responsible for the job descriptions should determine the precise arrangements for the attendance of those persons.

Suggested response

Regular meetings are unlikely to attract high attendances, even if they are co-ordinated so that several bodies are represented. If the area covered is too wide geographically, members of the public will be less likely to travel and to identify themselves with the bodies in question. The public tend to be more interested in local issues of topical significance such as a threatened hospital closure which does attract high attendances at public meetings. The result of the current proposal could be a plethora of poorly attended meetings but with leading figures present which would be an inefficient use of resources and time. If public bodies are to be held to account by the public, this would be best achieved through the strengthening of the scrutiny role of local authorities and the use of petitions to raise issues of concern.

If CLG intends to proceed with this proposal, it is preferable for the precise arrangements for public meetings and the determination as to who should attend to be dealt with by the public bodies themselves.

Question 10

The White Paper proposes a new right for people to petition to hold officers to account with senior officers working for a public body required to attend a public meeting. CLG therefore propose that the lead council in each LAA area should agree with partners a scheme for petitions to hold officers to account. The scheme should complement local petitions arrangements, set out the officers or category of officers to which it would apply, specify the petition criteria, the bodies affected and

how they will respond, and the arrangements for a hearing. Comments are invited on the proposal and the practical implications.

Suggested response

Officers implement rather than set policy. If representatives of public bodies are to be held to account in this way by the public, it is the decision makers who should be required to attend to respond to concerns. The opportunity to petition for a hearing is a much more tangible and meaningful way of ensuring public engagement than scheduled, poorly attended meetings. If the scheme is to cover the whole of an LAA area, there should be opportunities for some discretion to allow for local circumstances. The scheme also should enable issues that are local in nature to be dealt with through district scrutiny committees as opposed to the broader LAA area.

Question 11

Should the Government specify certain minimum standards for the scheme to hold public officers to account? These might include the timescale for the implementation of a scheme, which officers or category of officers should be required to attend and which local service providers should be involved. CLG suggest that officers should be restricted, in local government terms, to statutory officers and/or non-statutory officers as defined in legislation.

Suggested response

This is a subject that is best left to local discretion.

Question 12

CLG propose that a local authority and its partners should agree on which local service providers and agencies the scheme should apply to, subject to any statutory minimum requirements. Comments are invited as to whether the scope of the scheme should be agreed locally and whether this will be an effective means of empowering communities.

Suggested response

This is a subject that is best left to local discretion. There is little confidence that this will be an effective means of empowering communities and it is unlikely that it will prove popular, other than on those occasions when there is a local issue of concern.

Question 13

The report of the Councillors Commission recommended the introduction of virtual meetings with Members being able to take part and vote in meetings remotely. The Government intend to legislate to introduce the measure in the Community Empowerment, Housing and Economic Regeneration Bill. Authorities will be able to opt in to remote voting, the conditions being that at least one Member must be physically present at the meeting and members of the public present at the meeting must be able to witness what is happening. Comments are invited on the proposal.

Suggested response

While this may help overcome problems of time and distance, the practicalities should not be under-estimated and it should be at the discretion of individual authorities as to whether they choose to adopt this measure.

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NHS
East of England

Towards the best, together

A Clinical Vision for our NHS, now and for the next decade

The National Health Service in the east of England employs 125,000 people in 41 different organisations serving the health and healthcare needs of the 5.6 million people who call this region home. For years it has done the day job of delivering care in a financially unsustainable and debt laden environment.

That debt is gone; we have made debt history. Now is the time to look to the future. Clinicians from across the region have come together with patients and stakeholders to say this is our vision of a better future for our NHS.

A vision that is clinically led, evidence based, and patient centred. A vision across the full breadth of the NHS: from before birth for expectant mothers to after death for bereaved families, touching all our lives along the way. A vision based on principles that matter and outcomes that can be measured. A vision for our whole NHS.

We set out on this journey 18 months ago, with confidence that we would turn our financial position around and be ready to look to and plan for a better future. Three distinct but linked pieces of work have created *Towards the best, together.*

Looking to the Future brought together clinicians and managers, stakeholders and the patient voice to ensure that our pattern of hospital services was sustainable, effective and accessible.

Improving Lives; Saving Lives set out our immediate priorities, the pledges we make over the next three years in the key areas of delivering a better patient experience; improving people's health; and reducing unfairness in health. A consultation across the region showed us where we were right to pledge and where we needed to change. These pledges now form the basis of agreed priorities for our local NHS that are measurable, outcome focussed and patient centred.

Our NHS, Our Future was the brainchild of Professor Lord Ara Darzi, a world renowned surgeon, and mirrored the work we were already undertaking through Looking to the Future on a national but still locally led stage. It was designed to look across the health system and use best evidence to plot a path to the best.

Together these three pieces of work have involved hundreds of staff, patients and the public; and thousands of hours of work, analysis, testing, and thinking. A process, nearly two years in development once completed.

This document sets out the results of that work. The outcomes from the many clinicians and other staff who brought their own experiences and expertise to the table to answer the following questions:

- Are current NHS services the best, and if not, what is best?
- What are the barriers to the best and how do we overcome them?

It is a vision that gives new mothers the confidence to make their own decisions about care during childbirth, knowing that first class medical intervention is available if needed. It describes how, through both hospitals and in the community, we can provide the right services for children with mental or physical health problems in the right place at the right time. It creates the hospital infrastructure that allows specialists to operate in the best possible environments, with the best possible equipment, and the most skilled staff 24 hours a day, 7 days a week, 365 days a year. It plots a course for those with long term conditions that treats people as individuals not diseases. And it produces a plan that will allow people at the end of their life to be cared for with dignity, where they want, surrounded by those they are closest to. All of this is underpinned by a lifelong focus on staying healthy and a recognition that there is no health without mental health.

It does all of this whilst delivering stability and confidence for staff and local people. The vision clearly states that there is a sustainable future for 17 Acute Trusts in the region all continuing to operate Accident and Emergency and Maternity Services. This vision is based on cutting edge clinical evidence and is grounded in reality. And, it is deliverable. We have the resources to invest where we need to.

We commend this vision to you and, in the spirit of building an even better service in the future, ask for your views and for you to join us in our journey *Towards the best, together.*

Dr. Robert Winter
Clinical Leader for the Vision
East of England NHS

Neil McKay
Chief Executive
East of England NHS

For and on behalf of your NHS.

Executive Summary

Introduction

Towards the best, together is our vision for our NHS, now and for the next decade. It already represents the work of hundreds of staff, patients and the public across the east of England and now we seek your views.

The vision draws together three different but complementary pieces of work to forge a path towards our overall goal: to be the best health service in England. It is clinically led, evidence based and patient centred.

Looking to the Future was started in March 2007. It was based on five clinically led groups looking at different areas of our acute hospital infrastructure and sought to ensure the services they delivered were sustainable and fit for the future.

*Improving Lives; Saving Live*s was designed to make the benefits of our financial turnaround apparent and real to all 5.6 million people who call the region home. It made a series of measurable pledges for the next three years to 2011. These pledges were consulted on last year.

Our NHS, Our Future was launched by Lord Ara Darzi in July 2007. It extends Looking to the Future by including NHS services beyond the acute hospital sector but is based on the same approach of clinically led groups looking at specific areas. It is a national programme but is locally led with clinicians asking what is the best our NHS can be, and how do we get there?

These three pieces of work have seen over 200 members of 8 Clinical Pathway Groups (including more than 100 front line clinicians) work with over 1,500 members of staff, patients and the public to create *Towards the best, together*.

This vision is based on the latest clinical evidence locally, nationally and internationally. It draws on the wealth of experience that our clinicians and others have brought to the table. It analyses how current NHS services are delivered and how to make them more effective. It sets out clear areas for greater investment and more skilled staff. And it puts to bed concerns about the future of our hospitals by committing our NHS to having A&E departments and maternity services in all 17 of our Acute Trusts.

This is your chance to have your say. We want to hear your views over the next three months so that we, together, can become the best health service in England.

The Population, Health and Healthcare of the East of England

If we are to deliver the best health service in England we need to fully understand those we serve. The National Health Service was created to deliver effective, high quality care wherever you are through a network of local services, whilst recognising local priorities and differences. This is why this is our vision, driven by our clinicians and our patients and public.

The east of England is one of the most prosperous regions in the world, well served by road, air and sea transport. We have both rural and urban areas, with high levels of employment. The service industry is our largest sector but 71% of our land is agricultural.

We have 5.6 million people, with a higher than average proportion of people aged over 65. The vast majority of our people are from a white ethnic background, with about 400,000 people from non-white backgrounds.

Our population is expected to grow by 11% over the next 14 years with our population aged over 85 expected to double in the next 20 years.

We do have areas of deprivation and a significant number of people who find it difficult to access NHS and other public services. These include migrant workers; Gypsies and Travellers; and people in the criminal justice system.

Our life expectancy is above the national average, but this hides wide disparities. Norfolk has high life expectancy and low inequality, whereas Luton has low life expectancy and high inequality. This leads to a difference in life expectancy of up to 10 years depending on where you are born.

We do better on most national counts of poor health lifestyle factors. We have the lowest number of smokers in the country, but this still equates to almost 1 million smokers. We have lower levels of obesity in both adults and children, but the numbers continue to grow. However, we have higher levels of alcohol use than the rest of the country, both for adults and for children.

1.6 million people have a long term condition such as diabetes, coronary heart disease and others. As the incidence of long term conditions grows with age, this will be an even greater number in the future.

Cardiovascular disease and cancer account for more than 60% of all deaths in our region.

The NHS in the east of England has over 125,000 staff, with 3,500 GPs, 3,000 consultants, 34,000 nurses, 2,600 midwives and 2,500 dentists.

These staff are spread across 41 NHS organisations including 14 Primary Care Trusts (PCTs); 17 Acute Trusts; one specialist cardiothoracic Trust; seven Mental Health Trusts; one region wide Ambulance Trust and one Strategic Health Authority.

Our PCTs cover an average population of 400,000; and our general hospitals cover an average population of about 280,000. As a local NHS we tend to carry out about 10% of national NHS activity.

The Case for Change

The first question asked when we set out on this journey was where is the evidence that we need to change? We believe the evidence is clear and the case for change is stark.

People are not as healthy as they could be – We lag behind other European countries in many areas of care and cure. Our obesity rates are rising. Hazardous or harmful amounts of alcohol are still drunk by too many. Over 20% of adults and 10% of children have a mental health problem and 69,000 people in the east of England have dementia.

Patient outcomes and safety are not good enough – Death rates in our hospitals vary widely. We lag behind other EU countries in survival rates in breast and colorectal cancer. Our maternity and children's services do not meet national standards. Only 50% of people across a range of Long Term Conditions are receiving the best possible care. And we still have too many Healthcare Associated Infections.

There is too much unfairness in health – A region wide life expectancy difference of 10 years speaks for itself. Thousands of looked after children have very poor health compared to the rest of us. The 56,000 people with serious mental illnesses are far more likely to have physical problems as well.

We are not meeting the expectations of those we serve – Many people across the east of England have some dissatisfaction with NHS services. They want more attention on basic services and standards, easier access to services, less waiting and to be treated as an individual with respect.

It needs to be easier for people to choose and access the services they need – Nearly three quarters of people want to be able to book a GP appointment two days in advance, but only a third can do that. People also want an NHS dentist, choice of where to go for services, and women want choice on where they give birth.

We still send too many to hospital unnecessarily – There is a compelling case that too many people go to hospital when they do not need to. This is not good for patients, and it is not sustainable financially or environmentally. We also see 56% of our people die in hospital when the majority want to die at home.

Specialist care is not organised well enough to deliver the best – Specialist care, like stroke care, neonatal care for ill babies and others, needs specialist equipment, staff, facilities and a minimum number of patients if it is to save as many lives as it can. By failing to do this we are contributing to unnecessary deaths.

These seven elements were recognised as not good enough by the NHS and its clinicians which is why they are proposing change.

The Principles for Progress

It is clear that change is needed, but change based on principles that address the case for change.

We have developed six principles for progress which set a clear bottom line for judging our proposals.

The six principles are:

- A focus on prevention, health inequalities and timely interventions
- Services focussed on the needs of the individual and their carer
- Services localised as much as possible, but centralised where appropriate
- Services that are accessible and integrated, delivered by a flexible and skilled workforce
- Partnership with others where possible, with the patient always
- Outcomes that deliver measurable and meaningful improvement.

These principles have tested all the Clinical Pathway Groups' recommendations. The key proposals made meet all, or some, of these principles, and nowhere do they breach them.

The Vision and the Pledges

Last year NHS East of England consulted about a series of pledges we wanted to make to the people of the east of England.

Our vision for our NHS is simple; to provide the best health service in England, with an objective to add to the quality and length of life of local people. The pledges were split into three areas.

Delivering a better experience for patients:

1. We will deliver year on year improvements in patient experience
2. We will extend access guarantees to more of our services
3. We will ensure that GP practices improve access and become more responsive to the needs of all patients
4. We will ensure that NHS primary dental services are available locally to all who need them

Improving people's health:

5 We will ensure fewer people suffer from, or die prematurely from, heart disease, stroke and cancer

6 We will make our health service the safest in England

7 We will improve the lives of those with long term conditions

Reducing unfairness in health:

8 Working with our partners, we will reduce the difference in life expectancy between the poorest 20% of our communities and the average in each PCT

9 We will ensure healthcare is as available to marginalised groups and looked after children as it is to the rest of us

10 We will cut the number of smokers by 140,000

11 We will halt the rise in obesity in children, and then seek to reduce it.

We have also agreed the Staff Commitment with our unions. This will see our NHS leading the country in ensuring staff feel listened to, respected and rewarded for the work they do for us all.

The consultation also showed support for people taking more responsibility for their own health and how they used the NHS, which we have called the 'Two way street'.

The consultation also supported action on sustainability, more support for carers, and dealing with alcohol problems.

The work of the Clinical Pathway Groups sets out how we will deliver these pledges and how we will prepare for the longer term.

Towards the Best Health and Healthcare

We have considered eight broad areas, each driven by a group of clinically led experts identifying where services need to be better and making those recommendations for change.

Staying Healthy

Healthy lifestyles are the core of better health so, we will:

- Ensure we focus on improving health and wellbeing, through better prevention and treatment services for the whole population and wellbeing services targeted to reduce unfairness;
- Guarantee access to screening and immunisation programmes for all, to detect risk factors, early on-set of disease or prevent disease;
- Offer an assessment for the risk of heart disease to everyone aged 40 – 74 and provide lifestyle support and treatment to those who will benefit;
- Cut the number of smokers by 140,000 and seek to reduce childhood obesity;
- Deliver packages of integrated lifestyle support services to targeted groups;
- Create an innovation fund to support new approaches to staying healthy;
- Strengthen health partnerships across the local authority, voluntary, private and public sectors;
- Launch *Staying Healthy in the Workplace* with employers and our own staff;
- Do all we can to fight climate change and reduce its impact on health.

These initiatives will help us deliver pledges 3 4 5 8 9 10 and 11.

Mental Health

There is no health without mental health, so we will:

- Recognise the importance of prevention and the need to tackle the stigma associated with mental health problems;
- Ensure mental health services are recovery focussed;
- Introduce a maximum 18 week wait for services with shorter guarantees where appropriate;
- Seek to detect dementia earlier;
- Help more people with dementia live at home as long as possible;
- Recruit hundreds of new mental health professionals, including: at least 350 new psychological therapists; older people's mental health teams; recovery, time and support workers; and carer support workers;
- Deliver a new deal for carers through an expert carer's programme.

These initiatives will help us deliver pledges 1 2 7 and 9.

Maternity and New Born

A good start to life for new babies and their parents is the least that people can hope for, so we will:

- Ensure all 17 Acute Trusts will keep an obstetric unit, with a co-located midwife-led unit;
- Guarantee one-to-one midwifery care in established labour by recruiting at least 160 more midwives;
- Maximise care for ill babies by increasing level 3 intensive care cots, increasing the number of level 1 special care units and reducing the number of level 2 high dependency units;
- Offer pre-conception care to women with pre-existing health problems and lifestyle issues;
- Increase the overall number of NHS funded IVF cycles against standard criteria;
- Guarantee women direct access to midwives and choice of antenatal care;
- Promote normality of birth and guarantee women choice on where to give birth, based on an assessment of safety for mother and baby;
- Guarantee choice of postnatal care to women especially those most in need;
- Establish networks covering maternity and neonatal services.

Together, these initiatives will help deliver pledges 1 2 7 8 9 and 11.

Children's Services

Children have their own needs and wants that are separate and distinct from their parents and other adults and health interventions at a young age may have far-reaching long-term benefits. So, we will:

- Ensure children's services are truly designed for children, taking into account all their needs;
- Implement the Child Health Promotion Programme for all;
- Split non-urgent care from urgent care by providing more of it in the community, rather than hospitals;
- Develop new Children's Assessment Units, and review whether every acute hospital needs an inpatient ward;
- Create clinical networks for sub-speciality services, including surgery;

- Strengthen Child and Adolescent Mental Health Services;
- Ensure the needs of adolescents are properly catered for and there is a seamless transition to adult services;
- Have common information systems, integrated care and co-located staff to deliver better services for children;
- Create a region wide Children's Services Board to oversee the development of children's services.

These initiatives will help deliver pledges 1 7 8 9 and 11.

Planned Care

NHS planned care should be the most responsive and the easiest to organise and access, so we will:

- Deliver more care closer to home, away from acute hospitals;
- Guarantee better access to GPs, dentists and radiotherapy services;
- Provide direct access to specialist advice and diagnostics; and more local provision of diagnostics;
- Guarantee a maximum 18 week for more of our services, including speech therapy, podiatry, orthotics, wheelchair services and orthodontics;
- Ensure that all patients have a full and free choice of where to go for planned care;
- Develop better local support for post operative recovery;
- Agree, and measure, new clinical, quality of life and experience outcomes;
- Ensure that there is appropriate centralisation of complex care, particularly specialised surgery.

These initiatives will help us deliver pledges 1 2 3 4 6 and 7.

Acute Care

Acute Care is where we turn when things go wrong and we need urgent or emergency help or complicated surgery, so we will:

- Ensure all 17 Acute Trusts will continue to have an A&E department;
- Make access easier by creating a new memorable telephone number for urgent care and ensuring consistent triage across all services;
- Create a series of Urgent Care Centres;
- Work towards providing 24/7 access to a fuller range of key acute services;
- Create new specialist centres for stroke, primary angioplasty and major trauma;
- Introduce universal 24/7 coverage of stroke thrombolysis;
- Create clinical networks for specialised services.

These initiatives will help deliver pledges 1 5 and 6.

Long Term Conditions

Too many of our fellow citizens have their lives blighted by long term conditions, such as diabetes or high blood pressure, so we will:

- Remember that people with long term conditions s are people first – "a person with diabetes" and *not* "a diabetic"
- Ensure personal health plans for everyone with an long term conditions ;
- Extend expert patient programmes;
- Improve timely access to specialist advice and diagnostics in primary care;
- Guarantee access to cardiac and pulmonary rehabilitation;

- Ensure comprehensive disease registers are in place for long term conditions
- Increase the emphasis on self care and pilot patient held budgets;
- Agree and measure a new set of patient outcome and patient experience indicators;
- Ensure all relevant staff have received training on delivering a self care approach.

These initiatives will help us deliver pledges 1 2 5 7 and 9.

End of Life Care
Of the 55,000 people who die in the east of England each year we know that the majority of them would like to die at home, but at present only 20% do that. So, we will:

- Deliver world class standards in choice of place of death;
- Set and monitor core best practice standards for all end of life providers;
- Create and extend support services for all families and carers, including bereavement support;
- Ensure needs assessments and advance care planning for all identified as being in their last year of life;
- Guarantee better access to supportive and palliative care services, particularly out of our hours;
- Work with the public and partners to raise awareness of end of life issues;
- Establish a Palliative and End of Life Care Board and create managed Palliative and End of Life Care networks.

These initiatives will help deliver pledges 1 3 and 7.

Together the proposals are a step change for the NHS and the outcomes and experiences for patients. They meet the need to change; they abide by the principles for progress; they help deliver our pledges in the short term; and prepare the NHS for the next decade in our journey *Towards the best, together.*

How we move towards the best

The proposals in this vision will need to be supported by a series of delivery mechanisms that cut across systems, organisations and pathways, the basic infrastructure of delivery.

Here we identify seven areas which will help deliver the vision. These are:

- Leadership;
- Quality and Safety;
- Innovation and Improvement;
- Patient and Carer Experience;
- Workforce and Training;
- Information;
- Commissioning and System Management.

In each of these areas we are already delivering work, like the procurement of GP led health centres to fulfil our pledges, but we are also planning a series of initiatives so that we are ready to hit the ground running once the consultation has ended and final decisions taken.

We also outline 30 first steps, concrete actions that will be just the beginning of a delivery.

Introduction

The NHS in our region has turned a corner; after years of debt dogging every decision, we have made debt history. For the first time ever, the NHS in the east of England can look forward with confidence from a solid financial base allied to the most improved performance in the country.

Building on this strong base, clinicians, staff, stakeholders and patients came together to create a vision for the future of our NHS. A vision that is clinically led; evidence based; and patient centred. A vision that strives for the best; whilst being deliverable and grounded in reality.

This vision has been 18 months in the making, and this consultation document sets out the products of hundreds of clinicians and other NHS professionals working together for thousands of hours to answer two basic questions:

- Are current NHS services the best, and if not, what is best?
- What are the barriers to the best and how do we overcome them?

The answers are here: ***Towards the best, together – a clinical vision for now, and the next decade.***

This is a vision for how the NHS in the east of England should deliver better health and healthcare now, and over the next 10 years. The vision is based on a sustainable future for all 17 Acute Trusts in our region delivering both A&E and maternity services. It does not, however, and will not, reopen recent consultations and decisions. Local people have already spoken on those matters and this vision respects those decisions.

This vision brings together three major strands of work across the east of England over the last year:

- Looking to the Future
- Improving Lives; Saving Lives
- NHS Next Stage Review.

Looking to the Future

In March 2007, NHS East of England initiated *Looking to the Future*, following the publication of a Technical Analysis document. The purpose was to develop frameworks for the future delivery of acute and associated community services to create a clinically and financially sustainable pattern of healthcare delivery across the east of England for the next 10 years.

The programme was organised into seven workstreams; five clinical; one workforce; one technical. The five clinical workstreams were:

- Emergency care
- Surgery
- Maternity and neonatal care
- Paediatrics
- Out of hospital care.

Each clinical workstream was co-chaired by a clinician and a chief executive from across the east of England and had broad based clinical representation, together with patient representatives and operational managers. These clinical workstreams met from May through to September 2007 and produced their final reports at the end of September 2007*.

*These reports can be accessed on NHS East of England's website (www.eoe.nhs.uk) or are available from the Communications Department, NHS East of England, Victoria House, Capital Park, Fulbourn, Cambridge CB21 5XB

The workforce workstream produced a comprehensive set of data and projections which were used to inform the work of the clinical workstreams. The technical workstream also produced a number of supporting pieces of work, including a detailed assessment of the impact of the current financial allocation formula on the east of England. This analysis, which showed that we receive less than our fair share of NHS funds, has been shared with the Department of Health who are currently reviewing the financial allocation formula.

Improving Lives; Saving Lives

In parallel with *Looking to the Future*, a shorter term piece of work was initiated in April 2007 looking at the priorities for the NHS in the east of England over the three year period April 2008 to March 2011. This work was designed to say that the benefits of the newly confident and financially stable NHS should be felt by the people of the east of England now, whilst measures were being put in place to deliver a longer term vision.

The NHS made a series of pledges that were measurable and would deliver change and improvement in the short term. These pledges were made in three categories:

- Delivering a better patient experience
- Improving people's health
- Reducing unfairness in health.

These pledges were consulted on from September 2007 to December 2007. The consultation showed where we were right to pledge, and where changes needed to be made. The consultation was supported by formal meetings with staff and patients across the region, involving more than 1,500 people. The final list of pledges was agreed by the NHS East of England Board in December 2007.

NHS Next Stage Review

Following the appointment of Professor Lord Ara Darzi, a world-renowned surgeon, as a health minister in July 2007, the Department of Health initiated a major review of the NHS entitled *Our NHS, Our Future*. As part of that review, NHS East of England, in common with other Strategic Health Authorities, set up eight Clinical Pathway Groups:

- Staying healthy
- Mental health
- Maternity and newborn care
- Children's health
- Planned care
- Acute care
- Long term conditions
- End of life care.

This work mirrored, but extended, *Looking to the Future*. This synergy allowed us to move further and faster, recasting and extending our Looking to the Future workstreams with new faces, new information and greater engagement from public, patients and staff.

Each of these Clinical Pathway Groups was chaired by a clinician, involved over 20 clinicians, patient representatives and operational managers and met from September 2007 through to January 2008. In all, over 200 people were

formal members of these groups, including over 100 clinicians from every organisation and every county in the region. They produced final reports in March 2008*, having reviewed:

- The main problems and challenges in their area
- Current practice
- What best practice would look like, reviewing all current clinical evidence
- What the barriers are to delivering best practice
- How these barriers could be overcome.

Where relevant, the work of these groups was informed by *Looking to the Future*.

A key part of the work programme of these groups was engagement with patients, the public and staff to hear first hand the thoughts of service users and some of the people providing those services. Two regional deliberative events were held, one in September 2007 at the beginning of the process, where views were sought on current service provision and key priorities for change, and another in January 2008, where early findings from the groups were presented and discussed. Four local deliberative events were held across the region and a region-wide survey of over 500 people was carried out, seeking views on the four themes identified in Lord Darzi's interim report. In addition, individual workshops with recent users of the service areas they were considering were held by each of the Clinical Pathway Groups. All in all this process took on board the knowledge, views and advice of well over 1,000 patients, public and staff to support the work of the 200 Clinical Pathway Group members.

This is the largest ever exercise carried out by the NHS in our region to bring together the expertise and knowledge of our staff and our patients to create one, uniting, and lasting vision. The *Improving Lives; Saving Lives* pledges primarily represent "what" we need to do now and in the future: the Clinical Pathway Groups are about the "how".

*These reports can be accessed on NHS East of England's website (www.eoe.nhs.uk) or are available from the Communications Department, NHS East of England, Victoria House, Capital Park, Fulbourn, Cambridge CB21 5XB

Structure of this Report

This report draws together all of the work described above.

Chapter 3, "The East of England – its population, its health and its healthcare", provides background information on our population and some of its key health characteristics, compared to national averages. It also provides a brief outline of current healthcare services in the east of England.

Chapter 4, "The case for change" sets out why healthcare in the east of England needs to change. It outlines seven reasons why the status quo is not acceptable. It is this case for change, this call for improvement which energised the clinicians and others whose work this is. It describes why our current services are not the best, and says we need improvement now, and for the long term.

Chapter 5, "The principles for progress" sets out a core gateway to improvement, a set of principles drawn out of the case for change, and used to test the pledges and the proposals.

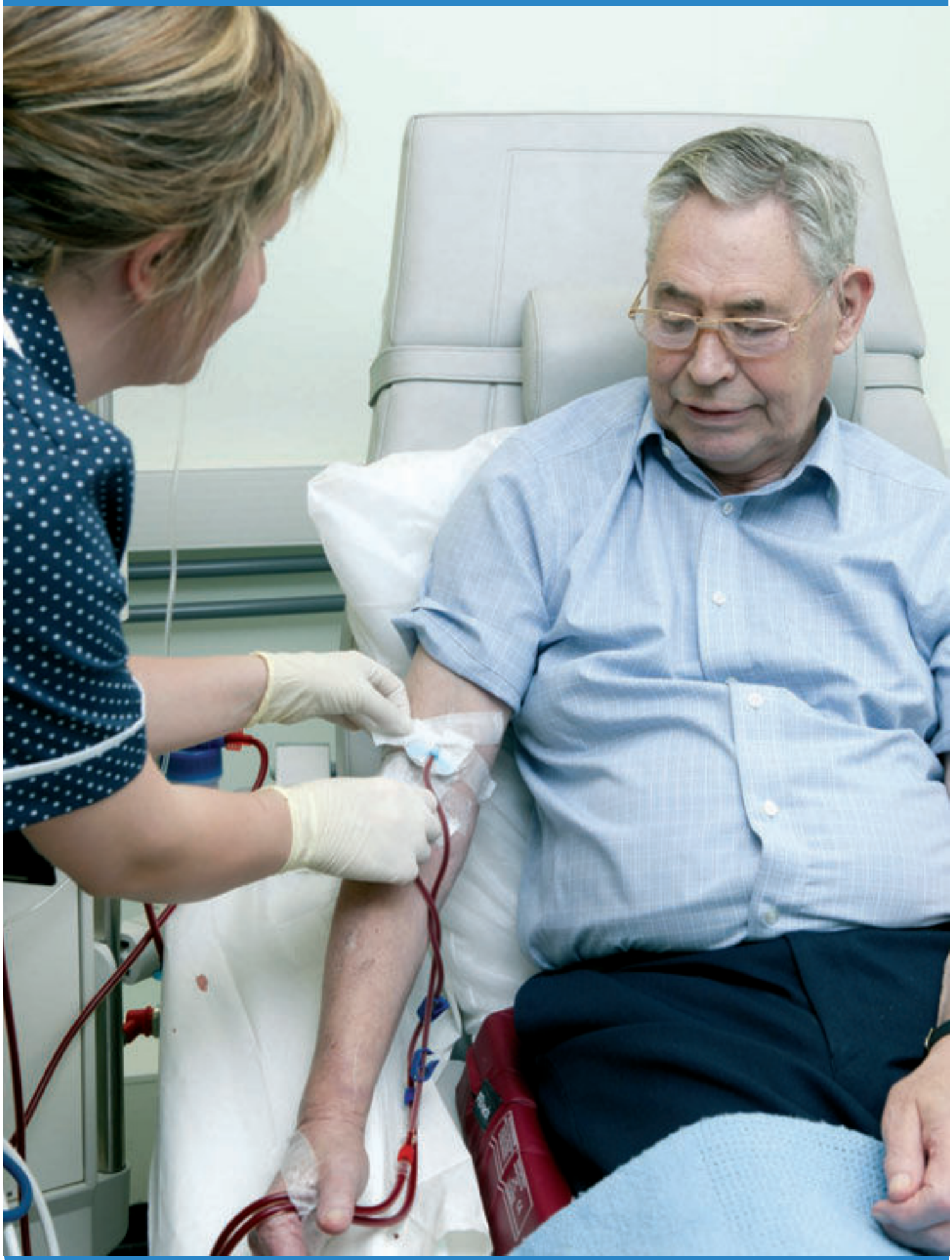
Chapter 6, "The vision and the pledges", sets out the overall vision for the NHS in the east of England and the key priorities and pledges agreed within *Improving Lives; Saving Lives*. This is the glue that underpins our work; the single uniting umbrella that will drive improvement across our NHS.

Chapter 7, "Towards the best health and healthcare", is probably the most important chapter. It sets out the recommendations for improvement from the Clinical Pathway Groups each addressing the case for change; tested against the principles for progress; and linked to the delivery of the pledges in the short term and an NHS fit for the next decade.

Chapter 8, "How we move towards the best" shows that the NHS is ready to deliver now, and in the longer term. It sets out the actions we are already taking to implement the pledges as well as what we are putting in place to drive the longer term agenda outlined in this vision. It does not set the proposed changes in stone, but shows that these proposals are deliverable if they are agreed as a result of this consultation. It answers the oft voiced criticism of visions – "warm words, but can you actually deliver?" The answer to this question is yes, and this chapter shows it.

This document is further supported by greater technical detail available through the NHS East of England website or direct from the Communications Department at NHS East of England; and by a summary consultation document which sets out the questions we are asking.

We believe that this is the most comprehensive look at the future of the NHS ever carried out in the east of England, involving thousands of people across three distinct but complementary pieces of work and we now ask you for your views.



The East of England-
Its population, its health and its healthcare

The National Health Service is first and foremost a local health service designed to deliver health and healthcare to local people according to need. This is the core of the NHS, national standards and expectations of care available to all, but recognising that health and healthcare needs differ region by region, and community by community. Geography, the make up of the local population and socio-economic factors all impact on health. That is why it is important to understand the area we serve and ensure that the proposals we make fit with the needs, now and in the future, of those who call the east of England home. This section gives a brief overview of some of the issues that were taken into account in drawing up these proposals.

Geography

The east of England covers Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. We have 250 miles of coastline and four major ports, as well as two international airports. We share borders with three other NHS regions: London to the south and South Central and East Midlands to the west. There is a mixture of urban and rural communities, and three significant growth areas: the M11 corridor, the Thames Gateway and the wider Milton Keynes growth area that includes parts of Bedfordshire. The main economic sector is the service industry, but agriculture is very important accounting for 71% of all land use.

Population

There are about 5.6 million people living in the east of England. On average, the east of England population is older than the England population, with a higher proportion of people aged 65 and older. The region is relatively affluent as one of only three regions (alongside London and the South East), that make net economic contributions to the Treasury, and a greater proportion of the population is employed than in England as a whole. There are however significant areas of deprivation in the region.

Ethnic Origin

Most people in the east of England come from a white ethnic background. Of the ethnic minority groups, the most predominant is Asian or Asian British (see Table 1).

Table 1: Ethnic origin in the east of England[3]

Ethnic Origin	East of England %	England %
White (1)	92.8	89.1
Mixed (2)	1.4	1.6
Asian or Asian British (3)	3.1	5.3
Black or black British (4)	1.6	2.7
Chinese or other	1.1	1.3

(1) White – British, Irish, other

(2) Mixed – white and black Caribbean, white and black African, white and Asian, other

(3) Asian or Asian British – Indian, Pakistani, Bangladeshi, other

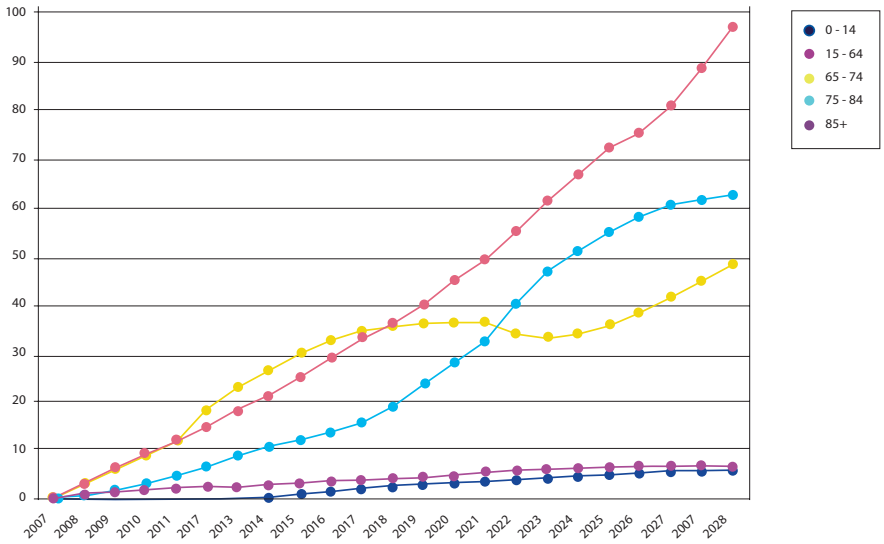
(4) Black or black British – Caribbean, African, other

Whilst this makes the east of England one of the least ethnically diverse regions in the country, there are over 400,000 people of non-white origin who live and work in the region. It is expected that this proportion of our population will grow in the coming years.

Population Growth
The population of the east of England is increasing significantly. Between 2001 and 2006, the population grew by 3.8%. Between 2006 and 2021 it is expected to increase by a further 617,000 (11%) to around 6,200,000. This growth will not be universal, with the projected growth rate for North East Essex being 17.1%, compared to only 1.7% for Luton.

There are also significant differences in projected growth rates between age bands. The population aged over 85 years is expected to double over the next 20 years whereas the population aged 15 – 64 years is expected to increase by less than 10% (see Figure 1). This will lead to an even older average population than we currently have.

Figure 1: East of England percentage increase in population size by age band, 2007 – 2028[4]



Marginalised Groups
Within our population there are number of groups who may have the greatest need of public services including the NHS, but find it difficult to access them. These include migrant workers, Gypsies and Travellers and those in the criminal justice system.

There are a significant number of ***migrant workers*** in the east of England. Over the past few years, the pattern of migration has changed. Previously, there were a few settled communities and population groups (e.g. Portuguese in Norfolk and Suffolk) and significant short-term seasonal migration. We are now seeing more inward migration, particularly from Eastern Europe (especially Poland). Latest estimates are that net international migration led to an increase in our population of 60,000 (just under 1%) over the three years 2004 – 2006[5]. Most registered migrant workers are young and intend to stay for less than a year. Key health issues for them are access to information and healthcare.

The east of England has the highest concentration of ***Gypsies and Travellers*** in its population, with 25% of English Gypsies and Travellers living in or passing through the region. As a group, Gypsies and Travellers have a life expectancy 10-12 years lower than the average, with higher rates of heart disease, in part due to lifestyle factors such as higher rates of smoking. The main health issues for Gypsies and Travellers are adequacy of site provision and continuity of healthcare. Many are not registered with a GP and are unable to access preventive services. Those who are pregnant seek healthcare support at a later stage than the average and have higher levels of infant mortality.

People in the criminal justice system and ***prisoners*** are another marginalised group. They have high rates of mental health problems and difficulties with lifestyle factors such as smoking and lack of exercise. A particular issue is the difficulty that many prisoners face in integrating with the healthcare system when they are discharged from prison.

Understanding the population we serve is vital to delivering the most effective health and healthcare. That is why we are committed over the lifetime of this vision to using all resources and avenues of research available to understand our population better and how to ensure they receive the interventions they need in ways that are effective and easy to access.

Health

The health of the east of England's population as a whole is relatively good compared to the national average. Life expectancy is an estimate of how long a child born today could expect to live. Our life expectancy is above the national average for both men and women. For men it is 78.1 years (national average 77.2 years) and for women it is 82.0 years (national average 81.5 years)[6]. However these numbers hide significant and unacceptable levels of inequality, with a 10-year difference in life expectancy between different parts of the region.

Lifestyle

There are a number of lifestyle factors that are commonly associated with poor health. As you would expect, most are less prevalent in the east of England than the national averages (see Table 2). This includes the lowest number of smokers in the whole country, but there are still almost 1 million smokers, 50% of whom will die from smoking related diseases.

Table 2: Prevalence of health-related behaviours in the east of England

	East of England %	England %
Cigarette smoking[7]	20	22
Obesity – adults[8]	22	24
Obesity – children aged 2 – 15 years[8]	12	16
Drank alcohol on 5 or more days last week[7]	20	18
Drank more than 7units of alcohol in the last week (children aged 13 to 15)[7]	13	8

Alcohol consumption is an area of particular concern with the proportion of children drinking seven or more units of alcohol a week much higher than it is nationally. Also, deaths in the east of England attributable to alcohol use increased by nearly 35% between 1998 and 2002, accounting for about 3.5% of all deaths.

Long Term Conditions

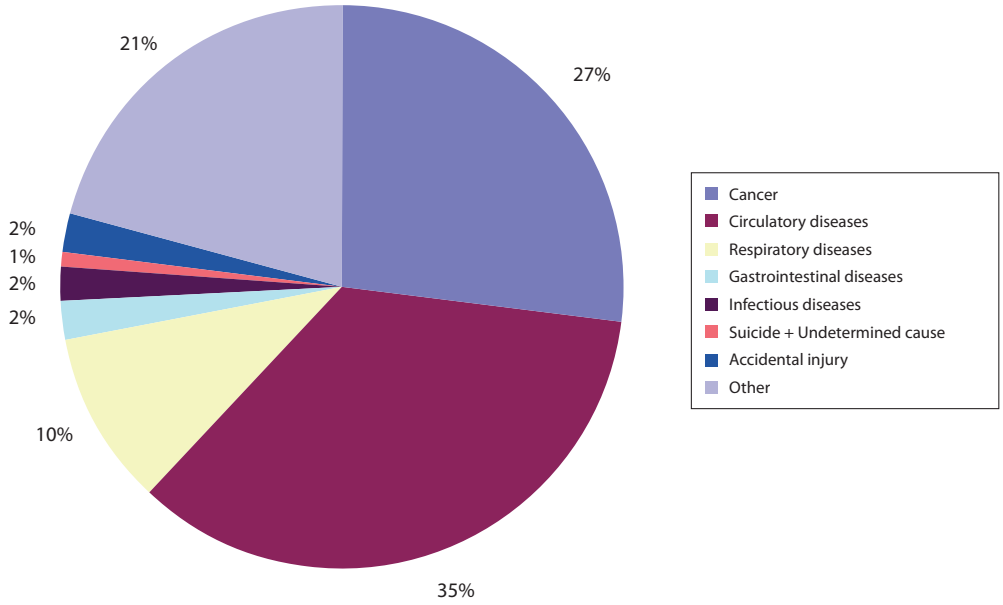
Long terms conditions such as diabetes; coronary heart disease; chronic obstructive pulmonary disease; neurological conditions; and other disabilities, are extremely common. There are about 1.6 million adults in the east of England with a long term condition, which impacts significantly on their quality of life and that of their carer(s) and family.

The incidence of long term conditions increases with age, so as our population ages the problem will get worse, with the number of people with long term conditions increasing by about 25% over the next 20 years. 70% of those over 75 have one or more long term condition compared with 20% of the 16-44 year old age group.

Causes of Death

The main causes of death in the east of England are cardiovascular diseases and cancer, which between them account for more than 60% of all deaths in the east of England for people over 1 year old (see Figure 2). This is similar to the national position. Cardiovascular diseases account for 35% of all deaths, cancer for 27%, and respiratory diseases for 10%.

Figure 2: Causes of Death in the East of England (people aged over one year), 2006[9]



Health Inequalities

There are significant differences in health outcomes between and within Primary Care Trust (PCT) areas. Differences in life expectancy at birth of more than ten years across the region encompass many other health inequalities. These inequalities are accounted for by variations in access to healthcare, differences in high risk lifestyle behaviours, such as smoking, obesity and physical activity and by wider socio-economic factors such as poverty, housing, employment and the built environment.

The figures 3 & 4 show this inequality between and within PCT areas. Figure 3 shows the region divided according to life expectancy, with the dark green representing those areas with the shortest life expectancy. These are mainly in urban areas, but there are also some in the more remote rural areas

Figure 4 shows the difference in life expectancy between the least and most deprived fifths of each PCT's population. Norfolk has the highest life expectancy and Luton has the lowest. Great Yarmouth, South West Essex and Luton have the highest inequalities within their boundaries and Norfolk has the lowest. This shows, starkly, that Norfolk has high life expectancy and low inequality, whereas Luton has both low life expectancy and high levels of inequality.

Figure 3: Life expectancy (2003-2005) by middle layer super output area (MSOA) in the east of England

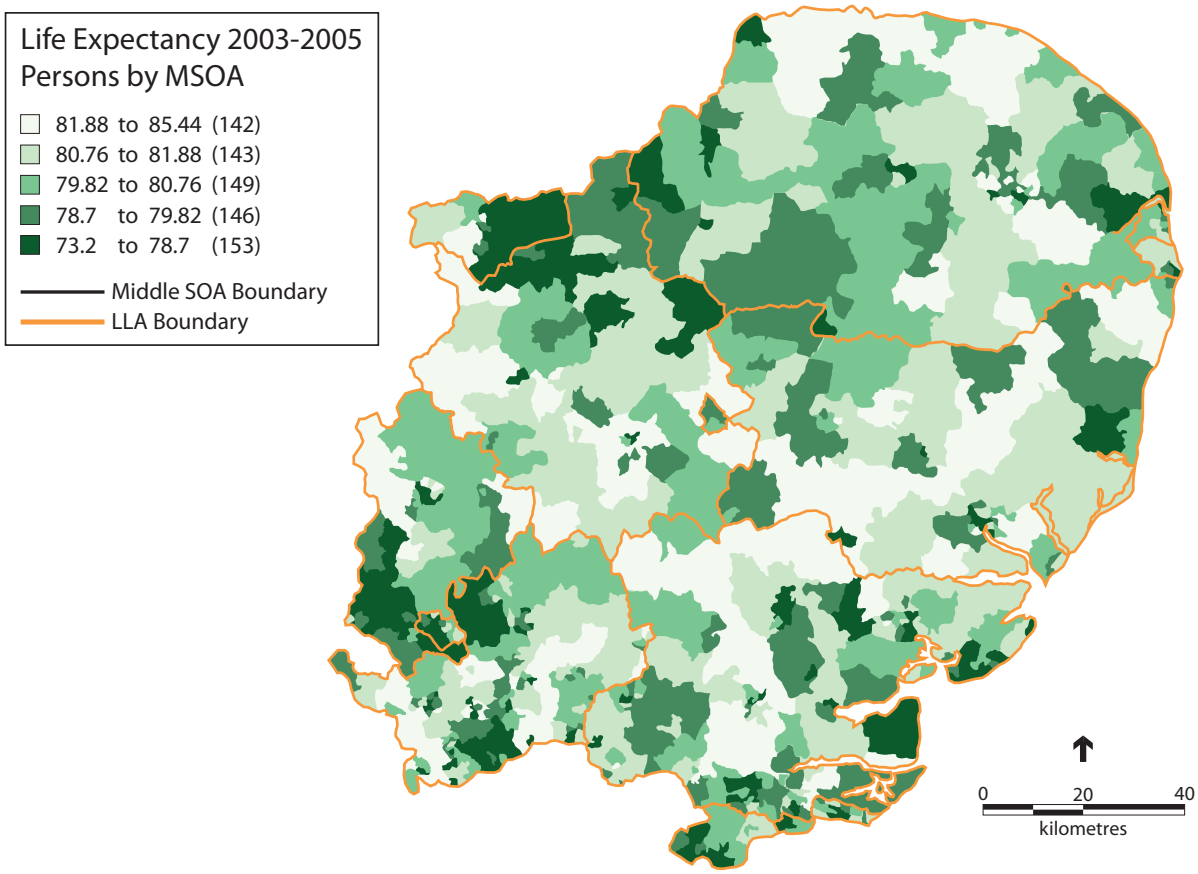
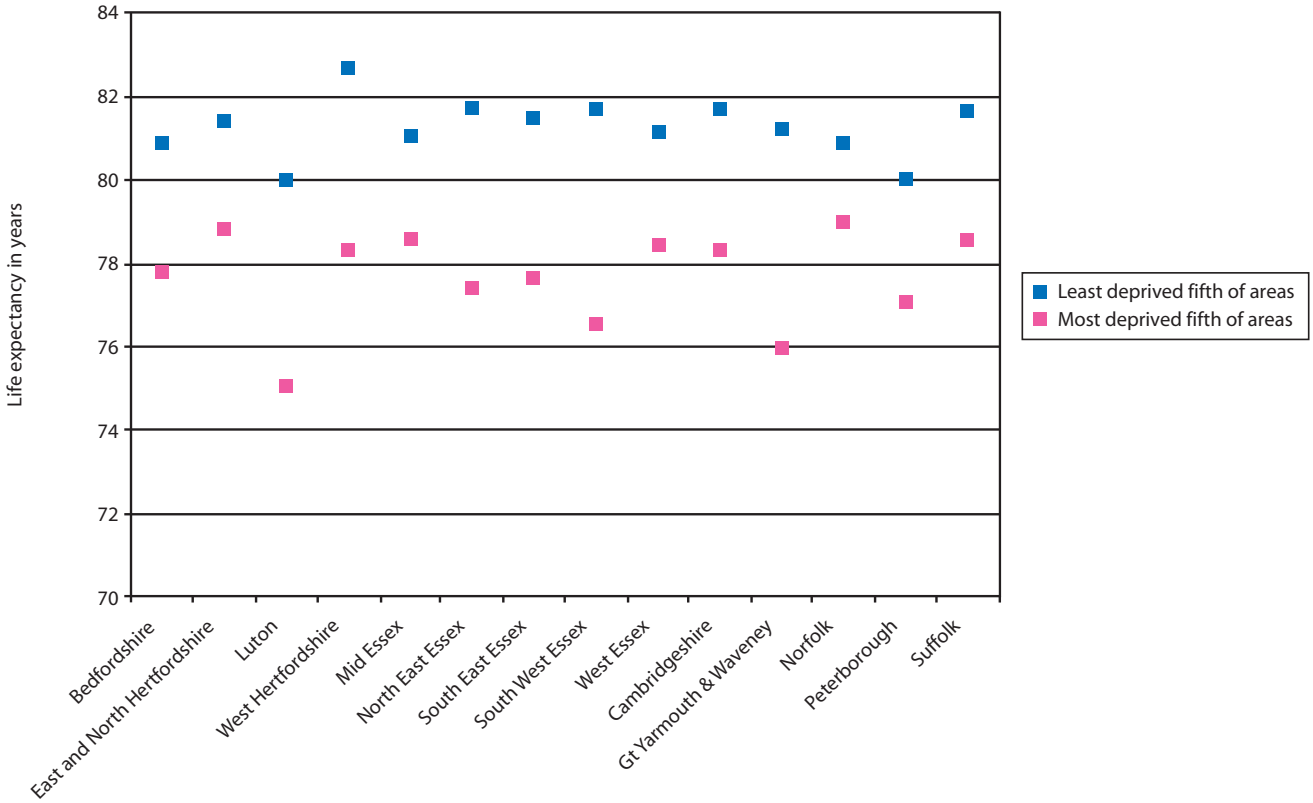


Figure 4: Difference in life expectancy between most and least deprived fifths of the population, by PCT (2003-2005)

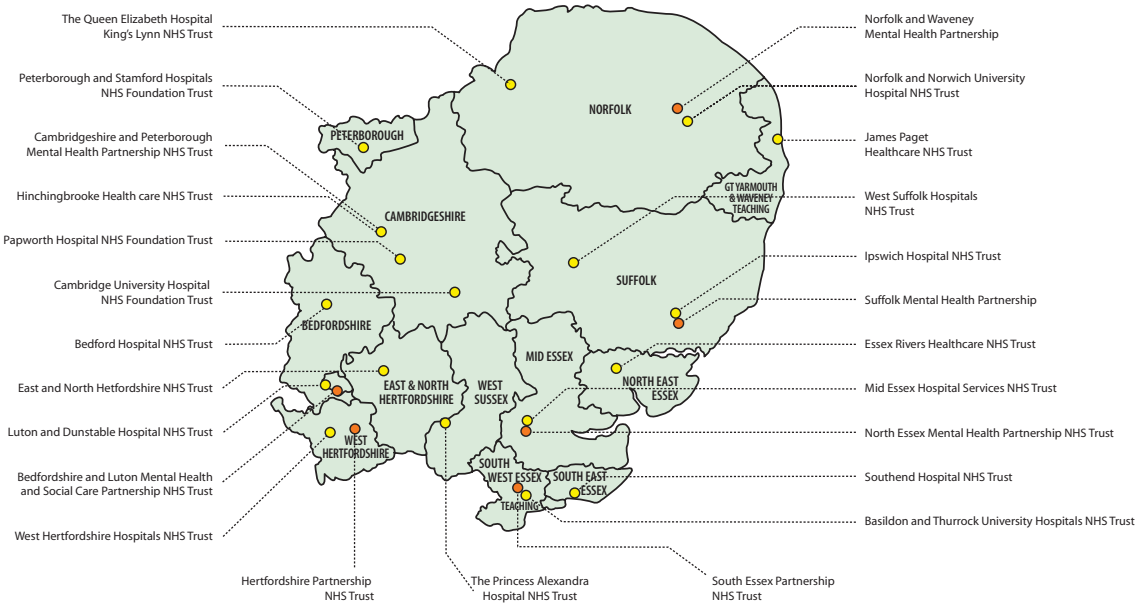


Healthcare in the East of England

The delivery of healthcare in the east of England is carried out by local organisations, those best able to understand and engage with local populations. Whilst part of a national and regional NHS family, their primary focus is their local populations. The NHS in the east of England has over 125,000 staff, of whom 3,500 are GPs, 3,000 are consultants, 34,000 are nurses, 2,600 are midwives and 2,500 are dentists[10]. This makes it the largest employer in the region. This year it has a budget of £8.2 billion, which is equivalent to about 8% of the entire regional economy.

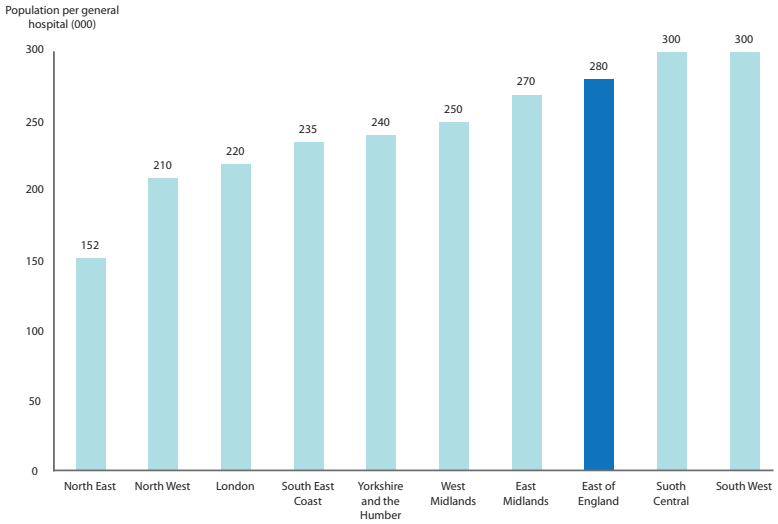
There are 14 PCTs; 17 Acute Trusts (including six Foundation Trusts) one specialist cardiothoracic trust (also a Foundation Trust), seven Mental Health Trusts (including four Foundation Trusts) and one Ambulance Service Trust in our region (see Figure 5). The service is overseen by NHS East of England, the Strategic Health Authority for our region. The PCTs serve populations ranging from 739,000 (Norfolk) to 163,000 (Peterborough), with an average size of 400,000.

Figure 5: Map of the NHS in the east of England



Hospitals in the east of England are larger than the national average (see Figure 6).

Figure 6: Population per general hospital[11]



In terms of total activity across the east of England, table 4 sets out some of the key activity figures. The population of the region is about 10% of the national population, so use of healthcare services also tends to be around 10%. The percentage is lower for A&E attendances as people in parts of south Hertfordshire and south-west Essex tends to go to hospitals in London.

Table 4: NHS activity figures across the east of England

	Total	England %
Registered Births, 2006	67,000	10.5%
Registered Deaths, 2006	52,000	11.0%
GP Consultations, 2006 (Q Research data)	29,000,000	11.0%
Dental courses of treatment (DH, 2006/07)	4,000,000	11.5%
A&E Attendances (EoE hospitals, 2006/07)	1,700,000	8.8%
Outpatient Attendances (HES, 2006/07)	5,100,000	10.0%
Ordinary Admissions (HES, 2006/07)	798,000	9.4%
Day Cases (HES, 2006/07)	452,000	10.3%

Conclusion

The facts and figures in this section are vital to the planning of effective health and healthcare services. They represent just a fraction of the information that our proposals are based on, but they do give an overview of the region.

They show that the NHS needs to take account of a growing and ageing population, who whilst having relatively good health do sometimes live in real pockets of deprivation and inequality. The NHS also needs to identify and understand our marginalised groups to ensure we have a more proportionate focus on meeting their needs than we do at present.

It is because of this diversity of need and geography that the NHS in our region is made up of 41 organisations and is the largest employer in the east of England. The complexities of the region require the NHS to have services available as locally as possible; tied into a real understanding of the needs of the local population and the barriers they face in accessing healthcare; and ready to work together as an NHS family to ensure better equality of care and the best possible outcomes.

This vision is designed to meet these requirements and move our NHS towards its goal of being the best in England.


AUX
FreeStyle
Lite

The Case for Change

This chapter answers the question – why are we doing this? Why have hundreds of clinicians and other professionals taken the time and energy to create this vision? In short, here we set out the case for change.

The evidence presented here is what convinced us, as an NHS, that we needed to get better, that the status quo was not good enough for the people of the east of England.

The case for change is stark:

- People are not as healthy as they could be
- Patient outcomes and safety are not good enough
- There is still too much unfairness in health
- We are not meeting the expectations of those we serve
- It needs to be easier to choose and access the services people need
- We still send too many people to hospital unnecessarily
- Specialist care is not organised well enough to deliver the best.

Individual Health

Life expectancy has increased year on year since the creation of the NHS in 1948. That is the good news: the bad news is that we still lag behind comparable Western European countries[12].

We can, and should, be doing more to help people lead healthier lifestyles because we could save many from poor health or even premature death if we acted earlier. We are a long way from the "fully engaged" scenario envisaged by Sir Derek Wanless, where everything is done to prevent ill health rather than just treat illness[13].

Smoking still remains the biggest single preventable cause of death and ill health. East of England **obesity** rates are increasing, especially in children. Obesity is one of the most important factors associated with poor health, including diabetes, heart disease, high blood pressure, some cancers, respiratory problems and joint problems.

Excess alcohol consumption causes harm to individual health and is directly linked to levels of crime, road traffic fatalities and domestic violence. In the east of England hazardous or harmful levels of alcohol are consumed by 24% of men and 14% of women[14].

People cannot be truly healthy unless they enjoy good **mental health**, but mental health problems are widespread and growing. For example:

- About 20% of the total population and 10% of children are coping with a mental health problem
- Depression affects 20% of all older people, rising to 40% for those living in care homes
- In our region 69,000 people are living with dementia, many with a family member as their main carer
- The UK is in the lower third of Europe with just 15% of the estimated number of people with dementia receiving treatment compared with over 40% in France, Sweden and Ireland[15]
- Hospital admission rates for those with mental health problems across the east of England are significantly higher than the national average[16].

We also have over 100,000 people with diabetes, chronic obstructive pulmonary disease, coronary heart disease or heart failure **not yet diagnosed**. This makes it more difficult to treat these people effectively.

The evidence is clear: prevention services like smoking cessation, immunisation and population screening can and do save lives and reduce illness. A recent study in the east of England[17] found that the combination of four behaviours (not smoking; being physically active; moderate alcohol intake; vitamin C intake equivalent to five servings a day of fruit and vegetables) in those aged 45–79 could help people live up to 14 years longer.

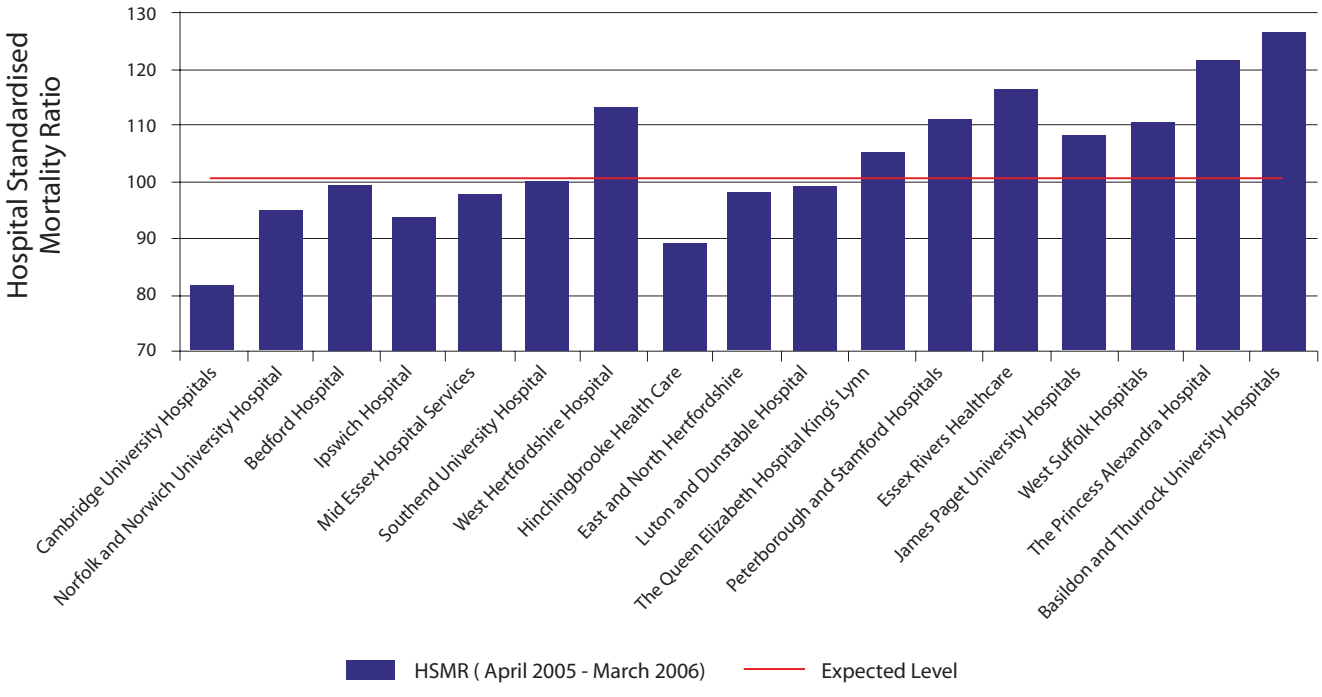
To help people live healthier, longer lives, we need to be better at prevention. This will improve the health of people in the region, and release resources currently spent on managing conditions associated with tobacco, obesity, substance misuse and other lifestyle factors for other priorities.

To do this, we will need to work with partners such as local authorities who have significant influence over our environment via their policies on education, planning, housing, transport and leisure facilities. This is something else we do not currently do well enough.

Improving Outcomes and Safety

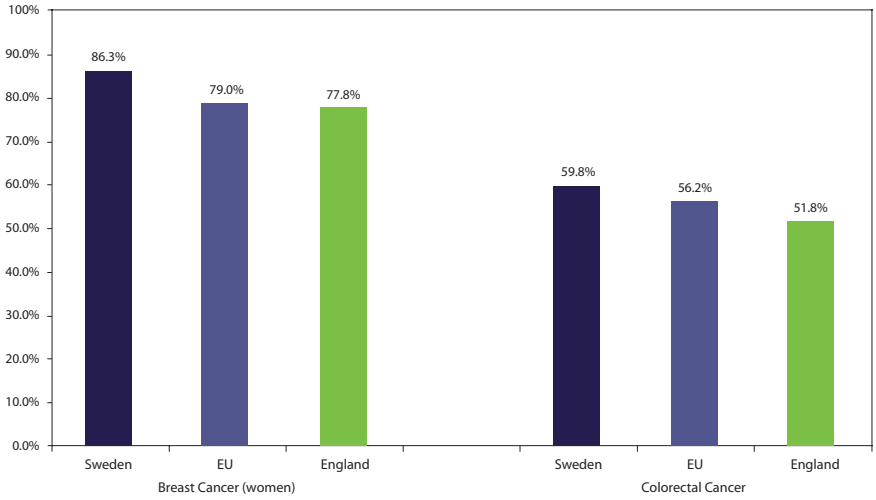
There is too great a difference across our region in the number of people who survive their stays in hospital. Against an expected average of 100 on the most common measure for hospital clinical outcomes, the standardised mortality ratio, our hospitals range from 81 to 126 (see Figure 7). This proves that more can be done to deliver a better and safer service. If some can do it, so can others.

Figure 7: Standardised Mortality Ratios across East of England, 2005 - 2006



Our clinical outcomes in some areas are not as good as they should be. In **cancer,** although mortality rates have reduced, they are still not as good as those achieved in other Western European countries (see Figure 8).

Figure 8: Cancer survival – percentage alive five years after diagnosis[18]



The same is also true for treating **stroke** and **heart attack** patients. If we adopted the latest thinking in stroke care across the east of England each year we could prevent about 130 strokes save about 140 lives and ensure 410 are independent rather than dependent following a stroke[19]. Similarly for heart attack patients, it is estimated that 50 more people a year across the east of England would survive a heart attack if they had primary angioplasty (a technique for unblocking arteries carrying blood to the heart muscle) as their main or first treatment.

Our **maternity services** are not able to meet national guidelines designed to deliver safer services and optimal outcomes. Currently few, if any, of our maternity units are able to achieve the recommended ratios of midwife or consultant cover to births. The care of sick babies takes place in 18 neonatal units across the region, many of which struggle to meet the designated standards, thereby jeopardising the quality and safety of care.

The Healthcare Commission recently concluded that many Trusts did not meet the necessary standards for **children's services** and that progress on improving them was patchy[20]. The position in the east of England is no different to the national position.

Care for people with **long term conditions** is not as good as it could be. For example, the National Service Framework for Diabetes recommends that patients with diabetes should agree a care plan to manage their condition. However, less than 50% nationally have an agreed care plan[21]. Similarly, 25% of people with serious mental health problems are not involved in drawing up their care plans[22]. Recent analysis also suggested that, across a range of long term conditions, less than 50% of patients eligible for treatment were receiving the best treatment for their condition[23].

The approach of the **end of life** can be difficult to identify, especially for people with long term conditions. Consequently, we are not always providing the best care and support for patients and their families and carers. The east of England has low compliance with national guidance on palliative and end of life care and we need to be more aware of the importance of end of life care planning and identifying patients approaching the end of life.

Hospital acquired infections such as MRSA and *C.difficile* are vital issues for patient safety and cause many to question whether they should attend hospital at all. Figures 9 and 10 show that, across the east of England, these rates have significantly reduced over the last year due to the hard work of staff, leadership from the top, and the help and support of patients and visitors. They also show that there is still more that can be done.

Figure 9: Rates of MRSA across the east of England

Total MRSA Bacteraemia reports by specimen date month
from East of England Hospitals microbiology labs (HCAI Data Capture System)

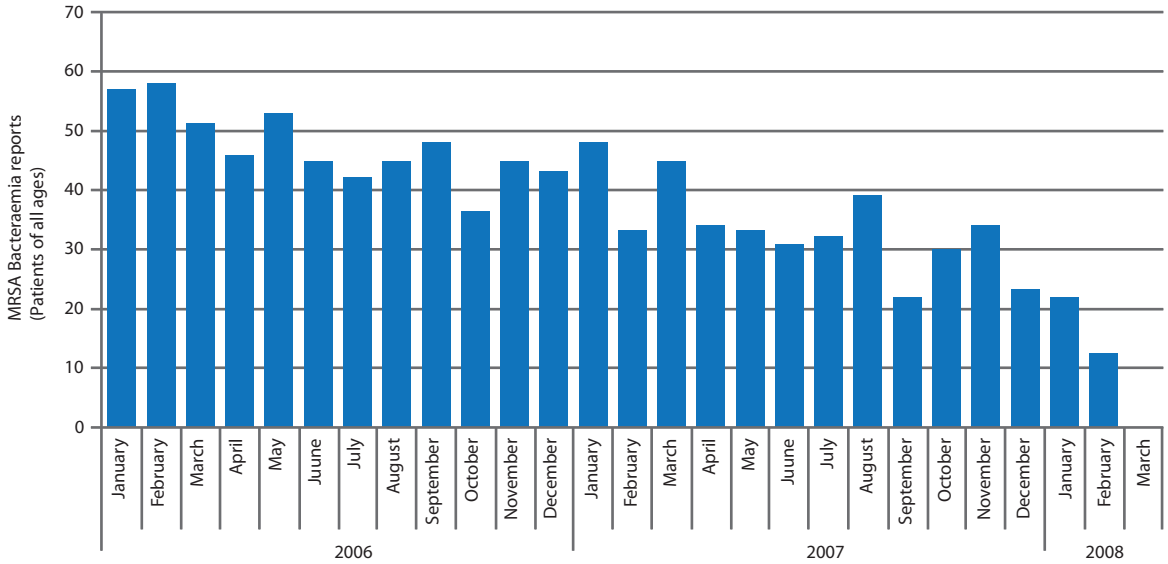
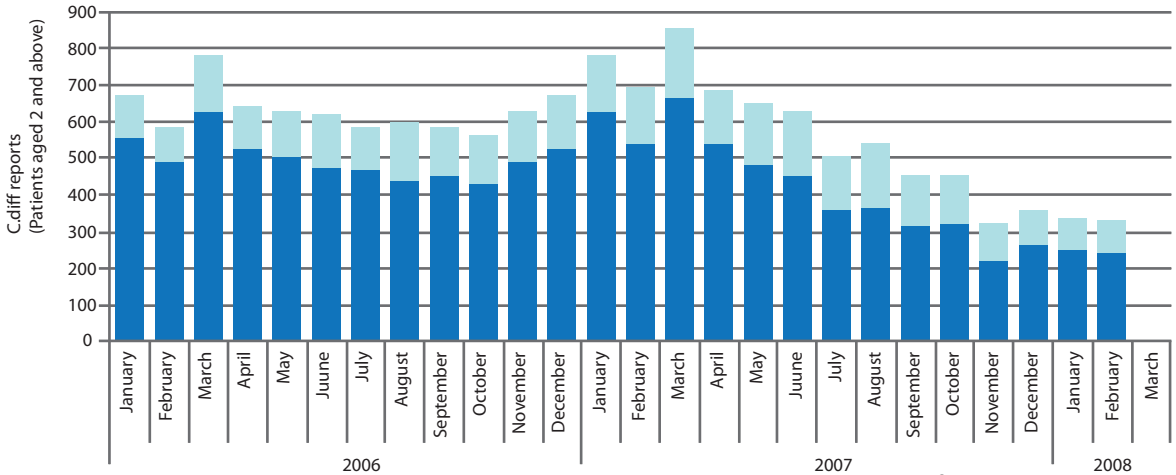


Figure 10: Rates of *C.difficile* across the east of England

Total *C.difficile* reports for patients aged 2 and above by
specimen date month from East of England Hospitals microbiology labs (HPA Cosurv data)



We can and should do more to make outcomes better and make our NHS safer – it is the right thing to do.

Reducing Unfairness in Health

The fact that there is a 10 year difference in life expectancy across the east of England is unacceptable. It is wrong that where you are born should have such an impact on how long you live.

Health inequalities are a symptom of underlying socio-economic issues, lifestyle factors and poorer access to high quality healthcare. For example, the higher number of those in the most deprived groups who smoke is the biggest single cause of inequalities in health, whilst cardiovascular disease, cancer and respiratory disease account for most of the inequalities in life expectancy.

There are several groups of our fellow citizens who need the most help:

- In the east of England there are over 3,500 children in care. These children have very poor health outcomes, especially when measured against the 'Every Child Matters' standards[24]
- Teenagers who become pregnant, including the especially high numbers among looked after children and care leavers which then, in turn, contributes to further inequalities in the health of their children
- Gypsies and Travellers, especially their children, who have life expectancies between 10-12 years less than the average
- Asylum seekers and migrant workers who find it difficult to access services
- The 56,000 across the east of England who suffer from a serious mental illness are also much more likely to suffer from serious physical illnesses. For example, they are four times as likely to suffer from diabetes and four times as likely to die from cardiovascular or respiratory disease
- Prisoners, many of whom have some form of mental disorder or addiction problem.

The majority of people accessing palliative and supportive care services have cancer, but others equally in need find it more difficult to access these services. People with other long term conditions, such as heart failure or respiratory disease, older people and those from lower socio-economic and black and minority ethnic groups all under-use palliative care services. As their needs are not currently being met, their health may deteriorate more rapidly.

The NHS should be a universal health service, accessible to all who need it, but we are not there yet. We need to get better.

Meeting Expectations

The NHS is one of the reasons people say they are proud to live in this country, it is a national icon and a source of immense national pride. Support for the principles of the NHS remains strong. However, that does not mean people are satisfied with the service they receive day in, day out.

The issues raised in this section draw on the concerns expressed by members of the public at six events organised across the east of England in the consultation process around this vision and Improving Lives; Saving Lives. However, they are supported by a plethora of other evidence including regular public opinion polling; the national patient survey and reports from patient involvement forums across the region, as well as analysing NHS complaints.

Around one third of people (32%), equivalent to nearly two million people across the region, expressed some degree of dissatisfaction with the NHS. This was slightly better than the national average of 34% but still a concern.

When asked which the most important area for improvement was, the top four responses were:

- Getting the most effective treatment and drugs (34%)
- Waiting times for hospital treatment (25%)
- Getting an appointment with a GP when you need one (21%)
- Providing clean facilities (12%).

The first of these is the **basic requirement of any health service**, that treatment is effective and is delivered by competent clinicians in a clean, safe, well equipped environment. When 34% of people demand this is done better, the NHS has to respond.

People acknowledged that **waiting times** had improved in recent years, but they wanted more improvement. Delays in receiving test results and the time between referral and seeing a consultant were seen as particular issues. People could not understand why diagnostic tests were often not ordered until after an outpatient clinic appointment. The national guarantee that no-one will wait more than 18 weeks for treatment will go a long way to dealing with this, but in the east of England we will go further.

Access to GP services was of greater concern to people in the east of England (35%) than it was nationally (28%).

> *"They need to make sure that services are available at times that don't clash with work."* – Patient, deliberative event, Bury St Edmunds

Strong support was also expressed for making **safety** a main NHS focus. In particular, it was felt that the NHS needs to take more responsibility for and be accountable for MRSA and *C.difficile*. As one patient at a public event put it, *"There's so much MRSA. People don't want to go into hospitals. You do hear a lot of horror stories."*

Patients and the public want:

- Screening for all hospital admissions and tougher action on those that fail to meet hygiene and infection control standards
- More information and education for visitors and patients about their role in preventing the spread of infection.

Being treated with **respect** as a person rather than a medical condition was also seen as vital, with 83% saying health care professionals needed to get better at this. This would need increased emphasis on holistic care and supportive self care – essential to improve the care and support of people with long term conditions; as well as better attitudes from healthcare professionals, communication, information, education, support (social and spiritual) and provision of 'non medical' services such as respite, home adaptations and emotional support and counselling.

Care at the **end of life** is another area where we are not meeting people's expectations. The majority of patients have a strong preference to die at home, but 56% of deaths in the east of England still occur in hospital. Care at the end of life and bereavement care is associated with 54% of all complaints about hospitals received by the Healthcare Commission – a powerful message of public concern about end of life care.

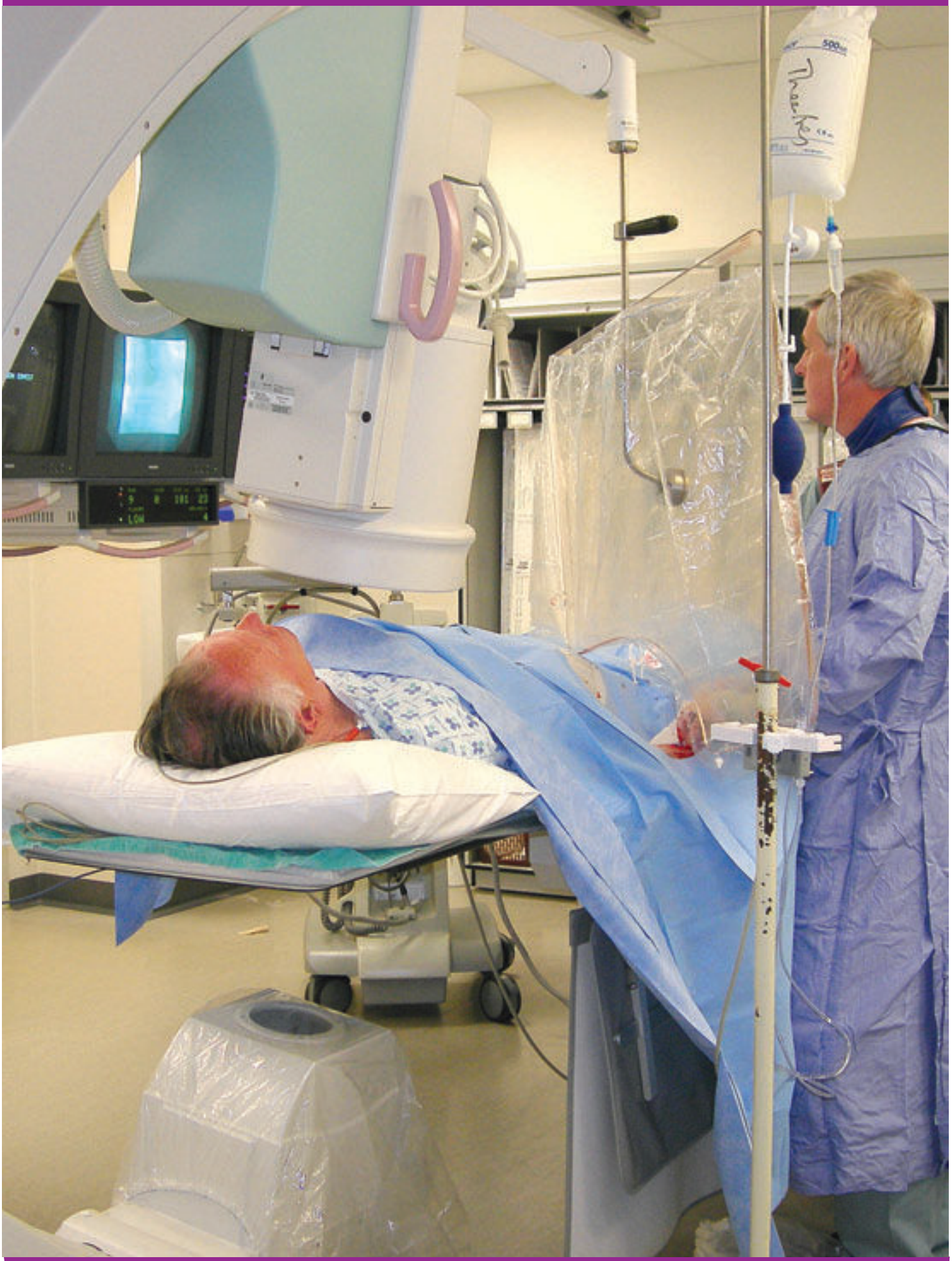
All in all, the message is clear. People love their local NHS, but they want it to be better at hearing and dealing with concerns. This message has been heard, and this vision is part of our answer.

Making it Easier to Choose the Services You Want

Choice is fundamental to the way we live our lives in this country. We make choices everyday and we expect those choices to deliver the services we want. This is an area where the NHS as a whole is running to catch up with people's expectations.

We know where to go when we are in an accident. We know to contact a GP, go to A&E or telephone 999, but new services such as NHS Direct, minor injury units, walk-in centres and various community response teams are less well known and understood. All of these are options for patients but only if they know what they are, what they offer, and how to access them. Choice without information and knowledge is no choice.

GP services are another area where we are failing on choice. At a recent public event, 72% said it was important to be able to book an appointment with a GP practice more than two days ahead, but 33% said they could not do so. They also said they would like GP surgeries to open later on weekdays and weekends and wanted to know what services they should access for specific conditions especially in the out-of-hours



period; pharmacist; NHS Direct; out-of-hours GP service or walk-in centres. At the moment the choice that people want is either not there, or is not understandable.

People should be able to choose any hospital they want for their treatment, whether NHS or independent sector providing NHS services, but too few people are being offered that choice. It is not good enough. Choose and Book – where patients can choose the hospital, the time and date of their first outpatient appointment – is supposed to support this choice, but only 44% of first consultant outpatient appointments in the east of England are made by Choose and Book. As well as delivering the basic service better, there is also a need to extend it to areas such as physiotherapy and rehabilitation.

People are also finding it increasingly difficult to choose an NHS dentist. Less than 60% of the east of England's population has visited an NHS dentist in the last two years and the proportion is still falling.

In maternity services, there is still a relatively limited choice for where mothers can give birth, with home births accounting for less than 4% of all births across the east of England. There is also a small but significant group of women who do not access antenatal care until later on in their pregnancy, missing the opportunity to obtain screening and advice and therefore having a higher risk of poor maternal and neonatal outcomes.

The common theme in this section is lack of information and understanding. Whether it is choice of hospital; knowing which service is most appropriate; having access to a GP when you want it: or access to an NHS dentist at all, we are failing on choice.

This is true across all groups, but is particularly hard felt by those who have traditionally found it difficult to access services, such as those with learning difficulties and mental health problems and those whose first language is not English. The failure of the NHS to provide choice to patients is not only inconvenient but can also stand in the way of effective and timely treatment.

Stopping Unnecessary Hospital Attendance

The bottom line is that we send too many people to hospital. It is the culture of the NHS that people go to the local hospital rather than having services closer to them which is why hospitals are often seen as the be all and end all of the NHS.

This is not sustainable clinically, financially or environmentally. The '*Our health, our care, our say*' White Paper presents a compelling argument that most people are best cared for by community services[25]. A review of the evidence by the University of Birmingham's Health Services Management Centre found that people with chronic obstructive pulmonary disease and those with heart failure benefit from a more community orientated approach[26].

Acute hospital care represents the most intensive and costly service provision in the NHS, yet it is not necessarily the best care for patients. This is a dichotomy that needs to be addressed.

There were over 1.5 million outpatient appointments in the east of England last year. The overwhelming majority of these took place in the main acute hospitals. There is also wide disparity across the region in the number of visits to a hospital A&E, equating from 15% of the total population to more than double that (33%) depending on where you live.

Admitting someone with mental health problems to hospital means that they are removed from their normal environment, thereby increasing their dependence and their social exclusion, yet in the east of England far more people with mental health problems are admitted to hospital than in the rest of the country.

Most people prefer to die at home rather than in a hospital, and yet 56% still die in hospital. Most of the community specialist palliative care teams are only available during normal working hours, from Monday to

Friday. These services are, therefore, not accessible when many patients and carers need them.

More can and is being done to solve these problems. In some areas of the east of England more people are already accessing more of their treatment outside a major acute setting, suggesting that best practice can and is being delivered already. In Hertfordshire, plans have already been drawn up to transfer in excess of 50% of A&E attendances to more local settings, leaving A&Es more time and space to deal with major emergencies.

If we invest more resources in community-based care we will be able to provide a better quality of care and to provide it more efficiently than if we continue to treat as many people in hospital as we currently do.

Better Organisation of Specialist Care

The NHS really comes into its own for patients and their families when catastrophe strikes, when only the most skilled clinicians using the most up to date equipment and clinical thinking will do. Specialist care is the ultimate safety net, no worries about costs or the expense of the treatment, just a service that gives the right treatment, by the right people in the right place.

However, here at the cutting edge of NHS care, change is needed to deliver the best. As with all specialisms in whatever walk of life, there is a need to do the work, day in - day out, if the specialism is to be honed, perfected, and delivered effectively every time. Specialist doctors and specialist teams need to see a large enough volume and variety of cases of a specific condition to perfect, sustain and develop their skills. Specialist units performing large numbers of cases achieve better results, particularly in more complex work[27]. This also makes it easier to train future specialist staff.

The increase of sub-specialisation, the breaking down of more general areas into areas of specific expertise, and the impact of guidelines such as the NICE *Improving Outcomes* guidance[28] again point to the need for change in how specialised services are delivered. Cutting edge technology is also driving the need for change. Complex cases require a range of diagnostic equipment, such as MRI scanners, gamma cameras and PET scanners, which can detect illness at a much earlier stage. All need to be available in one place where highly trained staff can use them and the cost is justified by the number of cases utilising the equipment.

Stroke services are a good example of this. It is recognised that services for patients who have just suffered a stroke are best provided in acute stroke units able to provide comprehensive and rapid access to services. There are six key features associated with high quality acute stroke care and services in the east of England compare poorly against those in other parts of the country (see Figure 11).

High quality acute stroke care requires specialist multi-disciplinary teams and high quality equipment all available 24/7. Currently too many places are trying to provide these services without the right equipment and the required numbers of skilled, specialist staff.

Another area where more change is needed is in neonatal care (services for ill babies). Currently, none of the neonatal units in the east of England are able to meet all of the recognised

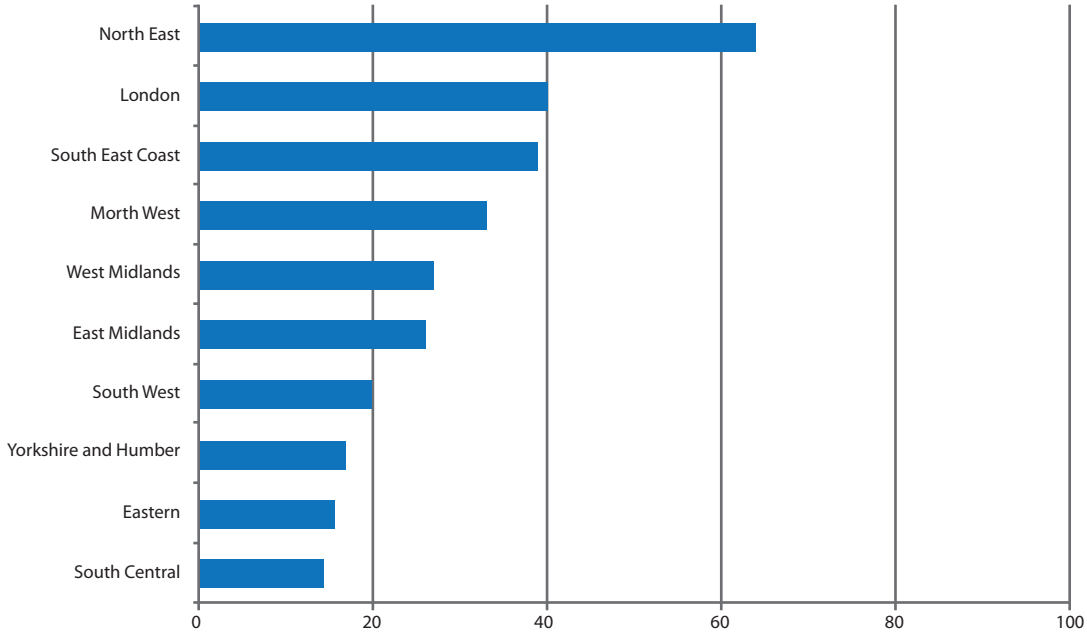
standards. Changes requiring junior doctors to work more reasonable hours are going to make it more difficult for the smaller units to provide the necessary staffing cover.

The clear lesson from all of this is that the NHS needs to centralise care where it can be most effective. By doing this we will ensure better care better outcomes for patients; and that the skilled, specialist staff such care relies on, are given the training, practice and equipment they need.

Conclusion

The provision of health care services is constantly evolving. Doctors and nurses know that 30% of medicine changes every 10 years as new techniques, research and understanding delivers better outcomes for patients. That is why the NHS has changed and reformed throughout its history, refusing to be hemmed in by sentiment and loyalty to buildings and old ways of working. That is why these seven reasons for change have captured the imaginations of the clinicians who have drawn up this vision, they recognise that change is vital and the following two chapters set out what that change should be.

Figure 11: Proportion of sites with acute stroke units with five or six key features, by SHA[29]




MARY HICKS
STAFF NURSE
NICU

The Principles for Progress

The case for change has been made. Now it is important that the proposals we make are judged against that case for change. This has led us to create a set of key principles, the watchwords of progress, against which any proposals now, and in the future must be judged.

The six principles
A focus on prevention, health inequalities and timely interventions
Services focused on the needs of the individual and their carer
Services localised as much as possible but centralised where appropriate
Services that are accessible and integrated, delivered by a flexible and skilled workforce
Partnership with others where possible; with patients always
Outcomes that deliver measurable and meaningful improvement

1. A focus on prevention, health inequalities and timely interventions
We need to be as concerned with preventing disease as we are with curing it. Disease prevention should be an objective for all NHS services. This includes primary prevention, e.g. smoking cessation, and secondary prevention to stop existing conditions from deteriorating.

Similarly, it is not acceptable in today's society that where you are born or live is such a major factor in determining how long you live. We need to give everyone access to the best possible care and reach out to those communities that have historically been marginalised. A health service for all.

The timing of healthcare interventions is also important. By identifying people at risk, we should be able to make targeted and timely interventions before things have reached a crisis stage. This is as relevant for people nearing the end of their life as it is for those just starting their lives.

2. Services focused on the needs of the individual and their carer
Services should be more personalised, focusing on the needs and preferences of both the individual and, where relevant, their carer. We must listen more to what patients are saying and see them as partners, and sometimes experts, in their care. This is particularly important for people with long term conditions, those suffering from mental health problems and for those at the end of their life.

Language is also important and needs to reflect a person-centred and holistic attitude to care. Language is often the first barrier to respect and understanding. For example, someone should be referred to as "a person with diabetes" and not "a diabetic" and the personal circumstances and preferences of individuals should be taken into account when prescribing treatment and agreeing the most appropriate care.

3. Services localised as much as possible but centralised where appropriate
More emphasis should be placed on self care, and routine care should be available as locally as possible. For example, more outpatient appointments could and should take place outside of major acute hospitals. Simple blood tests and more complex diagnostic tests, including scanning, should be readily available in the community. Wherever possible, specialist diagnosis should be carried out by a multi-disciplinary team in a "one stop" clinic based in a community setting.

However, some aspects of more complex care need to be centralised to ensure that care is provided by professionals with the necessary skills and equipment to treat rarer and more complex conditions. For example,

neonatal intensive care services need to be provided in a limited number of locations in order to be able to provide the highest quality services efficiently. Similarly, centres of excellence should be developed for people who have just had a heart attack.

4. Services that are more accessible and integrated, delivered by a flexible and skilled workforce
Services should be more accessible and it should be easy for patients to get the care they need, when they need it. Services should also be aligned so that they flow into each other alongside the patient rather than the patient being passed from unit to unit, team to team, and location to location with little communication with the patient or between the different services.

This should be done through increased use of networks of care. Increasingly, this means that care should be provided by multi-disciplinary teams – doctors, nurses, midwives, therapists, other allied health professionals, social care staff and others working together. Our experience of the cancer networks within the east of England has shown how an approach based on multi-disciplinary teams working across organisational boundaries can provide a much higher standard of care and better outcomes.

5.Partnership with others where possible, with patients always
The desire for the NHS to lead on healthy living and prevention can only be done through partnership with others, be it local authorities, employers, or the wider community and individuals. We cannot and should not try and forge on alone, it will not work and we will be letting down those we serve.

However, we must also remember that partnership within the NHS is as vital as partnership outside the NHS. New services and new approaches should not be constrained by organisational boundaries and old ways of working. If we are to deliver the whole pathways of care, with proper communication with patients and between clinicians along the way, then partnership with other organisations should be the norm, not the exception.

For patients, however, the norm is not good enough. We should always work in partnership with patients, recognising that there is much we can learn from each other about how we can improve health and healthcare individually and for the whole population.

6.Outcomes that deliver measurable and meaningful improvement
The case for change shows that the NHS is not currently meeting the expectations of patients or the public in terms of choice, accessibility, safety or clinical outcomes. That is why change is needed, but all proposals must be able to show they deliver better outcomes that can be measured and are meaningful to patients and their carers. This includes in the areas of patient experience confidence in the service and quality of life improvement, as well as in clinical outcomes for patients.

These six principles are the gateway to progress and improvement. We have subjected the pledges and the proposals from the Clinical Pathway Groups to this test and any future proposals will also be judged against these principles.

The chapters that follow set out the pledges and the proposals of the Clinical Pathway Groups and how they move us *Towards the best, together*, based on meeting the principles we have set out.

The Vision and the Pledges

The NHS in the east of England has one overall vision – **to provide the best health service in England** – and one clear objective – **to add to the quality and length of life of local people**. This document: *Towards the best, together*, is about how we will deliver this overall vision for the people of the east of England. It builds on the pledges we made last year as our immediate priorities, to share the benefits of financial turnaround widely, as soon as possible.

Those pledges are outlined below, the final pledges agreed after consultation which saw changes made; specifics added; and focus confirmed. The pledges respond to the case for change outlined in the last chapter of this document and have been taken on board by the Clinical Pathway Groups in designing their own visions of the future in the next chapter.

Change is important, it is needed and it will come, but change takes time. Some of the work of the Clinical Pathway Groups will immediately bear fruit, but other change will take longer. *Towards the best, together* is about a journey over the next decade, but these pledges are about the here and now.

We cannot deliver the pledges detailed below, and the wider vision found in the work of the Clinical Pathway Groups, without NHS staff. We recognised that when we asked people for their views on what pledge we should make to staff as part of the *Improving Lives; Saving Lives* consultation. We understood that improved health and healthcare for the people of the east of England cannot be achieved without the involvement and development of staff.

Therefore, as a result of what the consultation told us, the NHS in the east of England will adopt and implement the **Staff Commitment**. This commitment will:

- Be central to the delivery of our vision
- Be jointly promoted and monitored locally and regionally by staff partnership forums
- Ensure that issues raised during the consultation are prioritised alongside locally agreed priorities which include:

- Staff being supported and listened to
- Ensuring adequate time and resources for training and development
- Providing a safe and healthier working environment.

Year on year progress with the delivery of the Staff Commitment will be measured through each organisation's staff surveys.

Over the lifetime of the pledges we will ensure that all monies allocated to the SHA for training and development (c. £350 million a year) are spent on that on not diverted to other priorities. We will also promote the commitment through initiatives to improve staff engagement locally, which will be jointly funded by NHS East of England – approximately 50% of NHS organisations have already indicated an interest in piloting work this year. Discussions are continuing with unions and staff partnership forums to agree further concrete guarantees which we can measure in the same way as the pledges we make for patients and the public.

Our Pledges
The pledges are for the whole of the east of England, with all 41 NHS organisations committed to playing their part in delivery. The priority areas and their associated pledges are:

Delivering a Better Experience for Patients

We will deliver year on year improvements in patient experience. The NHS exists for patients and we rely on the trust and support of those patients. That support and the confidence patients have in the service they receive define attitudes to the NHS. That is why we need to know what they think of our services and ensure that we improve each year.

We will extend access guarantees to more of our services. The national 18 week target for the maximum time from GP referral to hospital treatment from December 2008 will represent a substantial improvement for NHS services. And we are well on the way to achieving it. However, it only applies to certain services. We want to extend the same level of guarantee to other services like mental health therapies.

We will ensure that GP practices improve access and become more responsive to the needs of all patients. For many, the GP is the first port of call when they are unwell. That is why GPs and their staff are so important. However, too many people have difficulty accessing GP services when it is convenient for them. We will make it more convenient to see a GP and improve the responsiveness of GP services.

We will ensure that NHS primary dental services are available locally to all who need them. Too many people cannot easily see a dentist through the NHS. This leads to poor dental health, or having to use non-NHS services. We will ensure that NHS primary dental services have the same standing as other NHS primary care services.

Improving People's Health

We will ensure fewer people suffer from, or die prematurely from, heart disease, stroke and cancer. These three conditions kill more people than any other. They are also major contributors to poor quality of life. That is why we are going to prioritise them, so we can save lives and improve lives.

We will make our health service the safest in England. Patient safety is vital for the NHS. People entrust themselves to us when they are ill and at their most vulnerable. It is our duty to care for them and to keep them safe so we will ensure that safety becomes everyone's priority.

We will improve the lives of those with long term conditions. Chronic long term conditions are extremely common and can be devastating for patients and their families. While we may not have a cure for these diseases, we can do a great deal to improve the quality of life for those who have them and, possibly, prolong their lives.

Reducing Unfairness in Health

Working with our partners, we will reduce the difference in life expectancy between the poorest 20% of our communities and the average in each PCT. We want to play our part in tackling preventable and avoidable differences in life expectancy. We will target resources at those areas and sections of our community where it will make the most difference.

We will ensure healthcare is as available to marginalised groups and looked after children as it is to the rest of us. Access to NHS services is something most of us take for granted. However some members of our society sometimes get lost in the system and have difficulty accessing NHS services. We will develop programmes and procedures to tackle this problem.

We will cut the number of smokers by 140,000. Smoking is responsible for 50% of the inequality in health outcomes in the UK. Smoking is not only one of our most dangerous killers, it also drives social inequality. That is why we want to target smoking and reduce the numbers of people in our region who smoke and will die from the habit.

We will halt the rise in obesity in children and then seek to reduce it. Obesity leads to health problems that adversely affect a person's quality of life and can lead to an early death. If we do not act now to reduce childhood obesity, our children could be the first generation in modern history to have a shorter life than their parents.

In addition to these pledges and the staff commitment there are a number of other important aspects to the *Improving Lives; Saving Lives* work. The first is that we recognise the responsibilities we all have to look after our own health and those of our families and ensure we use NHS services appropriately. We are calling this the "Two Way Street" and will ensure that, through an active programme of communication and promotion, patients and the public understand better their responsibilities in using the NHS.

The issue of sustainability and the impact of climate change on health were also seen as important. As NHS services develop to meet the changing needs of communities, it is important to reduce both the direct and indirect energy use and carbon production of the NHS wherever possible.

We also, through the consultation, were told that not enough focus was being provided on the role of carers or the need to tackle the problem of alcohol. Both of these issues are now reflected in the pathways that follow.

These pledges are about now and the next three years, the chapter that follows describing the work of the Clinical Pathway Groups is about how we deliver these pledges, and how we plan and prepare for the next decade.

Towards the Best Health & Healthcare

The core of our vision for the next decade is the combined work of 193 people: 106 of whom are clinicians; from all 41 NHS organisations in all six counties of the region. These are the Clinical Pathway Groups, clinically led and made up of consultants, doctors, nurses, therapists, community workers, patient representatives, local authority leaders and NHS support and management staff.

Each Clinical Pathway Group analysed the most cutting edge evidence; looked at best practice across the east of England, the rest of the country and the world; brought their own experience and expertise to the table; spoke to and listened to national and international experts; and engaged with patients, staff and the public at a series of 14 specially arranged events across the region.

With all this information and expertise they produced robust, in-depth reports which made a series of recommendations about what "best" looks like and how our NHS could reach its goal of being the best health service in England.

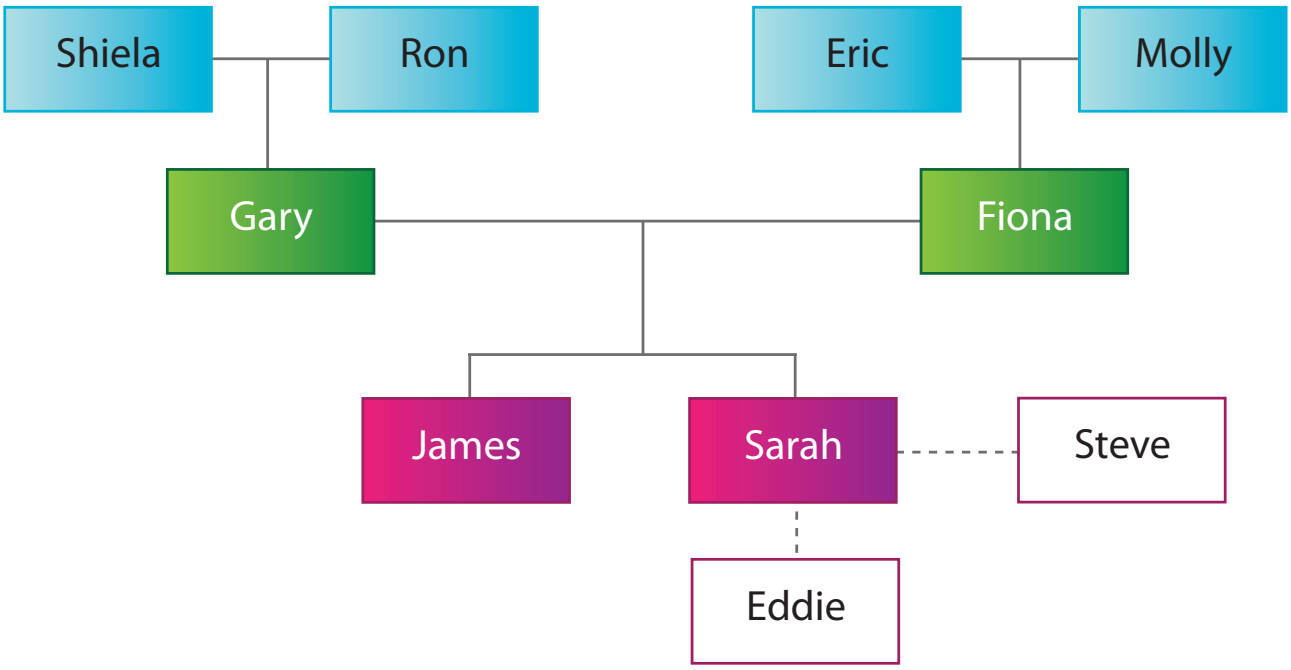
These recommendations were subjected to the *Case for Change*; and *the Principles for Progress* before becoming part of our vision: *Towards the best, together*.

This chapter sets out those recommendations and introduces the East family, through which we show how the NHS looks now and how it can and will change for the better.

The East Family

The East family are not real, but they are also all of us. Everyone will be able to recognise a bit of themselves, their family, or their experiences of the NHS in the trials and tribulations of the family. In a series of examples we will show how, for each pathway, the members of the East family receive treatment and care now, and then, after the vision has been implemented, what would be different for them.

So, meet the Easts.



The East Family

Fiona and Gary East have lived in Harlow since their two children, Sarah and James, were young teenagers. Fiona works as a receptionist at her local GP surgery. Gary is a painter and decorator. James is a teacher in South Norfolk. His sister, Sarah, who is unemployed and a single parent, lives in St Albans with her son Eddie who is six. Sarah has had a difficult relationship with Eddie's father over the last few years, but things are now more settled. She has a new partner, Steve a police officer, and is expecting their baby.

Fiona's parents, Eric and Molly, are in their 80's and live in Great Yarmouth. Gary's mother and father, Shelia and Ron, who are slightly younger, live in the same area. All are retired, but Ron still volunteers behind the bar of his local British Legion.

Fiona struggles with her weight and is clinically obese, but worries about her ageing parents; a new grandchild on the way; and the pressures of work have meant diet and exercise are low priorities. Gary, however, loves coaching the local under 11's football team, but his right knee is causing him real pain since he twisted it last year which is now beginning to impact on his work as well.

Sarah had an uneventful first pregnancy but has been very anxious over Eddie's slow development at school. The stress of dealing with Eddie's father caused her to start smoking again, but with the new baby due she is keen to stop.

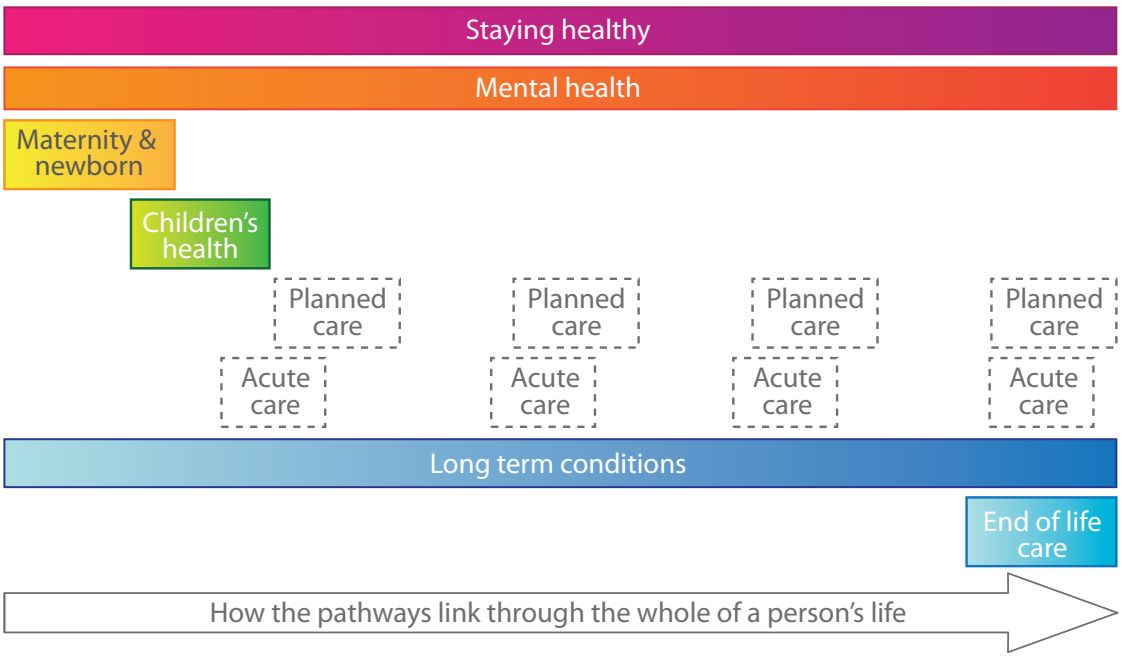
Eric has lived with chronic obstructive pulmonary disease for many years and his pride at managing his local allotment is now becoming a real burden. Molly his wife, who was a nurse in her younger days, was diagnosed with early dementia a year ago but with a carer coming in once a day they manage very well.

Sheila has chronic heart failure which has made even moving around the house quite difficult. Ron her husband is beginning to realise that she will need looking after as her health deteriorates which could make it impossible for him to carry on his volunteer work.

How it all Fits Together

Each of the Clinical Pathway Groups in this section have concentrated on their own area, ensuring their expertise is put to best use in designing what will be the best care for the people of the east of England. However, in keeping with the case for, and principles of, change, the work of the groups link together to deliver a whole service, whole life, vision for our NHS (see Figure 12).

Figure 12: Whole service, whole life vision



Staying Healthy and Mental Health are the basics of good health and therefore the cornerstones of a good life. That is why we have placed them at the forefront of our vision. From there, the other pathways touch our lives from maternity; through children's services up to end of life care. The other pathways; planned and acute; are episodic, reacting to illnesses and conditions as they arise through our lives. Long term conditions tend to be a greater issue as we age, but, as the pathway group identifies, conditions such as diabetes can be with us from early childhood.

All in all, these pathways create an holistic vision of the NHS and what it can do. Moving beyond what the founders of the NHS envisaged: cradle to the grave: to before birth for developing babies to after death for the families of those that die.

Staying Healthy

"There is a consensus that the NHS needs to change if it is to continue to be the comprehensive, tax-payer funded, free at the point of delivery service we have now. We need to ensure people are fully engaged in their own health for the benefit of themselves, their families and their communities. This pathway shows how the NHS can refocus and break down boundaries to deliver that step change in creating a prevention and wellbeing service as well as the vital safety net when we become ill." – Dennis Cox, GP and Chair, Staying Healthy Clinical Pathway Group

Key proposals – we will:

- Ensure we focus on improving health and wellbeing, through better prevention and treatment services for the whole population and wellbeing services targeted to reduce unfairness
- Guarantee access to screening and immunisation programmes for all, to detect risk factors, early on-set of disease or prevent disease
- Offer an assessment for the risk of heart disease to everyone aged 40-74 and provide lifestyle support and treatment for those who will benefit
- Cut the number of smokers by 140,000 and seek to reduce childhood obesity
- Deliver packages of integrated lifestyle support services to targeted groups
- Create an innovation fund to support new approaches to staying healthy
- Strengthen Health Partnerships across the local authority, voluntary, private and public sectors
- Launch Staying Healthy in the Workplace with employers and our own staff
- Do all we can to fight climate change and reduce its impact on health

Pen Portrait Before

Ron is rushed into hospital with chest pain and is diagnosed with a heart attack. He is discharged having been prescribed a statin for a raised cholesterol level but stops taking the tablets after a week. He would like to change his diet and take more exercise but struggles with this. A year later he is rushed to hospital again with his second heart attack.

> *"You just say, eat healthily, don't smoke, stuff like that. People go against that. The message you put out has got to be subtle. It's got to make people think."* – Member of the public, deliberative event, Bury St Edmunds

The NHS in the east of England, through the *Improving Lives; Saving Lives* programme, has committed itself to making a step change in improving health and reducing unfairness in health. Acting with ambition with partners, we aim to have the best health and lowest rates of inequality in England.

To do this, **the NHS in the east of England will place as much emphasis on improving health and wellbeing as we do on providing treatment. We will develop and strengthen our prevention programmes** so they are the best in England. We will also use every contact with the NHS as an opportunity to support people improve their health.

We will promote wellbeing to at-risk groups of the population by providing lifestyle support in key areas such as smoking, obesity and alcohol-related harm. We will also do this in a more integrated way than at present.

This work will be underpinned by commitments to reduce unfairness in health and recognise **the importance of partnership working**. These are the four cornerstones of the Staying Healthy pathway.

A Lifelong Prevention Pathway

The NHS will apply the same rigour to prevention of ill health as to clinical treatment services. This will be based on the most up to date evidence and a focus on finding new approaches through research and innovation. Our lifelong prevention pathway (Figure 13) begins with a healthy start in life, including pre-conception care and high quality maternity services and ends with support for older people to help them enjoy their later years as fully as possible. In between, it includes specific prevention interventions targeting a particular condition, such as cancer screening, and wellbeing programmes, such as smoking cessation services.

Figure 13: Being healthy, staying healthy - a preventative pathway

Age, sex, heredity • Individual lifestyle
Living and working conditions •General socio-economic and environmental conditions

Pregnancy and Childbirth	Children and Young People	Working Age Adults	Older Adults
• Pre-conception care	• Immunisation	• Dental health	• Dental health
• Early antenatal booking, including screening	• Dental health	• Chlamydia screening	• Cancer screening
• Antenatal screening	• Chlamydia screening	• Cancer screening	• CVD risk assessment
• Mental health	• Mental health	• CVD risk assessment	• Healthy eating
• Smoking cessation	• Healthy eating	• Healthy eating	• Physical activity
• Healthy eating	• Physical activity	• Physical activity	• Mental health
• Physical activity	• Smoking cessation	• Mental health	• Smoking cessation
• Reducing alcohol related harm	• Reducing alcohol related harm	• Smoking cessation	• Reducing alcohol related harm
		• Reducing alcohol related harm	

Reducing health inequalities • Health improvement messages as part of all clinical contacts
Health protection and preparedness for communicable diseases and other environmental hazards

We have to ensure that the information and support people need to make healthy decisions for them and their families is readily and easily accessible. This includes the best possible early clinical detection and screening programmes that will alert individuals and clinicians to potential serious health problems early, making intervention and treatment more effective.

One area where this approach will have the biggest impact is for cardiovascular disease and cancer which account for 60% of deaths in the east of England. If we combine primary prevention (preventing onset of the condition) and secondary prevention (early identification and appropriate treatment)[30] more effectively we can reduce the numbers who die from these diseases.

We will offer an assessment for risk of heart disease for everyone aged 40-74 and provide lifestyle support and treatment for those who will benefit. The initial focus will be identifying combined circulatory disease risk factors through the use of the "Qrisk" tool (a method of assessing a number of individual risk factors, such as blood pressure and cholesterol levels, to produce a combined risk factor for circulatory disease).

We will also ensure full coverage of NHS immunisation and screening programmes across the east of England, including the MMR immunisation programme and the programme for bowel cancer.

Another key to prevention is preventing mental ill health and improving mental wellbeing throughout life. This will need to include children and people with long term conditions and their carers, as well as adults with mental health problems.

Promoting Wellbeing

The NHS in the east of England will actively promote wellbeing to at-risk groups of the population and people at key stages of their life through effective lifestyle support programmes in important areas. This will immediately start to deliver two of our pledges:

- **To cut the number of smokers by 140,000** in the east of England by 2011, each PCT will track smoking prevalence through a regional lifestyle survey and will use Local Area Agreements to ensure targets are set and reached. NHS East of England will also run region-wide social marketing campaigns to raise awareness and seek to change behaviour, as well as a programme to support employers in helping employees stop smoking. The focus will be on reducing the number of teenagers taking up smoking, delivering smoking cessation support that is consistently the best in England and supporting a wider programme of action to reduce smoking.

- We will tackle **childhood obesity,** as part of an approach to obesity in all age groups. The aim is to halt the rise in childhood obesity by 2011 and see identifiable reductions thereafter. The NHS in the region will deliver the national weighing and measuring programme and then commission a range of services based on NICE and Foresight guidance, including breastfeeding support; the healthy schools programme; targeted early interventions; and programmes to support healthy eating and exercise by families. With our partners we will deliver community wide initiatives to help reduce childhood obesity, through work with individual children, their schools and their families. **We will also create an innovation fund which will support and pilot new approaches to tackling childhood obesity.**

It was also recognised in *Improving Lives; Saving Lives* that reducing alcohol related harm played a significant role in delivering our pledges. To this end we will strengthen the provision of brief and focussed interventions for which there is strong evidence but little capacity at present.

We will also create a more **integrated and personal approach to delivering lifestyle support services**. Personal support to improve health and lifestyles such as smoking quitting support, weight management and brief interventions to reduce alcohol related harm are currently delivered separately and, at times, in an ad hoc fashion. We will get better at this. People will be able to access advice on smoking; weight management; physical activity; diet; and alcohol harm reduction from the same service, rather than several different services.

Reducing Unfairness

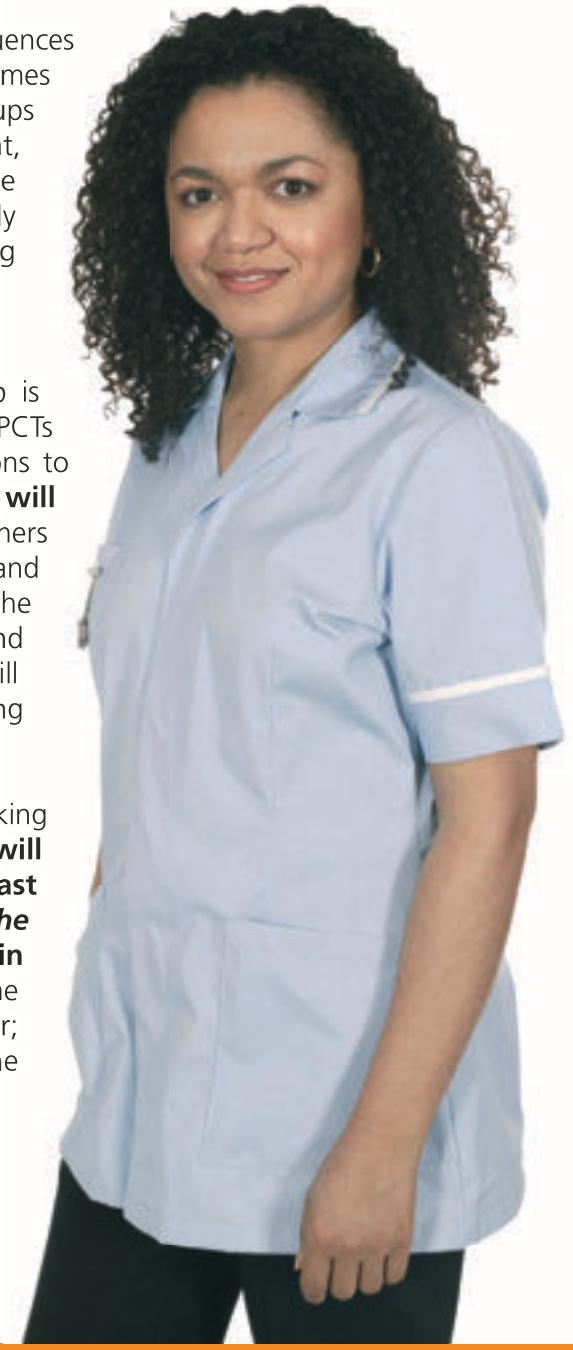
Inequalities in health are unfair and arise from a complex interaction between social, environmental and cultural factors. On average, people living in deprived areas, from lower socio-economic and marginalised groups still have poorer health and poorer access to health care than others. This is wrong, and the case for change makes it clear that action is needed to reduce unfairness in health across the most deprived and marginalised sections of our society. Our vision will make this a reality.

We will reduce the **differences in life expectancy** between the poorest 20% of our communities and the average in each PCT. Each PCT will clearly identify this 20% and then initiate a programme of targeted and intensive interventions, including population screening; smoking cessation; physical activity; antenatal care and early years support; alcohol harm reduction; and prevention of mental ill health.

We will also ensure services to improve health and access to healthcare are equally available to people from **marginalised groups**, including Gypsies; Travellers; looked after children; people from black and minority ethnic groups; prisoners; people with learning disabilities; and people with long term mental health problems. Each PCT will identify these groups within their population, assess their needs and develop clear plans to meet their needs.

We will need to align primary care to the delivery of more effective prevention programmes. Each PCT will monitor the quality of primary care and compare this with the health needs of their communities. They will produce specific plans to ensure that the quality of primary care and the coverage of prevention and treatment are at least as good in deprived communities as for the rest of us.

We will also consider how to cut through the unintended consequences of quality assurance systems (e.g. the Quality and Outcomes Framework), where people from deprived and marginalised groups can be excluded from indicators of quality. At the moment, achievement of a 70% coverage standard means that the people in greatest need are not a priority. We will therefore explicitly plan to reduce inequalities, rather than inadvertently increasing the gap.



Health Partnerships

Perhaps more than any other part of this vision, partnership is key to the delivery of Staying Healthy. The NHS, including PCTs and Trusts, must work with and influence partner organisations to promote better mental and physical health and wellbeing. **We will therefore strengthen Health Partnerships** and be full partners in Local Area Agreements. Local partners including the PCTs and Trusts will use joint strategic needs assessment to identify the groups and populations with the poorest health outcomes and define the health-related needs of their populations. They will then use these and annual public health reports to inform planning and commissioning of integrated services.

A significant part of our lives is spent at work and our working environment has a substantial impact on our health. **We will therefore create, and deliver in partnership with the East of England Development Agency, a *Staying Healthy in the Workplace* initiative designed to support employers in helping their staff live healthier lives.** This will benefit the individual; their families; their wider communities; their employer; and the local economy. The NHS is the largest employer in the region and we will become an exemplar in this area.

Case Study

The Healthy Steps to Employment project is funded by the East of England Development Agency and operates across Bedfordshire and Luton. The overall aim of the project, which became operational in October 2006, is to tackle work limiting illness by supporting Incapacity Benefit clients back into sustainable employment. The project is led by Bedfordshire PCT, in close partnership with Job Centre Plus, the Local Authorities and a range of voluntary sector organisations and has three main strands:

-Supporting clients on Incapacity Benefit to understand and manage their health condition better through a Health and Wellbeing programme so that they can successfully return to work

-Helping Incapacity Benefit clients feel more confident about returning to work, via a volunteer programme

-Offering pre-employment support for those clients who are ready to return to work.

Clients on Incapacity Benefit receive an initial 45 minute assessment by a clinically qualified Health and Wellbeing Adviser, during which an overall assessment of their health condition is made and a programme of supporting activity agreed. The Health and Wellbeing programme includes opportunities for referral to pain management sessions, support for mental health conditions and 1:1 physical activity sessions.

To date, the programme has seen 486 clients of whom:

-93 (19%) have moved off Incapacity Benefit

-65 (13%) have returned to work

-33 who had been on incapacity benefit for 6 months or longer have returned to sustainable employment for 13 weeks or more.

At local and regional level the NHS will work with planners, transport bodies, police and economic development organisations, as well as social care, children's and environmental services. This is to ensure that health and wellbeing are promoted through the built and natural environments, through the opportunities of population growth, through schools and through wider community strategies. This is vital to our programme on **fighting climate change, where the NHS will raise awareness of the health implications and then lead the public sector in identifying ways of reducing our own carbon footprint and negative impact on the environment by delivering our services more sustainably.**

Conclusion

Each programme initiated under the Staying Healthy pathway will pass the tests set out in the principles for progress. They will focus on prevention, health inequalities and timely interventions that work for individuals and populations. The programmes will be delivered locally, but where regional procurement or co-ordination will increase value for money or effectiveness this will be done, especially in the areas of effective research and social marketing programmes. We will break down traditional boundaries between preventative and clinically based interventions, throwing away the dividing lines between primary and secondary care. Partnership across, and beyond, the NHS will be key to delivery. And, the measures for success will be clear and understood.

The Staying Healthy pathway is the gateway to better health for all in the east of England, but also has a very focussed role to play in ensuring those who are most in need of help and support get it when they need it. Staying Healthy is fundamental to the delivery of our vision, and it and Mental Health are the foundations upon which we will deliver our vision.

Pen Portrait After

When Ron attends his GP for an annual flu jab the nurse asks if he would like to have a holistic lifestyle assessment which includes a circulatory risk factor assessment. Ron accepts and at the assessment it is discovered that he has a high blood pressure and a raised cholesterol level and therefore has a 35% risk of coronary heart disease in the next 10 years. He is prescribed a statin and blood pressure tablets and reviewed on a regular basis by the practice nurse. Over the next few appointments Ron's cholesterol and blood pressure fall to within normal limits and the nurse introduces Ron to some changes in his diet and recommends more physical exercise. He is given support to change his diet and starts walking regularly with a walking for health programme in his local community. This gives Ron the best opportunity of preventing coronary heart disease and he never has a heart attack.

Mental Health

"There is no health without mental health" – Royal College of Psychiatrists

"The work of the mental health pathway group was underpinned by the evidence that mental ill-health affects all individuals and all areas of the health service, hence the strap line 'there is no health without mental health'. We hope that this will be the first step of an ongoing process in improving mental health services, whereby staff of all disciplines, service users, their families and friends and managers can work together to develop better systems of care and treatment." – Gillian Oaker, Joint Chair, Mental Health Clinical Pathway Group

Key proposals – we will:

Recognise the importance of prevention and the need to tackle the stigma associated with mental health problems
Ensure mental health services are recovery focussed
Introduce a maximum wait of 18 weeks for services with shorter guarantees where appropriate
Seek to detect dementia earlier
Help more people with dementia live at home as long as possible
Recruit hundreds of new professionals including at least 350 new psychological therapists; older people's mental health teams; recovery, time and support workers; and carer support workers
Deliver a new deal for carers through an expert carers programme

Pen Portrait Before

A few days ago Molly developed a mild chest infection, making her much more confused and unsteady on her feet. Her GP prescribes antibiotics. The Community Mental Health Team visit Molly and attempt to increase the home carer visits to twice a day. Sadly this part of the care plan breaks down as Molly hits one of them whilst being helped to wash. Husband Eric and daughter Fiona, who is staying nearby with her son, struggle with her confusion and aggression. After three days Molly has to be admitted to the nearest Older Persons Mental Health inpatient assessment unit where she becomes much more confused and agitated in the unfamiliar surroundings and has to have medication and intensive nursing care to reduce her aggression. After 2 weeks her chest infection is better but she remains more confused and disorientated and has to stay in hospital still on medication and with highly specialised nursing care.

For too long mental health has been the health issue that has not got the attention it needed. It was marginalised and misunderstood. That is why our vision takes very seriously the maxim that there "is no health without mental health." *Our Improving Lives; Saving Lives* consultation confirmed what we believed; people recognised the need for a more focussed approach, telling us that carers needed more help and that mental health services needed more investment.

We have deliberately placed Mental Health services front and centre of the full service vision for our NHS, alongside Staying Healthy. Good mental health and good physical health are the mainstays of a good life.

Over the lifetime of this vision we are committed to delivering a better deal for people with mental health problems; for those who care for them; and for the wider circle of family, friends and community who come together with NHS and social care professionals to deliver care. We will increase staff numbers in vital areas; provide the right support for carers; and ensure mental health benefits from waiting time targets in the same way that they have driven improvements in other parts of the NHS.

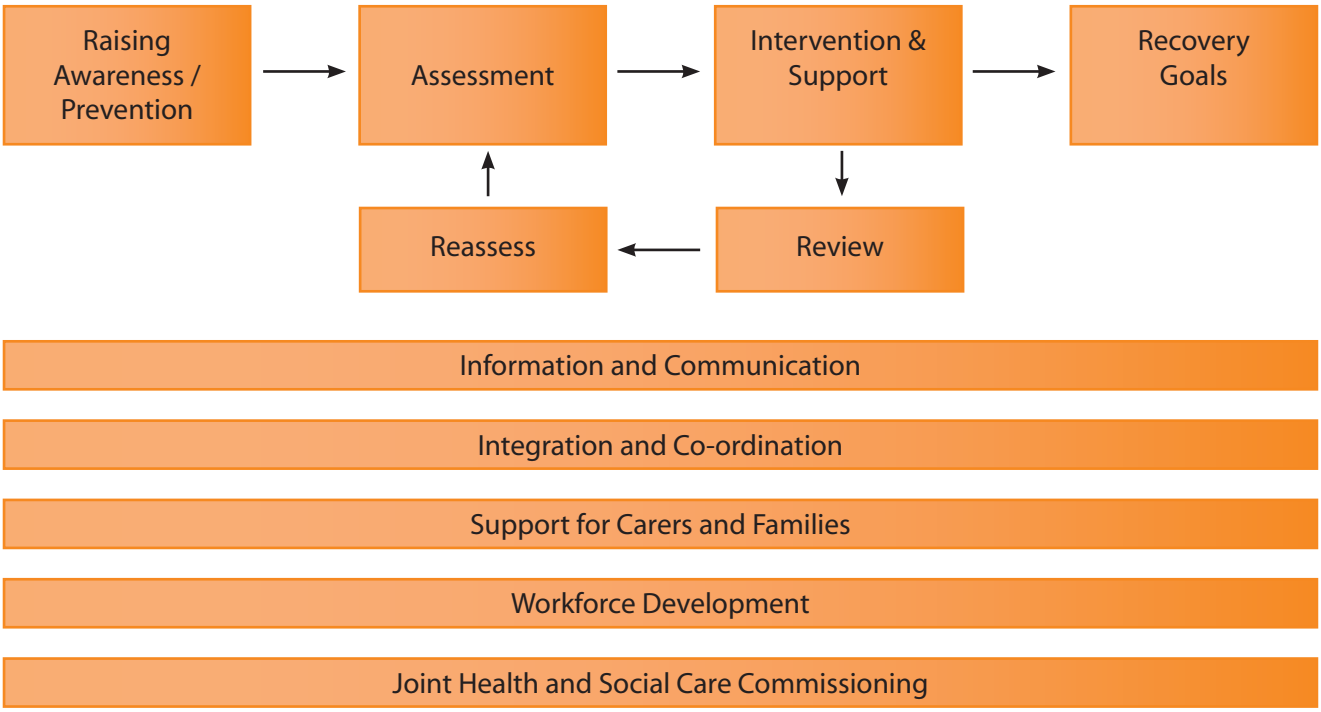
This section sets out a core framework of care; sets out a move from managing symptoms to working towards recovery; identifies the need to engage and support carers more effectively; and then addresses two immediate priorities – better access to psychological therapies and better services for people with dementia.

A Core Framework

The framework (see Figure 14), the building block for all our mental health care pathways, **recognises prevention** and early detection of mental health problems need to be aligned with an approach that is about recovery and outcomes as well as managing symptoms. **It also recognises the importance of raising awareness of mental health issues and tackling the stigma associated with mental health problems.**

Many people need to access mental health services outside of 'office hours' and in many cases timely intervention at this stage can prevent the situation escalating. We are therefore committed to ensuring that all of the region's Crisis Resolution and Home Treatment teams continue to operate 24 hours a day, enabling individuals to receive timely support and care in ways that best meet their needs.

Figure 14: Mental Health Core Pathway Framework



This pathway will be adapted and personalised for all mental health services, including eating disorders and substance misuse as well as the immediate priorities for investment and change outlined in this vision. In particular, **we will introduce an 18 week maximum waiting time for a range of services including eating disorders**. For some services we will go beyond this with shorter maximum waiting times.

This framework recognises the need for a full service approach involving carers; social services; the NHS; the voluntary sector and the patients themselves. It recognises the need for early recognition in primary care; and setting goals with the aim being to maximise recovery. And it places the patient and their carer at the centre of their care; not a symptom, not a disease, but individuals with specific needs and desires.

Recovery Focussed Services

This pathway will deliver a recovery focused approach for all mental health services. It will encourage anyone with a mental health problem to realise their maximum potential, with the help of timely, intensive and targeted interventions through partnerships across the whole system, not just healthcare providers alone.

A recovery-oriented system of mental health treatment and care will:

- Focus on people rather than services
- Monitor outcomes rather than processes
- Emphasise strengths rather than deficits or dysfunction
- Educate people who provide services, schools, employers, the media and the public to combat stigma
- Foster collaboration between those who need support and those who support them as an alternative to coercion
- Enable and support self-management, promote autonomy and, as a result, decrease the need for people to rely on formal services and professional support
- Develop clear, evidenced based, care pathways for each of the diagnostic categories through managed clinical networks.

To deliver this step change in our approach to mental health services, we will ensure that local joint commissioning, supported by evidence based clinical care pathways, fully reflects the values and principles of the recovery-focused approach and is introduced systematically across the system.

In order to do this we will change the archaic way of measuring how effective mental health services are by agreeing a series of outcome measures for patients and measuring those rather than processes. We will then build these into contracts so that those who deliver the services are accountable. And to support the introduction of this new approach **we will recruit more, and expand the roles of, Support, Time and Recovery Workers**, who provide support to the service user and thus promote their recovery.

Carers

One of the keys to excellent mental health services is recognising and supporting carers; those closest to patients who live with the situation day in and day out.

A carer is someone who provides help or support to a relative, partner, friend or neighbour[31]. There are over 100,000 people in the region who care for people with mental health problems, with around half of people with severe mental illness living with family or friends.

There is increasing evidence that supported and informed carers cope better; which in turn can help to reduce relapse and hospital admissions of those in their care as well as protecting the carer's own health. Carers have repeatedly asked for help, just to make their vocation that little bit easier; now through this vision we are committed to action to meet their needs.

Case Study

South Essex Partnership NHS Foundation Trust led an action research project exploring the needs of carers. This led to a series of recommendations and a Carers Awareness Steering Group, involving carers, staff, local authority representatives and people from the voluntary sector, being set up to take these forward. This has led to:

-A 'Caring for the Carers' Training Pack being produced by carers and staff to raise staff's awareness of carers' rights and needs

-Over 1,000 Crisis Cards for Carers being issued, with details of a central contact number to access support in a crisis 24/7

-A local newsletter 'For Carers' being produced in partnership with carers and distributed to over 1,000 carers in south Essex

-An email-based support network 'CarersChat.com' being piloted, using innovative approaches for carers to access peer support

-25 more carers volunteering to work on initiatives to improve service response to carer needs.

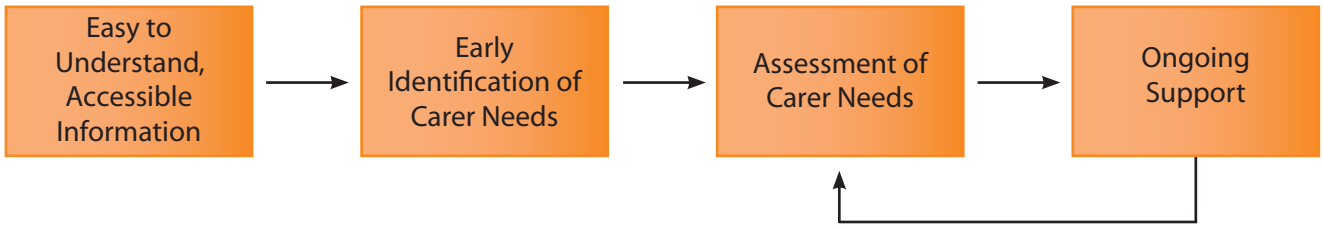
Nationally the New Deal for Carers promises to update and extend the 1999 strategy for carers as well as:

- Establish a Carer's Advice Helpline
- Ensure that short-term, home based break support is available to carers in crisis or emergency situations
- Create and fund an **Expert Carer's Programme** to help develop the skills they need to take greater control over their own health, and the health of those in their care.

We will deliver all of this, but in the east of England we want to build on these national commitments to become an exemplar for working with carers. We have already held a regional summit with the Eastern Regional Family Carers Organisations Network which brings together carer's representatives and those from the NHS and social care to agree a united agenda to supporting carers. This is a key action from the *Improving Lives; Saving Lives* consultation last year.

In a similar way to the pathway for patients, we aim to provide services to carers in line with the pathway at Figure 15.

Figure 15: Service Pathway for Carers



This pathway, and the work of the summit group, is designed to ensure that carers:

- Are recognised as partners for their role and expertise and are provided with the information they need to help them care
- Have relevant knowledge and skills to help manage and sustain their caring role, including what to do in times of crisis
- Feel that the care plan of the person they care for is working
- Have equal access to services (specifically young carers and carers from black and minority ethnic groups)
- Receive targeted support at high-risk times i.e. at the beginning of caring, any major changes to caring, on discharge from hospital and following bereavement
- And that they feel listened to and respected.

To deliver this step change in working with carers we will:

1. Deliver a systematic approach to identifying carers across the region and create a carers register which will help us ensure all carers are recognised and get the support they need.

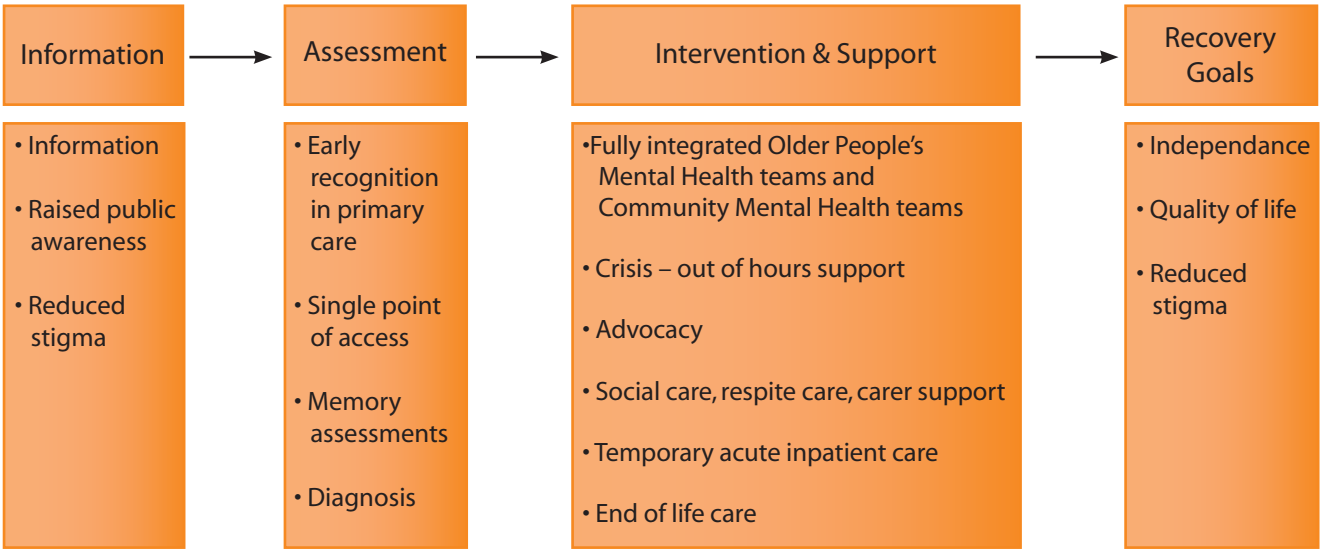
2. Ensure that carers get enhanced support at high risk times. In order to deliver on this **we will recruit new Carer Support Workers and broaden their range of responsibilities**.

3. Build on the summit we have already held to create an ongoing partnership and dialogue with carers to spread best practice and make sure their voice is heard and acted on.

Carers need to be aware of these services and support mechanisms, which is why we will work with the summit group to create bespoke information and communication channels specifically for carers in the east of England. By this, we mean all carers, not just those who care for people with mental health problems – recognising the full range of carers which numbers over 600,000 in our region and grows daily.

Services for People with Dementia
69,000 people in the east of England suffer from dementia, a condition normally found in older people, but one that can also impact on people with a learning difficulty and younger adults. It is also anticipated that the number of people with the condition will increase as our population ages. That is why we see investment in dementia services as an immediate priority. This pathway (see Figure 16) builds specifics into the core approach outlined above, a process that will play itself out across all mental health conditions as time progresses.

Figure 16: Proposed Service Pathway for People with Dementia



To ensure we can give the best possible treatment to people when they need it, we will aim to improve the early recognition of those people likely to develop dementia, thereby increasing awareness and, potentially, early detection and start of treatment.

Once diagnosis has been made, the emphasis will be on reducing stigma, promoting independence and preventing crises by placing the person, family, carers and social networks firmly at the heart of the pathway. **The person with dementia will be facilitated to make decisions for themselves and they and their carers will be fully supported to allow those who choose to be cared for at home to do so for as long as possible**. To do this we will ensure that people are served by Crisis Resolution Home Treatment Teams.

Services would be structured and delivered in a way that clearly reflects dementia as a long term, progressive condition requiring continuity of care and regular reviews. **New fully integrated Older People's Mental**

Health Teams would coordinate the care of all people with dementia in a locality. These partnership teams will draw on the skills and resources of carers and organisations in the voluntary and independent sectors and will be prioritised and funded.

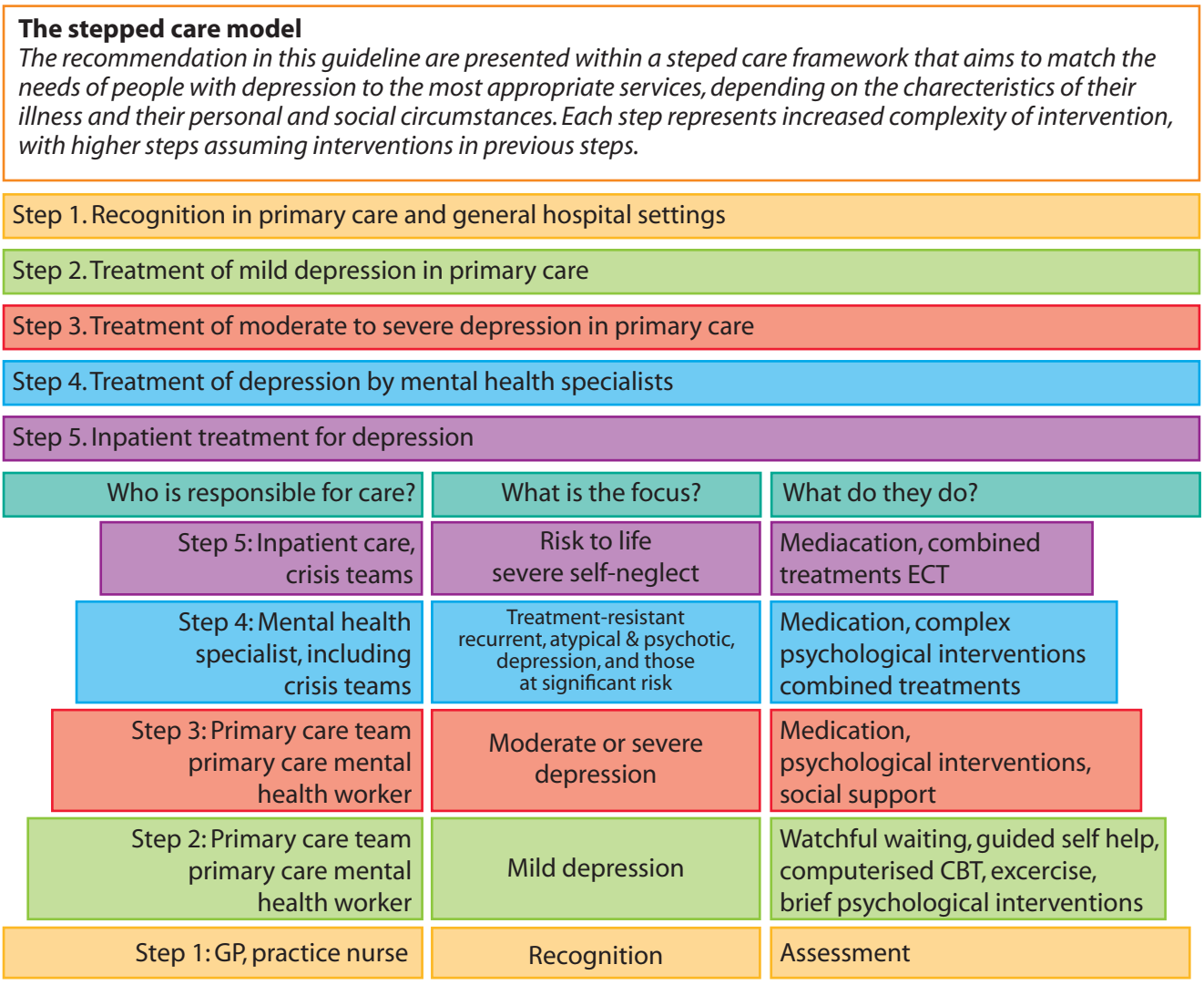
Improving Access to Psychological Therapies
Treating depression and anxiety disorders using psychological therapies increases the health and wellbeing of patients, as people can recover if treatment is timely and effective. Psychological therapies improve choice, bring treatment closer to home and increase the number of people who can return to work after mild to moderate mental health problems.

That is why it is not good enough that our region has the lowest number of clinical psychologists and psychological therapists in the UK.

So, we will recruit at least 350 new psychological therapists by 2011 and ensure that access is made easier, quicker and more equal. The rest of the NHS has benefited from waiting time targets which concentrate the minds of managers and clinicians, which is why **we want to extend this principle to mental health and pledge to introduce a maximum wait of 18 weeks for all psychological therapies with shorter maximum waits for certain services**.

We will also ensure the full implementation of The National Institute for Clinical Excellence's[32] guidelines for a stepped care approach (see Figure 17).

Figure 17: NICE Stepped Care Model for Depression



The model aims to match people to the right psychological therapies at the right time, ensuring patients 'enter' at the right level for their needs and receive some or all of the services indicated. Their changing needs and outcomes of treatment are then systematically monitored meaning patients only move up to the next level if treatment is ineffective[33].

The stepped care approach enables more individuals to have access to treatment, more quickly, and ensures appropriate use of specialist resources.

Better Mental Health
Our vision for mental health services places them in their rightful place at the core of our strategy for health and healthcare across the region. It changes the focus of mental health services to recovery rather than management and sets outcomes for patients as the measure of success. It is based on a core pathway that serves as the cornerstone of all mental healthcare and then builds on it with our immediate priorities in dementia and psychological therapies. It promises more specialist staff, more partnership working, more support for carers and quicker more equal access to services.

Pen Portrait After
A few days ago Molly developed a mild chest infection, making her much more confused and unsteady on her feet. After her GP prescribes antibiotics, Molly is referred to the Crisis Resolution Home Team who visit and assess the situation. They immediately set up a package of care that includes two visits a day, seven days a week, from members of their team. They provide skilled practical assistance with Molly's personal care needs, working alongside her regular carer and the family, using the opportunity to train them on how best to manage challenging behavior. Molly's daughter, Fiona, and husband, Eric, are given the contact number for the expert carers programme which provides training, information and support to develop skills to take care of the carer's own health and those they care for. The consultant psychiatrist in the Community Mental Health Team provides expert advice on the reasonable use of sedative medication for a few days until the antibiotics begin to clear the infection and Molly's acute confusion subsides. Two weeks later Molly has returned to how she was prior to the chest infection, with the carer coming in once a day as before.

Maternity and Newborn Care

"Having children is the greatest moment in many people's lives and it is up to us, the NHS, to provide services that are comprehensive, safe and as local as possible, and to support mothers, families and their babies in those critical first hours, days and weeks. This pathway will deliver a service second to none in the future, building on what we have now, but recognising that we need to provide more choice and make services more personal." – Boon Lim, Consultant Obstetrician Chair, Maternity and New Born Clinical Pathway Group

Key proposals – we will:

- Ensure all 17 Acute Trusts will keep an obstetric unit, with a co-located midwife-led unit
- Guarantee one-to-one midwifery care in established labour by recruiting at least 160 more midwives
- Maximise care for ill babies by increasing level 3 intensive care cots, increasing the number of level 1 special care units and reducing the number of level 2 high dependency units
- Offer pre-conception care to women with pre-existing health problems and lifestyle issues
- Increase the overall number of NHS-funded IVF cycles against standard criteria
- Guarantee women direct access to midwives and choice of antenatal care
- Promote normality of birth and guarantee women choice on where to give birth, based on an assessment of safety for mother and baby
- Guarantee choice of postnatal care to women, especially those most in need
- Establish networks covering maternity and neonatal services

Before Pen Portrait

Sarah is pregnant again and goes to her GP. Her first son Eddie was born at the local hospital but she would like her second baby to be born at home. Sarah discusses this with her midwife but Sarah feels she is just too far away from the hospital if there are any problems at delivery. So her second baby is also born in hospital. Sarah breast feeds for a week and then gives up.

"Most midwives don't ever really get to know you personally. They just see the notes and then ask: have you got any problems?" – Mother, maternity and newborn workshop

The birth of our children is life defining and the support we are given when it happens should be the best. It is the job of the NHS to make the process as easy and safe as it can possibly be, to help deliver a healthy baby to a healthy mother. It is also the job of the NHS to be there when things go wrong, to prepare mothers for what is coming, and support them after birth. That is because good maternity services increase survival rates and life chances of children, improve the physical and emotional health of their mothers, as well as addressing inequalities in health from birth.

The pathway for maternity (see Figure 18) sets out how we will deliver what women want and need in childbirth; from support before birth; to the best possible care during labour in a place of the woman's choosing; through to high class treatment for ill babies should problems occur; ending with friendly and accessible support for new mothers and their babies.

Figure 18: Maternity and Neonatal Pathway

Pre-Conception Care	Antenatal Care	Labour and Birth	Neonatal Care	Postnatal Care
• Staying healthy – smoking, obesity, substance/alcohol abuse, healthy diet, exercise • Preconception care for women with diabetes, epilepsy, cardiac disease (congenital or acquired) • Preconception advice for women with genetic disorders and mental health problems • Education and advice on teenage pregnancy • IVF treatment	• Staying healthy – smoking, obesity, substance/alcohol abuse, domestic violence, healthy diet, teenage pregnancy, mental health, targeted support for marginalised groups • Direct access to midwife • Support of named midwife • Risk and needs assessment identifying physical and mental health risks and social complexity • Screening and scans • Access to specialist services • Antenatal and "parentcraft" classes • Breastfeeding counselling	• Promotion of normality of birth • Choice of place of birth - home birth, midwife-led unit, obstetric unit • Risk assessment • Clear pathways for transfer for home births & midwife-led units • 1:1 midwifery care in established labour • Access to specialist medical care when needed	• Network of care • Transfer protocols	• Individualised postnatal care plan • Health and wellbeing • Breastfeeding support • Focus on women from disadvantaged groups • Advice on signs and symptoms to look out for • Coping strategies • Parenting support • Mental health issues

Pre-Conception Care

Childbirth is a natural process, but it can still be scary for women especially those with pre-existing conditions, such as congenital heart disease or mental health problems, and those with lifestyle issues. That is why **we will work with GPs (who know their patients best) to identify women who could benefit from support before conception**, as well as enhanced support through pregnancy and post birth. It will not be forced on women, but the choice will be there. We will seek to ensure this support for potentially high-risk women is part of GPs' contracts, nationally if possible, locally if necessary.

We also want to increase fairness for those that need help to get pregnant. **We will agree a standard set of criteria for IVF across the region and then commit ourselves to increasing the number of funded cycles**.

Antenatal Care

Antenatal care should be coordinated and women should know where to turn for help and support throughout the course of their pregnancy. That is why the pathway increases choice and personalisation for women at every turn.

Women should not always have to go to a GP before being referred to a midwife, they should be able to go direct. This is a choice women should have, it does not stop women going to their GP, a trusted health professional they know well, but it gives them alternatives. It is also likely to mean that women with potential

problems are identified earlier and referred to a consultant, since some women, particularly those from marginalised groups, are reluctant to visit their GP.

The relationship between a pregnant woman and their midwife should be strong, supportive and lasting. That is why we will guarantee all women a named midwife throughout pregnancy who they can contact at any stage. We will further increase choice for mothers by providing antenatal care locally in a range of friendly, accessible community venues such as children's centres or primary care facilities.

We will carry out a risk and needs assessment for all pregnant women to ensure that every woman is offered the type of antenatal care that most suits her own particular requirements. Women will also be able to choose between midwifery care or shared care between midwives and obstetricians.

We will encourage all pregnant women to book for antenatal care before 12 weeks gestation to ensure that all screening tests are made available in a timely fashion. When the pregnancy has progressed beyond 12 weeks gestation, we will guarantee referral for booking and assessment within 2 weeks of presentation. Where a need is identified for specialist services, such as feto-maternal services, we will guarantee access through the new maternity networks.

We will also proactively promote breast feeding as the best route for the baby, providing support and dealing with concerns to prepare the woman for the first time they feed their new baby. This will be especially true of those sections of society who traditionally have low breast feeding rates, to promote better life chances for all from birth and further reduce unfairness in health. Smoking cessation advice will also be offered at the earliest opportunity and intensive specialist support will be available to help women stop smoking.

Labour and Birth

The majority of births in the east of England are normal, vaginal deliveries supported by family and health professionals in hospital. However this does not tell the full story. Sometimes mothers do not feel as supported as they would like. Sometimes mothers would choose to give birth outside an acute hospital but end up not having that choice. Sometimes interventions by health professionals are too quick, or not quick enough. And sometimes mothers don't think they can have vaginal births when they have already had caesarean sections.

That is why we are going to be very clear about what women can expect during labour, and what the NHS is committed to delivering.

The pathway for labour and birth should provide:

- **Normality – no intervention when progress is normal**
- Communication – respect, control, rapport, choice
- Support – one-to-one care in labour, not left alone
- **Choice of place of birth – home birth, midwife-led unit or obstetric unit.**

We will do this by applying the recommendations of Maternity Matters[34], including:

- Greater encouragement of home births
- Increased use of midwife led birthing units
- Policies to provide vaginal birth after caesarean section.

Women who have a planned home birth have a higher rate of spontaneous vaginal birth, a reduced likelihood of caesarean section and more likelihood of an intact perineum, compared with those who have a planned birth in an obstetric unit[35].

Greater choice will be based on better information about risks, it is only right that choice is informed. For home births and midwife led birthing units, we will undertake an assessment of risk and suitability for proposed place of birth. At low levels of medical risk and social complexity, women should have a wide choice of place of birth. However, as the level of medical risk and social complexity increases, delivering a safe birth for mother and baby becomes paramount and the choice of location will need to be reduced on expert clinical advice.

Vaginal birth after a previous caesarean section will be more available in obstetric units. Early data suggests that where clinics are in place to assess women and prepare them for a vaginal birth after caesarean section, good results have been achieved. One unit showed an 80% success rate for those women who opted for a vaginal birth after caesarean section instead of an elective caesarean section[36].

We will guarantee one-to-one midwifery care for all women during established labour. To ensure this we will recruit at least 160 more midwives across the region, meeting the *Looking to the Future* recommended ratio of 1:30 deliveries as an average caseload for midwives in the region. Further work will be required, to confirm the exact number of new midwives and ensure that opportunities to develop new ways of working are properly considered. If we discover we need even more midwives to meet this guarantee, we will recruit them.

Evidence shows that direct involvement of senior medical staff in the care of high risk women in labour improves outcomes and intervention rates[37]. New standards have recently been recommended for medical staffing of obstetric units based on activity and these will be implemented[38]. All obstetric units in the east of England should provide at least 60 hours of consultant presence a week on the labour ward by 2009, with units with more than 4,000 births moving towards 98 hours a week.

To support this wider choice, but also the requirement to ensure safety for mother and baby through access to senior medical staff if needed, **we will co-locate midwife led birthing units with flexible staffing alongside existing obstetric units**. Where standalone midwifery led units exist, PCTs should ensure that they can continue to provide consistent, high quality, safe services. Recent guidance from the Royal College of Midwives indicates that standalone midwife led units delivering fewer than 300 babies a year are unlikely to be independently financially sustainable[39].

Neonatal Care
When problems arise, high quality, safe neonatal units with the right equipment and skilled staff save babies' lives. Neonatal care is an integral part of care for high-risk pregnancies and requires the multi-disciplinary support of children's services in order to deliver high quality care. Neonatal services in the east of England are increasingly networked, with services classified as level 1 (special care), level 2 (high dependency care) or level 3 (intensive care).

The majority of babies requiring special care should be looked after close to their homes and every obstetric unit will have at least one short term intensive care cot for resuscitation and stabilisation. There are clear standards set out by The British Association of Perinatal Medicine for the operation of neonatal units at each of the three levels and all units will work towards these standards. We will also ensure that an integrated 24 hours transport service to ensure timely and safe transfers is available across our NHS.

Postnatal Care
The first few days and weeks after babies are born are often the most difficult for parents which is why NHS care does not end when babies are safely at home. **We will continue to provide general parenting support and ensure that women are able to choose how and where to access their postnatal care. This will include providing postnatal care in the community to ensure that the women most in need are targeted to receive the most attention**.

Case Study

The midwifery team based in Sudbury covers a market town and rural hinterlands. The community is a mix of affluent and needy people with 2 wards in the top 20 for the highest teenage pregnancy rate in Suffolk. They have promoted choice for women as to where they receive their postnatal care, either in a town centre clinic or their own home. The clinic is open 7 days a week and accessed via a 'drop in' or through an appointment.

Benefits have included:

-A 35% increase in the number of women visiting the clinic, with only 2% of women not accessing any midwifery service. These are followed up and offered a home or clinic appointment

-An increase in targeted home visiting to vulnerable women and families including teenagers, victims of domestic violence, substance misuse and multiple social problems during both the ante and postnatal period, using the time released from more women attending the clinic

-A 9% increase in the number of women still breastfeeding at 6 weeks

-An increase in women accessing parenting skills through the clinic.

A personal postnatal care plan will be developed with the mother, ideally in the antenatal period or as soon as possible after birth. Communication and information to the new mother during this period will include:

- Relevant and timely information to enable them to promote their own and their babies' health and well-being
- Advice about signs and symptoms of potentially life-threatening conditions
- Encouragement of breastfeeding, particularly for women from the disadvantaged groups of the population
- Discussions about their emotional well-being, family and social support and their usual coping strategies for dealing with day to day matters.

Potential mental health issues will also be addressed as early as the pre-conception or antenatal period so that appropriate multi-disciplinary arrangements can be made for the postnatal period. There are many examples of good practice in the region and it is important that such pathways are shared and a uniform approach adopted so that all across the east of England can benefit from the best.

Proposed Model

This pathway, from pre-conception for some, to postnatal for all, includes many new commitments and guarantees by the NHS. These will be supported by new staff and new midwife-led birthing units across the region. They will also need to be supported by a different model of care if we are to ensure safety, normality of birth and choice for mothers.

Many services have proved that managed clinical networks work and deliver better outcomes for patients. **We will create robust networks for maternity and neonatal services**. This will ensure that common pathways are shared and equality of care exists across the region should mothers and babies need to be transferred. It will also enable demand and capacity to be managed more efficiently within flexible populations.

Properly established clinical networks will ensure:

- All obstetric units offer safe high quality services for straightforward births and ante and postnatal care to their local populations
- The larger obstetric units also offer safe high quality services for more complex births and ante and postnatal care to the wider population where necessary.

Each of the four smaller obstetric units in the east of England (at West Suffolk Hospital, Hinchingbrooke Hospital, James Paget Hospital and Queen Elizabeth Hospital, King's Lynn) will be supported by pairing with a larger unit. This, together with an increase in their consultant and midwife cover, will enable them to provide high quality, patient centred care and ensure their clinical viability.

However, their financial viability also needs to be considered. *Looking to the Future* indicated that PCTs might need to support these smaller units with up to an extra £500,000 a year to ensure continued local access for patients. If it is necessary, PCTs will do this, as it is far preferable to the alternative which would involve the two large obstetric units in Cambridge and Norwich expanding to over 7,000 births a year.

This means that we can pledge that all Acute Trusts will keep an obstetric unit. We will also make every effort to increase the populations served by the smaller obstetric units, by ensuring they develop excellent, patient centred services for straightforward births.

For neonatal services all units will work towards the required British Association of Perinatal Medicine standards. This will enable patient outcomes to be improved and a better alignment of demand and capacity.

To deliver this we will need more level 3 capacity to ensure that all pregnant women or babies who need a place have one. There should be sufficient high dependency capacity in the region to allow for transfer back to the local hospitals, whilst allowing for the sickest and smallest babies to continue to be treated in the level 3 units.

Various scenarios have been modelled and the **preferred option** is:

- **Increased capacity at the current level 3 units** at Luton, Norwich and Cambridge, with Essex continuing to utilise facilities in Cambridge, Norwich and London. These would provide intensive care services for their network, high dependency care services for their own babies and for the network and special care services for their own babies
- To create a working network that will deliver the safest possible care within available resources, we will then need to create **more level 1 units**. These would provide stabilisation and transfer of intensive care and high dependency care (both for a maximum of 24 hours and requiring at least one short term intensive care cot) and special care services for their own babies.
- This means we will need **fewer level 2 units**. These provide short term ventilation (less than 5 days) and transfer of intensive care, high dependency care services for their own babies and for the network and special care services for their own babies.

Due to staffing arrangements, hospitals providing level 3 or 2 neonatal services would also need to be providing full children's inpatient services, whereas hospitals providing level 1 neonatal services would not necessarily need to do so. This is dealt with in the section on children's services.

Conclusion

This pathway delivers more choice and support for women with guarantees never before made by the NHS. To support the delivery of this we are committed to increasing the numbers of midwives and also reorganising current services to best meet the needs of patients and save more babies' lives.

It also, once again, delivers against our key principles and the case for change by extending choice and personalised services, whilst ensuring services are delivered locally where possible, but are centralised when appropriate. It also implements changes that are evidence based to deliver better outcomes for mothers and babies.

We think this is the least that women expect for themselves and their babies.

After Pen Portrait

Sarah is able to register with a midwife early on in her pregnancy through her local children's centre. She receives a medical, mental health and social risk assessment and is provided with a comprehensive care plan. Her care plan is reviewed at regular intervals. Sarah is regarded as a low clinical risk and she chooses to give birth at the midwife-led birthing unit, located on the local hospital site, which is far more homely than the main delivery suite at the hospital. She breast feeds for 3 months as she gets support from the midwifery team who are based at the local children's centre at Eddie's school.

Children's Health

"Children are not, and should not be treated by the NHS as mini adults who require nothing more than some colour and a cheerful face in a bright uniform to make the services we have for adults right for children. This pathway takes the needs and wants of children, as children, and puts them at the centre of devising the new approach." – Chris Upton, Consultants Paediatrician ,Chair, Children's Clinical Pathway Group

Key proposals – we will:

- Ensure children's services are truly designed for children, taking into account all their needs
- Implement the Child Health Promotion Programme for all
- Split non-urgent from urgent care by providing more of it in the community, rather than hospitals
- Develop new Children's Assessment Units, and review whether every acute hospital needs an inpatient ward
- Create clinical networks for sub-specialty children's services, including surgery
- Strengthen Child and Adolescent Mental Health services
- Ensure the needs of adolescents are properly catered for and there is a seamless transition to adult services
- Have common information systems, integrated care and co-located staff to deliver better services for children
- Create a region wide Children's Services Board to oversee the development of children's services

Pen Portrait Before

Eddie is six years old. One evening at home, he has a violent seizure which he recovers from, but Sarah is extremely concerned. She takes Eddie to the nearest A&E department where he is seen by an A&E doctor and then by a paediatrician (child specialist). The paediatrician suspects that Eddie may have underlying problems in his brain which require further investigation, which cannot be done locally and can only be done at the request of a neurology specialist. He is referred to see a paediatric neurologist at the specialist hospital 30 miles away and, after a wait, he is referred to and the investigations requested. He has another wait for the tests to be performed and then sees the paediatric neurologist who diagnoses epilepsy and tells Sarah about the condition. Eddie visits the specialist hospital as an outpatient on a regular basis to treat his epilepsy.

"I couldn't understand the words he was using. He was using very technical language." – Parent, deliberative event, Norwich

Children's services should not simply be adult services provided to children. Children have very specific health needs and the NHS will get better at meeting them, with services designed around those specific needs.

Children and young people make up one fifth of the population and interventions in childhood often have significant long term consequences. The five desired outcomes for every child set out in Every Child Matters are[40]:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being.

The core pathway for children's services set out in Figure 19 shows how the NHS can play its role in delivering these outcomes. However, there can be no single pathway for all children's services. Rather, there should be children's versions of all the other pathways. In effect, children's services should be a mini-NHS – one where the child or young person is central to the planning and delivery of their services. This mini-NHS will need to recognise that partnerships outside the NHS are absolutely crucial in the delivery of comprehensive children's services.

Figure 19: Core Children's Pathway

Prevention	Identification	Assessment	Management	Long Term Support
• Child Health Promotion Programme	• Parental concern	• Timely assessment in child friendly facilities	• Universal care through primary and community care and the education services	• Universal care – support through education and primary and community care services
• Immunisation programme	• Professional concern	• Multi-disciplinary assessment of health and wellbeing including psychological health	• Medical	• Education
• Newborn screening programmes	• Child Health Promotion Programme	• Access to primary care services	• Surgical	• Social care
• Parenting support	• Newborn screening programme	• Access to secondary care and specialist services	• Psychological, behavioural	• Family support
• Support for breast feeding	• Safeguarding		• Educational	• Psychological and behavioural support
• Family needs assessment completed by age 1 year	• Integrated information systems between health, education and social care		• Multi-disciplinary team management	• Access to physical activity and a healthy diet
• Safeguarding	• Access to primary care services			• Access to age appropriate services
• Targeted support for lifestyle changes, e.g. smoking cessation	• Access to secondary care and specialist services			• Personal, social and health education in schools
• Support for healthy eating				• Sexual health advice and services
• Education				• Obesity services
				• Smoking cessation services
				• Alcohol services

Universal and Targeted Services

Universal services, such as screening and immunisation, are available to all children. Many of these are part of **the Child Health Promotion Programme which will be fully implemented across the east of England**. This includes a needs assessment of the family that starts during the ante-natal period and should be complete by the time the child is a year old. Universal services should address key lifestyle priorities, including reducing family smoking, obesity, alcohol related harm, sexually transmitted infections and teenage pregnancies.

On top of these universal services are services targeted at sections of the population with a higher risk of poor health and adverse lifestyle behaviours. Priority groups include Gypsy and Traveller children, Looked after Children, parents with problems or low self-esteem and families in areas of high deprivation. Services to these groups should focus on prevention as well as tackling health inequalities.

Case Study

An example of good practice from the region is the Health Led Parenting Pilot in south-east Essex, which is a joint project between the PCT and the local authority. The pilot is testing an intensive home visiting programme for young, vulnerable first-time mothers during their pregnancy and the first two years of their child's life. 100 families have been recruited onto the programme and early results are encouraging, particularly around the continued engagement and enthusiasm of a group of young people who have historically been reluctant to engage with statutory services:

-A 20% increase in breast feeding

-A reduction in low birth weights

-A 15% reduction in smoking in pregnancy

-25% of the young mothers accessing Children's Centres.

Safeguarding, which means the NHS and its partners taking all reasonable measures to ensure the risk of harm to childrens welfare are minimised and their wellbeing is promoted, is a particularly important element of targeted services. Prevention is obviously the primary aim and parenting programmes are a key component of this, but we will also strengthen out-of-hours services and training for all involved in the care of children.

Universal and targeted services are better provided in partnership between health, social care and education and, for safeguarding, the police. This requires the joint development of care pathways, e.g. for Looked after Children, better integrated information systems than currently exist and the development of multi-disciplinary training programmes. **We are committed to creating and developing these partnerships**.

As well as universal and targeted services, there are a range of specific services for children with particular needs, the most important of which are covered in the following sections.

Services for Children with Long Term Conditions

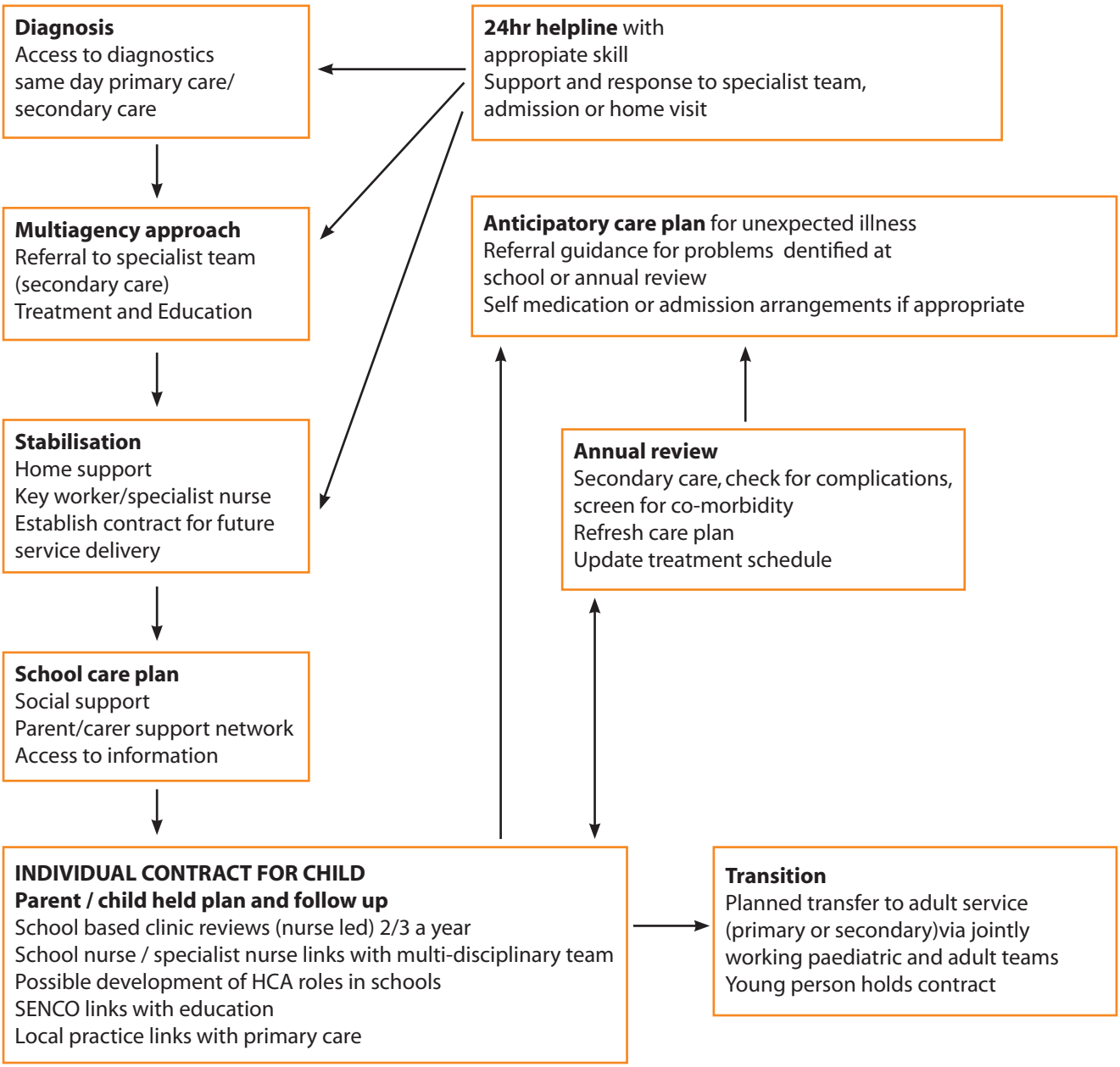
Around 18% of children aged 0-19 have a long-standing illness or disability[14]. These children live with this condition every day, and many for the rest of their lives, which is why they should be respected as knowledgeable expert patients and supported by a multi-disciplinary team including nurses, therapists, teachers and social workers. Their condition should be proactively managed, aided by a personal health plan, decision trees and algorithms for both patients and staff, with 24-hour access to telephone advice and shared health records.

Even more so than for adults these services should be seamless as set out in the case for change. Whole pathways of care will be commissioned together and be provided in community facilities such as children's centres, community hospitals or extended schools. This enables the child to be cared for closer to home, thereby improving their long-term health and well-being.

The multi-agency multi-disciplinary teams should work together and be located together, supported by a high quality information system to ensure better decision-making, audit and communication. In the longer term, Community Children's Nursing Teams will form the core of the larger multi-agency team.

Figure 20 describes this pathway.

Figure 20: Pathway for the care of children with long term conditions



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Acute Children's Services

Primary care will continue to provide care for most acute illness as it does now. Children should not have to go to hospital unless it is absolutely necessary, so **we will create a greater separation between non-urgent children's services and urgent and emergency services**. In addition to care provided in GP surgeries, **non-urgent care will be focussed in a community setting** to deliver an extensive range of planned care services, including diagnostics, management of long term conditions, outpatient clinics, child protection work and multi-disciplinary work with partner agencies. These centres could be located in a Children's Centre or a local healthcare centre, depending on local availability and condition. In some locations, it may also be possible to deliver children's urgent care in these centres during normal working hours.

For urgent care, as with adult services, specific Children's Urgent Care Centres run by primary care will be established, where geographically appropriate. These should primarily be co-located with an A&E Department and act as the main point of entry to emergency children's services.
As medicine and treatment gets better, fewer and fewer children need to stay overnight in hospital, especially

if they have early assessment by a senior clinician. The emphasis in hospital services is therefore shifting away from the traditional inpatient ward to Children's Assessment Units run by consultant paediatricians.

Children's Assessment Units will be established at all acute hospitals, ideally co-located with the Urgent Care Centre and the A&E department. These units would include beds for children requiring observation for a planned duration of less than 24 hours.

With fewer children needing an inpatient stay, those that do tend to be more complex cases so the care needed is becoming increasingly specialised. There is a broad clinical view that such children with complex needs would receive more effective care if these services were centralised with access to a mix of professionals in a multi-disciplinary team. In addition, there is also a strong clinical view, including from the Royal College of Paediatrics and Child Health[42], that it will not be possible to continue to staff all the existing inpatient units in their current format. To comply with the European Working Time Directive, acute hospitals will need at least eight paediatricians each at junior, middle grade and consultant levels to run a 24/7 rota from 2009.

We therefore propose to review whether some hospitals should consider withdrawing from providing full inpatient children's services and instead develop their Children's Assessment Unit. In addition, PCTs would invest in additional children's community nurses. Where this model has already been established, including in Hertfordshire, hospitals have demonstrated that they can manage about 90% of children without having to transfer them to another facility, but that where a transfer is necessary the inpatient care is better provided in a larger, more specialised unit. Acute hospitals that do not have a full inpatient children's service would still be able to provide a Level 1 neonatal unit (special care) but not a Level 2 unit (high dependency care) or a Level 3 unit (intensive care).

We believe this move from children's inpatient wards in all acute Trusts to new Children's Assessment Units supported by more specialised teams in central locations would deliver better care for children. We will use the consultation period to seek views on this proposal and work up detailed proposals for how this could work.

Children's Surgery and Sub-Specialty Care

In the same way that children's services should be distinct from adult services, children's surgery is becoming more specialised. However, we do not recommend a wholesale shift to specialist centres, rather **we will create local networks for children's surgery**, based on a maximum ambulance travel time of 60 minutes to a childrens surgical centre from all our acute hospitals.

These networks will see different levels of surgery carried out at different centres depending on the child and the complexity of the case:

- Planned day case surgery and routine surgery for fit children of five and over with planned stays of less than 24 hours will continue at all acute hospitals
- Routine surgery for fit children of five and over with planned stays of more than 24 hours will be provided by acute hospitals with full inpatient facilities
- Complex surgery, surgery for children less than 1 year and for those with significant other health problems should be centralised to provide the best outcomes.

For children between one and five years old, the continuation of local services will depend on the skills and competencies of the local surgeons and anaesthetists and the numbers of cases they treat. We will ensure that an independent peer review is carried out across the east of England to determine which hospitals will continue to provide these services.

Further work will be required to determine the right number of childrens surgical centres. On the basis of the proposed 60 minute maximum travel time, however, it is likely that at least five such centres would be required.

It is not possible for all acute hospitals in the east of England, or anywhere in the country, to appoint paediatricians experienced in all sub-specialties. However, **Trusts can and will work together to provide cover between them and ensure that sufficient sub-specialty expertise is available locally**.

Some sub-speciality work will continue to be provided only in specialist centres, for example paediatric intensive care and complex endocrinology, where the numbers of children being treated are relatively small and a critical mass is required to ensure appropriate expertise and facilities.

This revision of how we provide children's surgery and sub-specialty services is designed to ensure that the most appropriate staff with the right skills and equipment are ready and available when needed. This meets the case for change in ensuring specialists continue to get the practice they need to deliver better outcomes but also keeping the vast majority of surgery as local as possible.

Child and Adolescent Mental Health Services
Probably even more so than those services affecting a child's physical well-being, those that deal with mental health problems need to be focussed entirely on the child and be separate from adult services. Child and Adolescent Mental Health services need to both be comprehensive and responsive. They should also be provided by integrated multi-agency multi-disciplinary teams across all children's services and we will explore whether these services could be provided from Children's Centres. **We are committed to a focus on the delivery of mental health services for young people as part of our aim to be the best health service in England**.

Local services will place greater emphasis on the early years of a child's life, supporting parents and young children and promoting the development of positive parent-child relationships. We will focus on vulnerable parents; early detection; and intervention for children with developmental disabilities. This will require close partnership working with social services, education and the voluntary sector. As with adults, there will be an emphasis on developing effective intensive services to support young people in crisis and prevent admission to an inpatient unit unless absolutely necessary.

For specialist services across a number of PCTs and local authorities, more emphasis will be placed on services for young offenders in secure and non-secure settings, particularly those who have drug or alcohol problems and learning difficulties. Help for these young people goes to the heart of what a civilised society is.

A regional service for young people with forensic mental health problems will also be developed.

In addition, we will recognise the importance of non-health specific services such as specialist social care, therapeutic foster care, educational behaviour support and voluntary sector support, by working more closely with partners and integrating these services into health provision.

Children's Palliative Care Services

There are not enough palliative care services for children and young people. These services are supposed to support children and their families at their lowest ebb, but they have been developed in an ad hoc unplanned manner, with no consistent funding or commissioning streams, particularly for services provided or funded by charitable organisations.

We commit ourselves to the creation of a region-wide, multi-agency palliative care network for children and young people. This means the NHS, especially those who commission services putting their money where it is needed, and ensuring that funding streams are more secure and less reliant on voluntary sector contributions.

Adolescent Care and Transition to Adult Services

The move from childhood to adulthood is hard enough without the added complications of health problems, which is why **we are committed to delivering the specific facilities adolescents need across the region. The transition of care from children's to adult services for young people with chronic health needs will receive particular attention**, with condition-specific transition arrangements being developed. This will be particularly challenging for young people with complex needs, including learning difficulties and physical impairments, where multi-agency co-operation is required.

Conclusion

Children's services should be as professional, accessible, and effective as adult services, but they also need to be different. If we are to create this mini NHS for children, with experts in their care caring for them on their terms, we will need a full service approach that accepts the need for planning and change. The pathways described in this section pass the tests based on the *Principles for Progress*. They respect patients as individuals by treating them as children; they accept and promote the need for partnership working across organisations and with partners; they localise where possible but centralise where appropriate; and include prevention as a key part of the pathway whilst insisting on better evidence-based outcomes.

To ensure children's services get the attention they need and deserve **we will create a region wide Children's Services Board**. This board will bring together clinicians, managers and other experts to oversee the development of a specification for the provision of all care for children and young people and the production of guidelines for care and referral at all levels. The specification made by this board will then be commissioned by PCTs within their local children's network. This region-wide approach is vital as we will have to develop transport and other policies as well as plan together for a future workforce and rotate staff between hospitals in order to maintain skill levels.

Pen Portrait After

Eddie is six years old. One evening at home, he has a violent seizure which he recovers from, but Sarah is extremely concerned. She takes Eddie to the nearest A&E department where he is seen by a paediatric nurse and then by a paediatrician (child specialist). The paediatrician, who is part of the networked epilepsy team, refers Eddie to a neurological (brain) children's specialist who holds clinics locally. He requests a brain scan which is carried out locally and Eddie is diagnosed as having epilepsy. A multi-disciplinary team led by an epilepsy nurse conducts an early assessment of Eddie's needs. Advice and guidance is provided to Sarah and to Eddie himself and early treatment options discussed with the paediatrician and the epilepsy nurse. A key worker from the multi-disciplinary team, based in the community, liaises with Eddie's mother, school and GP practice. A heath plan is agreed with Eddie and Sarah and fed back to all members of the multi-disciplinary team. The health plan is reviewed at regular intervals.

Planned Care

"Planned care cannot be truly planned whilst it is tied so closely to the use of acute hospitals and is at the mercy of the other priorities they and their consultants quite rightly have. Care can only be truly planned if it is planned together, between the NHS and the patient, rather than the NHS telling the patient what treatment to have, where to have it and when. That is why we place localisation, choice and a split from acute services at the centre of this new pathway." – Jane McCue, Consultant colorectal surgeon and co-chair, Planned Care Clinical Pathway Group

Key proposals – we will:

- Deliver more care closer to home, away from acute hospitals
- Guarantee better access to GPs, dentists and radiotherapy services
- Provide direct access to specialist advice and diagnostics and more local provision of diagnostics
- Guarantee a maximum 18 week wait for more of our services including speech therapy, podiatry, orthotics, wheelchair services and orthodontics
- Ensure that all patients have a full and free choice of where to go for planned care
- Develop better local support for post-operative recovery
- Agree, and measure, new clinical, quality of life and experience outcomes
- Ensure that there is appropriate centralisation for complex care, particularly specialised surgery

Pen Portrait Before

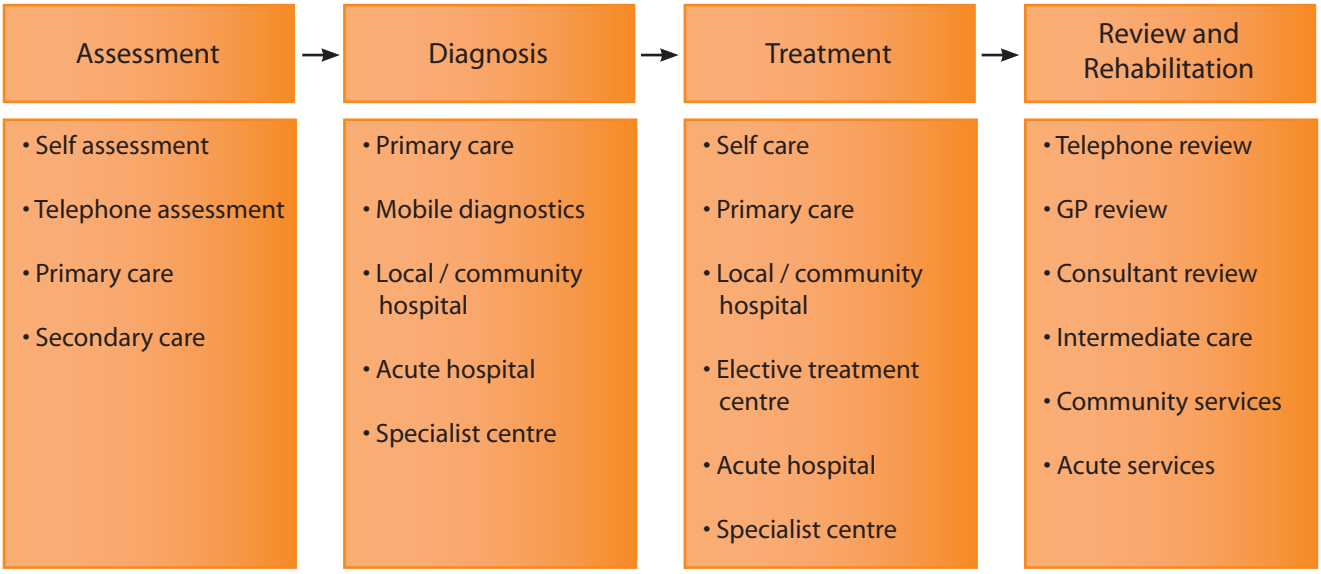
Gary has continual pain in his knee which makes him very irritable. He sees his GP who refers him to a consultant at the acute hospital. At the hospital the consultant requests an MRI scan which Gary returns for on another day. Taking more time off work, he returns for another appointment to be told the result of the scan. With a confirmed diagnosis he is given a date for an operation. After the operation Gary attends physiotherapy and his follow-up appointment with the consultant on a different day. It normally takes Gary just over half an hour to drive to the acute hospital and parking is difficult. However, the time of his physiotherapy appointments means he has to travel in the rush hour and it takes him almost an hour.

> *"In my view, there was no real planning for my breast reconstruction in the longer term. In other words, I came out of hospital and I thought well, where do I go from here ?"* – Patient, planned care workshop

Planned care should provide the most convenient services for patients in the whole system. Patients should have a choice about where and when to get treatment that fits with their lives rather than the structures and bureaucracy of the NHS. And, when the services are delivered, they should be safe and of the highest quality. In other words, if we cannot deliver choice, safety and quality in planned care, then we have a real problem.

In this section the core principle of localise as much as possible, centralise where appropriate is the lynchpin of better services. The emphasis should be on providing as much care as is practical closer to home, rather than in acute hospitals. The pathway, Figure 21, sets out how we will provide services for patients that deliver on the principles, providing what patients need and expect.

Figure 21: Core Planned Care Pathway



Assessment

Most initial assessments for planned care take place in primary care, mainly by GPs but also by dentists, optometrists and occasionally by others, such as pharmacists. The most important thing is that patients have good access to these services. Currently, a sizeable proportion of the public are concerned that access to, and responsiveness of, primary care is not good enough.

To address this, each PCT will work with its practices to tackle issues identified in the national patient access survey and our research identified in the *Case for Change*, in particular ensuring that patients can book ahead. **We want to ensure that public satisfaction on access and responsiveness of primary care is the best in England**, as measured by research both nationally and regionally. PCTs will develop incentives for GP practices to achieve this.

Initially, at least half of the practices in each PCT will offer extended hours outside the core hours of 8am to 6.30pm Monday to Friday. Each PCT will also commission at least one new health centre that will be open 12 hours a day, seven days a week. These new centres will be open by April 2009.

Dentistry is another area where we will improve access. We will ensure that NHS primary dental services are available locally to all who need them. All PCTs will set out clear local standards for access and then identify where there is unmet need and expand provision. PCTs will also be responsible for giving patients information about where to find an NHS dentist who will give them an appointment, as currently happens with GPs.

A further specific area where we will improve access is by greater use of telephone assessment. Telephone assessment can be used to provide both pre-procedure assessment and post-procedure follow-up for many procedures, as is increasingly being used for non-complex surgical procedures.

Together, these new access measures will make it easier and far more convenient for patients to seek help. The next stage of the pathway ensures that diagnosis and routine treatment also becomes much easier.

Diagnosis and Routine Treatment

We will make it easier and quicker for patients to have direct access to diagnostics and obtain results before going to see a consultant thereby reducing the overall length of most care pathways. This approach will be applied wherever possible, with the current system becoming the exception rather than the rule. **A greater range of diagnostics, such as X-rays, ultrasound scans, blood tests and potentially simple MRI scans, will also be available outside of acute hospitals**.

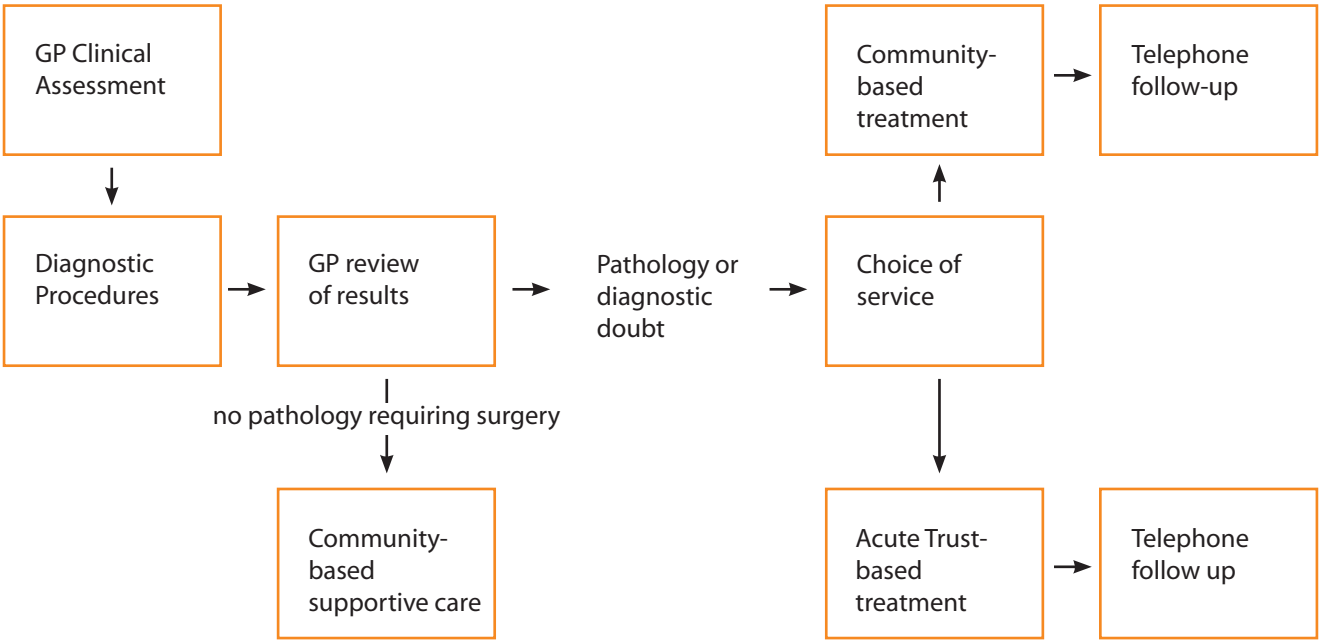
Case Study

Peterborough District Hospital runs a 'one stop' service for people who need a cataract operation. People see an optometrist in their opticians and are directly referred to the hospital for an operation. To increase the convenience for patients, they attend the hospital just once, on the day of their operation. Patients can also still follow the traditional pathway, with a referral for an outpatient appointment with a consultant.

Those patients using the 'one-stop' service are treated quicker than those following the traditional pathway because there are fewer waits in their pathway. This also releases outpatient appointments for the consultants to see other patients, which has helped bring the waiting time between decision to treat and treatment down to eight weeks.

Where the diagnostic results can be assessed by a GP, they will be and GPs will be able to refer directly for surgery depending on the nature of the diagnosis and treatment required. The pathway, Figure 22, is suitable for conditions that are easy to diagnose, are relatively common, have a high conversion rate, i.e. percentage of referrals resulting in a surgical procedure being necessary, and for patients without complex needs.

Figure 22: Pathway with direct access to diagnostics and surgery



Again, to make the planned care pathway more efficient we will split planned care away from acute care as much as possible. This will free acute care to deal with more complex care and emergencies, and reduce the possibility of planned care being disrupted. **There are also a range of more straightforward procedures, such as minor and routine surgical procedures, that do not need to take place in a major acute hospital at all. More of these procedures will be carried out locally through GP practices, community hospitals and elective treatment centres.**

Looking to the Future identified that as services are redesigned, we should aim to commission the following care currently provided in acute hospitals from out-of-hospital settings:

- 40% of outpatients
- 60% of minor planned surgery
- 20% of non-complex planned medicine[43].

This will, of course, vary according to local need but the principles of splitting planned care from acute care; making it easier and quicker to get the diagnosis and treatment you need; and reducing the numbers sent routinely to acute hospitals hold true across the system.

Since 1 April 2008, patients have been free to have their planned care at any provider who meets the national quality standards and can provide that care at NHS prices. We support this policy as key to increasing choice and delivering the quicker and more efficient planned care pathway outlined here. **We will ensure that all patients have a full and free choice of where to go to for planned care**. We will prioritise the roll-out of Choose and Book to make appointments easier for all, and will ensure that all organisations are using the system. We will also ensure all providers extend the range of services available through Choose and Book to more than just consultant-led services.

We want to go further on guaranteeing waiting times as well. As a result of the *Improving Lives; Saving Lives* consultation we have pledged to introduce a maximum waiting time of 18 weeks for a wider range of services including speech therapy, podiatry, orthotics, wheelchair services and orthodontics.

Complex Treatments

As outlined in the *Case for Change* and our *Principles for Progress*, complex treatments, such as pancreatic cancer surgery or cleft lip and palate surgery, are best provided in specialist centres to improve patient safety and clinical outcomes.

The best way to provide complex treatments in a predominantly rural area such as the east of England is through hub and spoke services, with larger hospitals providing a centre for a network of smaller hospitals. This ensures that as much as possible of the care pathway, such as outpatients, diagnostics and follow-up clinics, is local and only the treatment is centralised.

To do this we need to ensure appropriate diagnostic tests, such as early pre-assessment, are arranged before specialist opinion is sought. Patients can then be managed by specific multi-disciplinary teams, specialising in their condition, ensuring continuity of care. One member of the team will be clearly identified as the main point of patient contact, to help them understand their treatment plan and make informed choices at appropriate stages. Integrated information networks will be needed to support these services, with reporting of results available across the network from general practice to the specialist unit.

The majority of planned complex care in the east of England is already provided on a hub and spoke basis. Our immediate priorities relate to the Cancer Reform Strategy and aspects of specialised surgery.

In cancer, we will increase radiotherapy capacity to meet the new waiting time guarantees and increase the availability of chemotherapy in the community, thereby improving access. We are also developing plans to implement the Improving Outcomes Guidance for supportive and palliative care[44] and continuing to implement the guidance on rarer cancers.

***Looking to the Future* identified that alternative arrangements were needed in a number of the surgical sub-specialties to ensure appropriate access to expertise and ensure their sustainability**. These mainly related to specialised and complex orthopaedic surgery, specialised and complex urology, oral and maxillofacial surgery, complex ENT surgery and complex major elective gynaecology surgery and gynaecological oncology. We will establish a programme of work for each of these specialties and agree specific arrangements which will be tested through the principles we have agreed in response to the *Case for Change*.

Review and Rehabilitation

We will make treatment reviews more accessible and convenient because that is what patients have told us they want. We will ensure the most appropriate approach to recovery review is used for each procedure, recognising the needs of the patient and the complexity of the treatment. In keeping with the *Case for Change*, an increasing number of treatment reviews will take place away from acute hospitals, so three approaches will be the key to accessible and efficient review:

- Some procedures do not need a face-to-face follow-up and could be followed up by telephone
- For some procedures the follow-up appointment could be with the GP and not the consultant
- If a consultant appointment is required, the appointment could take place in the local community rather than the hospital.

Greater emphasis will be placed on effective rehabilitation and community-based services to ensure that the patient's stay in hospital is as short as it can be and that recovery is as complete and swift as possible. Care will be provided by the right person, in the right place, at the right time. The ingredients for success which we are committed to making work are:

- Single point of access to community services
- Appropriate skill-mix of community staff and rotation into various settings to increase knowledge and skill
- Joint base for health and social care
- Development of comprehensive intermediate care services and better use of community hospitals
- Co-ordination of rehabilitation and treatment centres.

Conclusion

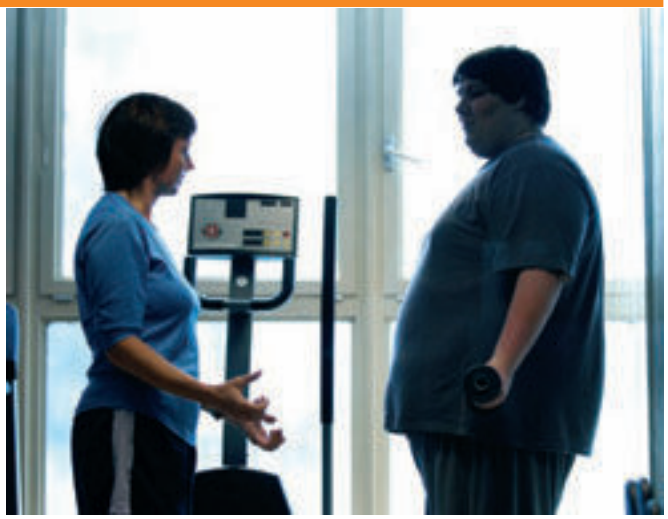
Our proposed changes to planned care all place the convenience of the patient at their centre. Once again, the pathway delivers greater personalisation and care closer to home; cooperation across organisational boundaries; **and a commitment to better outcomes, which will be identified, communicated to patients and the public, and then measured**.

Pen Portrait After

Gary has continual pain in his knee which makes him very irritable. He has an evening appointment with his GP who examines him and refers Gary directly for an MRI scan. The mobile MRI scanner is based at the local hospital and a diagnosis is confirmed. Gary is given a choice of location for his treatment and treatment options are discussed with him, (physiotherapy and/or surgery). Gary decides to have day case surgery at his local hospital, which means his wife can easily pick him up after the operation. He also gets physiotherapy locally rather than at the acute hospital. The new information system in the NHS enables Gary to be reminded of his various appointments by text to his mobile phone and he selects an appointment time with the physiotherapist to fit in with work commitments. His views are also collected on a patient experience tracker. Gary goes back to his GP for his follow-up appointment and is back coaching football within two months.

Acute Care

"Acute care is where we turn when things go wrong, sometimes suddenly. However, we need to recognise that not every hospital can do everything well. Cooperation and specialisation in acute care will save more lives and that is why we make the proposals we do. We need to be prepared to take the tough decisions about centralisation with the clinical confidence that they will produce better outcomes for our patients." – Robert Winter, Consultant and Chair of Acute Care Clinical Pathway Group



Key proposals – we will:

Ensure all 17 Acute Trusts will continue to have an A&E department
Make access easier by creating a new memorable telephone number for urgent care and ensuring consistent triage across all services
Create a series of Urgent Care Centres
Work towards providing 24/7 access to a fuller range of key acute services
Create a series of Urgent Care Centres
Work towards providing key acute services 24/7
Create new specialist centres for stroke, primary angioplasty and major trauma
Introduce universal 24/7 coverage of stroke thrombolysis
Create clinical networks for specialised services

Pen Portrait Before

Fiona is found collapsed in the kitchen by her husband Gary when he returns from doing some shopping. He has only been out of the house for 30 minutes and his wife was perfectly well when he left. Gary immediately phones for an ambulance. A paramedic crew arrive and take Fiona to the nearest Emergency Department. Following triage by a nurse and examination by a junior doctor, a diagnosis of stroke is confirmed. Fiona is admitted to a medical ward and has a CT scan the next day. Over the following weeks in hospital she receives physiotherapy and general nursing care. Fiona makes a gradual recovery over the next few weeks and is eventually discharged home with walking aids and social support.

"You need one part of the system knowing what the other is doing"
– Patient, deliberative event, Norwich

To many the local hospital is the NHS, the largest and most visible symbol of the whole service. It is where we go when catastrophe strikes, and it is where we go for many of our routine treatments and consultations. It is also where we go when we need complex surgery delivered by the most expert staff in the most up to date facilities with the best equipment.

In other parts of this vision we explain how the whole system needs to get better at using, and in many cases, not using the facilities and expertise found in our acute hospitals. This section explains that we must also change the way we deliver acute hospital services to make those services better.

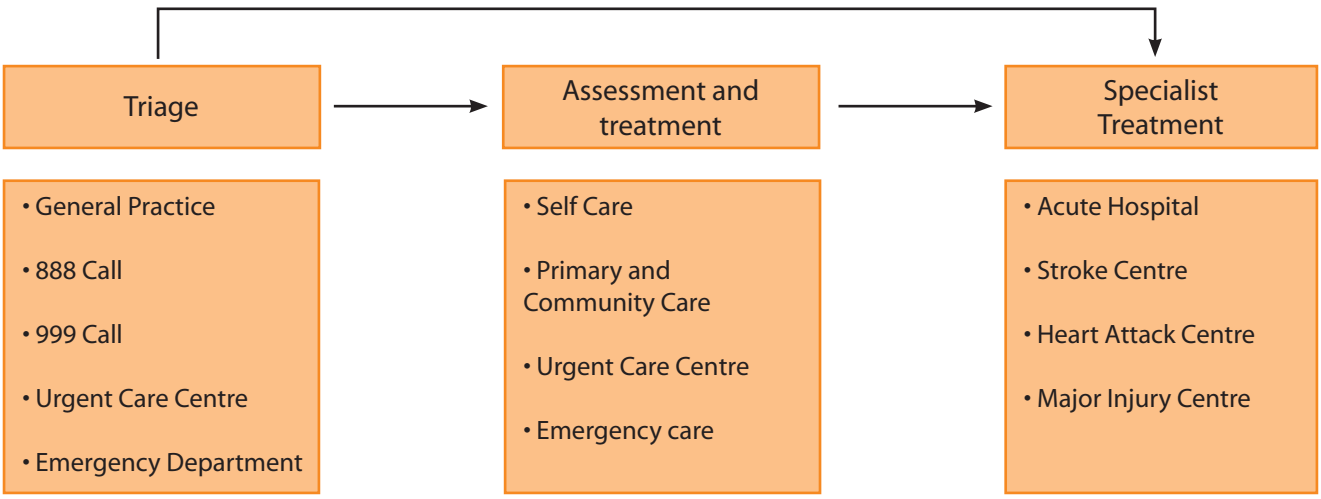
In order to deliver effective A&E care for all, we need an A&E department in every Acute Trust in the region. However, how we access A&E, how it fits with other services, and how we make it the last resort rather than the first port of call all need to change.

In considering acute care services, there are three main issues to address:

1. Where and how are patients triaged and assessed and to which pathway are they directed?
2. What is the first point of contact for patients who:
   a. do not require specialist services and who can be assessed and treated in settings other than an acute hospital?
   b. have acute conditions that should be treated in an acute hospital, either as an emergency or planned episode?
3. How should clinical networks of care be operated, and what are the transport implications, taking account of the rural nature of the east of England?

The proposed pathway (Figure 23) makes it simpler for people who need help to get it by ensuring they are at the start of the pathway and then directed appropriately. **The pathway calls for a single point of telephone access for urgent care**. This approach was supported in Our NHS, our future, NHS Next Stage Review, Interim report, October 2007 – "We should consider options to improve and simplify access for the public to urgent healthcare by exploring the introduction of a single three-digit number in addition to the emergency service number 999." We, in the east of England, believe this will make access easier for patients, and ensure that NHS services are most effectively used to deliver better patient outcomes. We will therefore work with other Strategic Health Authorities and the Department of Health to explore how a new national number (possibly 888) could be introduced. We will also explore how a localised NHS Direct service might fit in with this.

Figure 23: Pathway for Patients with Acute Needs



Triage

The development of new services has given patients more choice but it has also caused confusion about which is the most appropriate service. At present, the system does not always enable patients to have consistent advice about whether their condition requires emergency or urgent attention. It is often this failing that leads to unnecessary use of A&E, rather than a lack of alternative services.

For many patients, A&E is not the right place to go, but it is seen as the catch all answer, the place they know and the easiest choice to make. This is often not good for the patient or for the A&E team and it is this inappropriate attendance which can lead to long waits as emergencies come first.

We will create a system where a clinician assesses the needs of the patient consistently, whether by phone or in person, and then directs them to the most appropriate service. Experienced GPs will be our front line. They have the right skills and are proven to make the right decisions and reduce the number of unnecessary referrals.

We will create a system for guiding patients who arrive at A&E by themselves back to primary care if that is best for them. **To do this we will create a series of Urgent Care Centres, managed by primary care** working with Emergency Care Clinicians. These would act as a gateway to emergency and urgent care, making sure people get the service they need, and freeing up A&E departments for blue light ambulances. The Urgent Care Centres could also be integrated with GP out-of-hours services and the new urgent care number.

Primary and Community Care

Primary care will continue to provide care for most acute illness as it does now, providing continuing care for those with chronic conditions and offering oversight and co-ordination of care. However, if we are to reduce unnecessary hospital attendances as outlined in the case for change then we need to make improvements to primary and community care, especially in out-of-hours provision.

There is no one answer to this, but we will work with PCTs and Acute Trusts to enable services to be delivered beyond 6.00pm Monday to Friday. Some of this has already been addressed in the increased access guarantees we make in the planned care pathway, but we will also look at further use of Urgent Care Centres, GP federations, primary care booking services, next day appointments, pharmacy links and other ideas to create a full service approach after 6.00pm.

The principle of only sending people to hospital when absolutely necessary is key to other areas of care. The management of Long Term Conditions should include clearer plans to avoid unplanned hospital admissions – but also provide acute hospital admission when needed. This is further explored in the section on Long Term

Conditions. Secondary care admissions from residential nursing and care homes should only occur when there is a clearly defined benefit. End of life care plans should also avoid distressing and unnecessary hospital admission at the end of life. Again, this is further explored in the section on end of life.

PCTs and Practice Based Commissioning groups will need to commission new models of care by developing more local alternative services to A&E, as is currently planned in Hertfordshire. In the long run as many as 50% of existing A&E attendances could be seen in an alternative setting. However, the delivery of such a shift will be very challenging and will depend on the development of alternative services that are recognised by the public as being easy to access and reliable, with robust processes to guide patients through the system.

Acute Hospital Care

We know that only people who really need to should go to hospital, but it is important for those patients that their experience is as good as it can be. **We are committed to raising and then maintaining standards for emergency care in all our acute hospitals, providing a fuller range of key services, including diagnostics, 24/7**. Below we set out what patients and their families can expect from acute hospitals who will have to sign up to these basics as a condition of providing acute hospital services.

- Patients attending A&E should be seen quickly by a sufficiently senior doctor able to assess whether they need to be admitted. Wherever possible, the emphasis should be on avoiding the need for admission
- Following admission, the initial assessment of emergency patients should include a doctor of sufficient experience and authority to implement a management plan
- Patients admitted should be seen by a senior doctor within 4 hours
- All assessments must have clear documented management and monitoring plans
- Consultants when on-call should deal with emergency admissions only
- Trainees should have the training and supervision to recognise critically ill patients
- Hospitals who admit emergency patients must have access to both conventional radiology and CT scanning 24 hours a day with immediate reporting
- Following initial assessment and treatment, subsequent transfer should be to a ward that is appropriate for the patient's clinical condition both in terms of required specialty and presenting complaints. Failsafe systems need to be in place for handover of patients between clinical teams
- Excessive transfers should be avoided as these may be detrimental to patients
- Appropriate mechanisms, in terms of alternatives to hospital admission and availability of specialist palliative care, should be in place so that unnecessary admissions are avoided.

The above sections deal with services across all our acute hospitals; local services available to all. This meets the case for change that services should be as local as possible and we should do all we can to find alternatives to hospital admission.

The following sections are about following the best clinical advice on where centralisation of services will save more lives and deliver better clinical outcomes, as identified in our principles for progress.

Stroke Services

About 10,000 people a year in the east of England will have a stroke of varying degrees of severity and up to 2,000 people a year will have a Transient Ischaemic Attack (TIA – a so called mini-stroke where a patient recovers but is at very high risk of having a major stroke). The key to treating these patients effectively is to get them to appropriate care as quickly as possible. The evidence is clear that treating patients this way will lead to better outcomes[45]. Across the east of England, we believe we could save about 50 lives each year, ensure about 50 people did not suffer from major lifelong disability and improve the outcomes for a further 450 people.

The ideal pathway is to treat stroke as an emergency, meaning patients are taken to a specialist stroke centre which has:

- 24/7 access to brain imaging on a routine basis and expert interpretation with an authoritative report within 60 minutes
- 24/7 thrombolysis for those patients who would benefit from it as soon as possible after it is indicated by the brain scan and within three hours of the onset of stroke symptoms. Specialist stroke centres should expect to give urgent thrombolysis to at least two patients a month
- Direct admission to an acute stroke unit with specialist nurses and a multi-disciplinary team
- At least two stroke physicians or consultants with an interest in stroke
- Access to neuro-radiological opinion
- MRI scans for high-risk patients experiencing TIA symptoms within 24 hours and for other patients within seven days
- An ongoing training and educational programme.

After the initial high-risk period has passed, typically 48 hours, the patient should be transferred back to their local acute hospital for further multi-disciplinary treatment and rehabilitation services, again provided in dedicated facilities. **All stroke patients will be seen within a managed clinical network under the care of a stroke specialist at all times**.

We will assess with the cardiac/stroke networks here and in London (recognising that some of our patients use London hospitals) how and by when 24/7 specialist stroke care provision can be delivered. This will include consideration of transfer times and specialist staff availability and will involve a process of accrediting local providers of both specialist and rehabilitation services. **The aim is to guarantee that 100% of our population will be able to have thrombolysis within three hours of the onset of stroke symptoms, should they need it, provided a 999 call is made immediately and the timing of the onset of stroke is clear**.

Primary Angioplasty

Evidence shows that patients who have recently suffered a heart attack have a greater chance of survival and recovery if they are treated in a specialist centre that provides primary angioplasty services[46]. This is an emergency procedure that uses a balloon catheter to open up blocked blood vessels in the heart. It is estimated that about 50 lives a year would be saved by having such services provided across the east of England.

Services for heart attack patients will be developed on the basis of the following principles:

- Heart Attack Centres should provide primary angioplasty services 24/7
- They should be high volume centres undertaking in excess of the recommended minimum activity of 50 primary angioplasties a year
- They should be located to maximise the chance that patients can receive primary angioplasty within two and a half hours of calling for help
- They must have enough interventional cardiologists to provide a 24/7 service, which implies an on-call rota of not less than 1 in 6, and catheter laboratories must be staffed 24/7 by a multi skilled team, including anaesthetic cover
- Patients should be discharged within 48 hours, with follow up and cardiac rehabilitation services established locally with appropriate communication.

This means there can only be a limited number of 24/7 Heart Attack Centres in the east of England. An initial mapping exercise was carried out by the Eastern Region Public Health Observatory to understand the issues of travel times and potential populations served. Taking into account transfer times into and out of an ambulance, the 'door to balloon' times in hospitals, and the requirement for patients to receive primary angioplasty within two and a half hours of having a heart attack, this equates to an ambulance journey time of no more than 75 minutes. Taking these principles into account, and recognising that the southern parts of Hertfordshire and parts of south-west Essex look to providers in North London, the exercise demonstrated that about 93% of the population would be less than 75 minutes from a primary angioplasty centre if there were three such centres in the east of England. This is a significant increase on the 9% who currently have access to these services.

Where it is not possible to transfer patients to a hospital providing primary angioplasty services within 75 minutes, the best treatment is likely to be thrombolysis. In these circumstances, consideration should be given to providing pre-hospital thrombolysis to minimise the delay in providing treatment. Pre-hospital thrombolysis is already provided by the East of England Ambulance Service for some of our PCTs.

Further work will be needed to assess the feasibility and timescales for developing these Heart Attack Centres and to ensure we maximise the proportion of our population who are able to be transferred to a Heart Attack Centre within 75 minutes. Every 2% rise in coverage we can deliver will save one extra life a year in our region. We will therefore explore whether, in addition to the 24/7 Heart Attack Centres, other acute hospitals could provide a primary angioplasty service during daytime hours in the week. This would reduce the delay before patients receive treatment, thereby potentially improving outcomes further.

Major Injury Services

Evidence shows that outcomes are better when patients suffering from severe injury or multiple trauma are treated in centres with all the necessary supporting services and facilities on site[47]. There is a clearly recognised standard for such centres[48]. The future care of the small number of patients with very severe injury should be planned on the basis of:

- Designated major injury centres, with 24/7 access to CT, MRI, vascular surgery, plastic surgery, cardiothoracic surgery and neurosurgery, each serving a population of 2 to 3 million
- Strategic partnerships and clinical networks, covering populations of around 500,000, to provide care for people with less severe injury
- The development of clear protocols and the return, where appropriate, of patients from these major injury centres to local acute hospitals for their ongoing care.

It is likely that this would mean we need one designated major injury centre in the east of England, with some patients from south Hertfordshire and Essex going to similar units in London, in line with existing patient flows. **We will work** with the latest evidence and the best information about how services are currently accessed in the east of England **to identify this major injury centre and make these services available to the people of our region. We will also review the provision of spinal injury services to ensure effective coverage across the east of England.**

Emergency Surgery

The provision of emergency general surgery is a key service for acute hospitals who will need to ensure that the service they provide:

- Is clinically safe
- Has sustainable rotas for all staff
- Is financially viable.

To achieve these criteria they will need to:

- Have a consultant rota that frees consultants of elective commitments when on call
- Be able to staff a rota that complies with the requirements of the European Working Time Directive for 2009
- Have a separate vascular rota that conforms with the proposed vascular surgery model (see below).

Acute hospitals which are unable to meet the above criteria for general surgery on their own will need to provide services in conjunction with another unit on a network basis. The absolute priority is the provision of a clinically safe service.

There is strong evidence that emergency vascular surgery should be provided by specialist vascular surgeons rather than general surgeons, to improve outcomes[49]. This requires a sustainable emergency on-call rota for vascular surgeons. Given current workload, this is likely to mean a rota of 1 in 6 and a broad population range between 600,000 and 900,000.

However, emergency vascular rotas have implications for other disciplines and services. Careful consideration will need to be given to local circumstances, including local morbidity and local geography in terms of travel times. Where services are to be reorganised, **it is likely that a clinical network approach**, whereby two or more hospitals operate a joint on-call rota, rather than centralisation of services **would be the favoured option**, as this will facilitate the maintenance of local elective services to deliver against the principle of local where possible, only centralise where appropriate.

Case Study

The emergency treatment of vascular conditions such as a ruptured aortic aneurysm requires specialist vascular surgeons for the best clinical outcomes. The ideal population for a rota of specialist vascular surgeons to cover is 800,000. A single on-call rota was formed for the 750,000 catchment population between Ipswich and Colchester Hospitals, based on:
3 vascular surgeons on each site and a workable rota of 6 vascular surgeons
An operational policy for the management of vascular emergencies led by the vascular surgeons and with Primary Care Trusts, the Ambulance Service, hospital switchboards, intensive care clinicians, radiologists and Trust management all working together.

Benefits have included:
-The "vascular surgeon of the day" not having to cancel routine elective operating
-Working together on the development of joint screening for abdominal aortic aneurysm across the two sites and a joint audit
-General practitioners being able to get an urgent vascular opinion.

We will also apply our principles for progress to critical care and a series of other surgical sub-specialties to assess the need for the development of clinical networks. These are:

- Emergency out-of-hours ophthalmology services and out-of-hours vitreo-retinal surgery
- Out-of-hours ear, nose and throat services
- Major emergency gynaecology surgery.

Conclusion

The proposals for acute care may appear the most radical in the whole vision, mainly because they deal with the most recognisable parts of the NHS. However each proposal delivers against the case for change and the principles for progress.

They break down organisational boundaries for the benefit of patients; they centralise where needed, but remain local when possible; and they deliver better, measurable, outcomes based on the latest evidence. We make these proposals, on the advice of senior surgeons, GPs and emergency physicians because they pass the ultimate test for change. They will, if implemented in full, save more lives.

Pen Portrait After

Fiona is found collapsed in the kitchen by her husband Gary when he returns from doing some shopping. He has only been out of the house for 30 minutes and his wife was perfectly well when he left. Gary immediately phones 999 for an ambulance. The paramedics carry out a Face, Arm and Speech Test on Fiona which suggests she has probably had a stroke. Whilst transferring her on 'blue light' to the nearest specialist stroke centre, the paramedics collect essential clinical information on the electronic care record which is immediately available to the stroke centre so that staff there can arrange an urgent scan. On arrival, Fiona is met by the stroke physician, assessed and taken for a CT scan. It is estimated that Fiona has had a stroke in the last 60 – 90 minutes and as the scan shows a clot in the brain she is given thrombolysis. Fiona spends a couple of days on the stroke unit and makes enough progress to be transferred to her local acute hospital where she receives multi-disciplinary rehabilitation and life-style advice. She is discharged under the care of her GP and specialist stroke nurse after a further week.

Long Term Conditions

"There is a clear consenus from patients and clinicians about the best care of people with long term conditions: we should do what we can to prevent long term conditions: we should treat people with long term conditions with respect and as individuals (not as long term condition labels): and we should empower people to take control of their long term condition(s) through support, education and their own personal health plan." –
Steve Laitner, GP and Chair, Long Term Conditions Clinical Pathway Group

Key proposals – we will:

Rember that people with long term conditions are people first - "a person with diabetes" and *not* "a diabetic"
Ensure personal health plans for everyone with a long term condition
Extend expert patient programmes
Improve timely access to specialist advice and diagnostics in primary care
Guarantee access to cardiac and pulmonary rehabilitation
Ensure comprehensive disease registers are in place for long term conditions
Increase the emphasis on self care and pilot patient held budgets
Agree and measure a new set of patient outcome and patient experience indicators
Ensure all relevant staff have received training on delivering a self care approach

Pen Portrait Before
Eric has been diagnosed with chronic obstructive pulmonary disease. One weekend he doesn't feel so well. He has a cold affecting his breathing and feels too weak to get out of bed. His wife Molly does not know who to call and she is so concerned at his breathing that she phones 999 for an ambulance. Eric is taken to the local hospital where he is admitted. He is discharged home after 3 weeks. His discharge was delayed as he developed C difficile with the antibiotics he was given.
Molly found it difficult to visit Eric in hospital as public transport to the hospital in Great Yarmouth is poor from where they live. She relied heavily on friends and her daughter in Harlow to give her lifts, but she disliked being so dependant on other people.

"If you know a little they (the doctors) see you as undermining their authority. But we need to know." – Patient, long term conditions workshop

Long Term Conditions such as diabetes, coronary heart disease, high blood pressure, chronic obstructive pulmonary disease, neurological conditions and other disabilities, are extremely common. It is estimated that there are 1.6 million adults in the east of England with a long term conditions . Having an Long term condition can impact significantly on a person's quality of life and that of their carer(s) and family.

One of the cores of our approach is that **we must treat individuals with Long term conditions with dignity and respect, seeing them as an individual who happens to have a Long term conditions, and not an Long term conditions label – importantly, as "a person with diabetes" not "a diabetic"**.

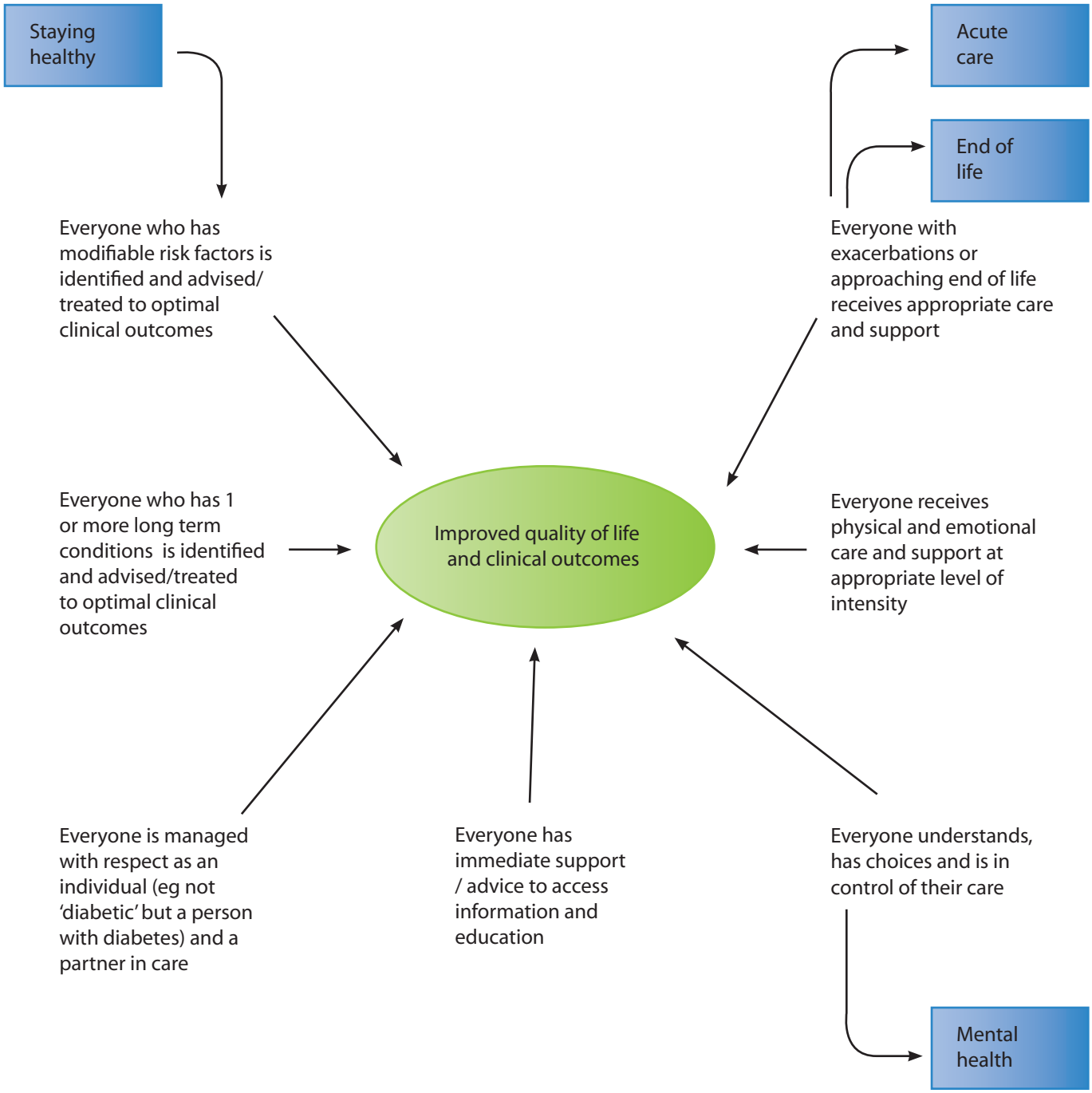
The nature of these conditions means that those who have them and their families need help that is long term and supportive, but also based on an understanding of the individual patient and when and where interventions are needed and wanted. Primary Care Trusts, Practice Based Commissioners, Local Authorities and individuals with long term conditions need to be partners in commissioning multi-disciplinary and integrated Long term conditions services which cover the whole system, using the principles and attributes set out in Figure 24.

Figure 24: Core Long Term Condition Pathway

Prevention	Case Finding & Diagnosis	Management Plan	Exacerbations	Palliative Care
• Population based preventative measures (healthy eating, exercise opportunities, smoking cessation and alcohol harm reduction) will be delivered as part of national and regional programmes • Focussed on children and schools • Prevention of long term conditions is directed at specific at risk groups. • Opportunistic health promotion advice at any health setting • Addresses poor environmental factors	•Screening for long term conditions risk factors is opportunistic and based on personal and family history and lifestyle risk factors • Diagnosis of long term conditions involves; - Knowledge of the presenting symptoms -Prompts and triggers - Protocols - Prompt access to diagnostics and expert advice - Prompt communication of results to patients - Multidisciplinary approach	• Person centred assessment • Personal health plan • Supported self care and management • Supportive attitude of health professionals • Structured education • Easily accessible information • Regular "as required" reviews • Carer/family support – peer and professional • Transitions • Personal care package • Equipment • Enabling rehabilitation • Housing • Finance • Psychological support • Effective medicines management • Pre-conception advice and obstetric care	• Anticipatory care plans linked with out-of-hours and ambulance services • 24/7 community health and social care services • Consistent regardless of entry point • Post exacerbation review	• Integral part of the management plan • Advanced care planning (preferred place of care) • Gold Standards Framework (last year of life) • Liverpool Care Pathway (end of life) • Anticipatory care plans linked with out-of-hours and ambulance services
Services that are: personalised, empowering, effective, integrated = IMPROVED QUALITY OF LIFE				
OUTCOMES				
• Reduction in smoking prevalance • Reduction in childhood BMI levels • Increas in population activity levels	• Improved observed to expected prevelance ratio of long term conditions • Patient survey of diagnostic process	• Patient satisfaction with process of care • Improved condition specific and generic quality of life measures	• Post exacerbation review demonstrates that anticipatory care plan followed • Reduction in emergency admissions for long term conditions	• Clinical review shows advanced care plan followed • Improved ratio of patients wishing to die at home who do die at home

More than any other part of this vision, perhaps due to the sheer number of different Long term conditions and the longevity of the conditions, the links to different parts of the NHS need to be as robust as possible. This is highlighted in Figure 25, which shows how the work of other Clinical Pathway Groups is vital to the delivery of better care for those with long term conditions.

Figure 25: Person (and carer) centred service



Prevention
Many Long term conditions are preventable so we will deliver evidence based interventions known to prevent Long term conditions. These services will be both whole population focussed (such as smoking cessation and encouraging physical activity) and targeted at specific risk groups (for example healthy eating and physical activity promotion for the elderly and certain ethnic groups at greater risk of diabetes). Services need to be both proactive and opportunistic as set out in the Staying Healthy section of this vision.

Case Finding and Diagnosis
As well as preventing Long term conditions, we need to intervene for those who have risk factors or show early signs associated with their onset. We need to use case finding, which includes finding out about smoking status whilst advising cessation support and checking body mass index or blood pressure. We also need to target at risk groups such as smokers aged over 35 years of age (for chronic obstructive pulmonary disease), or obese people with a family history of type 2 diabetes (for diabetes).

As well as identifying those at risk, and providing the appropriate prevention support, we also need to ensure early diagnosis to get treatment quicker and improve outcomes. **We will**, as identified in the planned care section, **ensure timely specialist advice and diagnostic services are available in primary care** including: early recognition of significant symptoms (e.g. chronic cough); diagnostic tests; and specialist advice and support to confirm diagnoses and advise on treatment plans.

To ensure we have the processes, facilities and properly skilled staffing in place to support all with Long term conditions, **we will create comprehensive disease registers and then build a specific staff training programme that supports the self care approach we are proposing.**

Management
There are 8,760 hours in a year – a person with a well managed long term condition may spend 3 hours with their health care professional – that leaves 8,757 hours where they manage their own care, health and well-being.

That is why people need to be empowered to manage their own long term condition. **An increased emphasis on supportive self care and patient empowerment**, recognising the expertise patients and their carers have in managing their own condition, **is essential to improve care and support. To do this we will fund a significant increase of the expert patient programme** and disease related programmes such as DESMOND[50].

To achieve this, people need timely, high quality and personalised information, education, advice and support for themselves and their carers. There are also individuals with particular needs, such as those with depression, dementia, learning disabilities and multiple conditions, who are less able to 'self care' and require additional support and rehabilitation for themselves and their carers, for example through a key worker.

Case Study

The Parkinson's Disease service in Peterborough has been redesigned to ensure appropriate and timely access to specialist advice; improved access to support during times of crises; improved understanding of the condition to enable self management; and improved signposting to therapies and other services.

The hospital and community based clinicians worked with commissioners to move ongoing maintenance care to a community based service focussing on education and support to individuals with Parkinson's Disease and their carers. The service also provides information and local signposting to services such as therapists, benefits advice and vocational rehabilitation.

With less than a full year in operation, the achievements are:
-97 people referred from consultant led, hospital based clinic to nurse led community based clinic

-73% reporting reduced anxiety about having the disease and 91% reporting increased understanding of the disease

-Exercise classes which have resulted in 82% of people continuing with exercise after the programme

-Savings in outpatient appointments alone of nearly £30,000.

To deliver this approach **we will ensure that all people with Long term conditions have an agreed personal health plan** describing their day-to-day self-care, reviews, tests and what to do and who to contact if things get worse. Health plans will also describe and communicate the individual's wishes, choices, and goals for their well being. We will ensure these are delivered across the east of England by 2010, based on a national standard if possible, or one developed specifically for the east of England if necessary.

Our priorities for delivering improvements in disease management are chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, multiple sclerosis and Parkinson's Disease. PCTs will identify two they wish to develop specific improvement plans for over the next year, with a further three areas to be developed the following year and the rest the year after.

These improvements in care will be further supported by us guaranteeing access to cardiac and pulmonary rehabilitation to all who meet the criteria over the next two years. We will also increase renal dialysis capacity by 40% over the next 7 years to ensure the capacity we need is there for projected demand.

Exacerbations
People experiencing a worsening or acute complication of their long term condition need to understand exactly what to do which is why we will give everyone and their carers one contact number for help and consistent high quality advice according to their needs and preferences. This requires us to ensure sufficient services available in the community 24/7 to manage most exacerbations of Long term conditions.

Palliative Care
People with Long term conditions also need clear advance plans for palliative care in their personal health plan. Those nearing the end of their life will be identified using indicators in the Gold Standards Framework[51] which will enable them to enter the end of life pathway identified in the next section of this vision.

Process and Outcome Measurement
To ensure this pathway is delivering the better outcomes it is designed to, **we will collect and review measures which describe the person's experience of the health and social care services they receive and patient outcome measures** such as quality of life (e.g. Euroqol[52]) and condition specific measures (e.g. SGRQ for chronic obstructive pulmonary disease).

All of this work will be supported by a series of pilots we will set up to assess the viability and success of patient held budgets that put even more control and choice into the hands of patients and their carers.

Conclusion

If we implement this pathway comprehensively across the whole region, people with Long term conditions will enjoy an improved quality of life; a feeling of being more in control of their condition; fewer or no exacerbations or complications; a reduction in unnecessary acute admissions or unscheduled care; and potentially for some, if it is their choice, death at home.

These proposals meet the principles for progress in that they are all based upon the creation and measurement of better outcomes whilst putting respect for, and partnership with, the patient at the centre of a pathway that links services across the NHS and beyond. Together, this approach will deliver on one of our *Improving Lives; Saving Lives* pledges, that we will improve the lives of those with long term conditions. It also links to the proposals we make in the mental health section of this vision about increasing support for carers.

Pen Portrait After

Eric has been diagnosed with chronic obstructive pulmonary disease. One weekend he doesn't feel so well. He has a cold affecting his breathing and feels too weak to get out of bed. His wife Molly knows which number to call. The call handler sees on Eric's electronic record that he is on the vulnerable patient scheme and in his record it states that he would prefer not to go to hospital if at all possible. Eric has a management plan for his condition and has supplies of medication at home which he can begin to take immediately. The respiratory nurse is contacted and goes to Eric's house to support him and his wife. With daily visits from the district nursing team, five days later and Eric's breathing is back to its usual condition and he is up and about.

End of Life Care

"We only have one chance to get End of Life Care right. Our aim is to enable people to live well until they die, focussing on quality of life as well as quality of dying. It is essential that the services we deliver provide the best level of care and by putting the patient and their family at the heart of care planning, the End of Life care pathway can deliver this." – Dee Traue, Consultant in Palliative Medicine and Chair, End of Life Clinical Pathway Group

Key proposals – we will:

Deliver world class standards in choice of place of death
Set and monitor core best practice standards for all end of life providers
Create and extend support services for all families and carers, including bereavement support
Ensure needs assessments and advance care planning for all identified as being in their last year of life
Guarantee better access to supportive and palliative care services, particularly out-of-hours
Work with the public and partners to raise awareness of end of life issues
Establish a Palliative and End of Life Care Board and create managed Palliative and End of Life Care networks

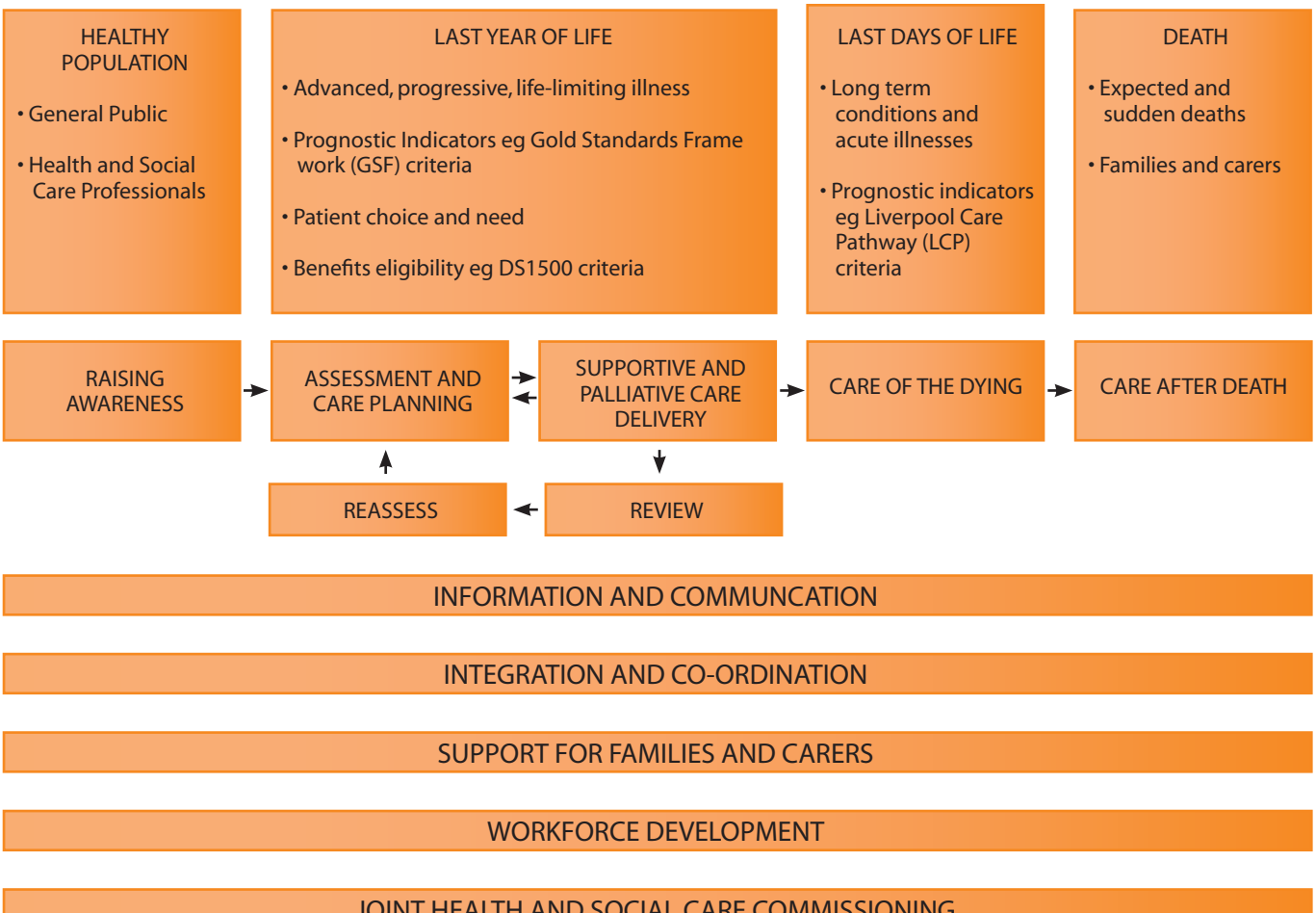
Pen Portrait Before

Sheila is 78 years old and has chronic heart failure. Doctors have told her that this is now very advanced and she has expressed a wish to die at home. One night Sheila has problems breathing and Ron, her husband, calls 999. An ambulance arrives and takes her to A&E from where she is admitted to a general ward. Sheila's condition initially improves slightly but she dies a few hours later in an unfamiliar hospital bed.

> *"Two weeks in hospital, before she died, she was seen by a number of people … including an oncologist, who said chemotherapy was not helpful … The final things that were said to me before she died were, we'll do some more tests and then during the night the nurse said you'd better prepare yourself ..."* – Carer, end of life workshop

More than 55,000 people die every year in the east of England. On average these people are admitted to hospital three times and spend nearly a month of the last year of their life in hospital. Over half of them actually die in hospital. Despite more than 50% of people wishing to die at home, only 20% of them do. Many of these people will have received high levels of support in that last year of life by both NHS and social care services but this may not have met their specific needs and choices. This is reflected by the high number of complaints about end of life care in acute hospitals.

Our vision is to ensure high quality, integrated end of life care to all who need it, irrespective of diagnosis or place of care. We propose a five stage end of life care pathway (Figure 26) to ensure that the level of all care in the east of England is raised to that of the best.



This pathway will need to be delivered across organisational boundaries, making sure that people at the end of their lives and their families receive an integrated service with excellent communication amongst those delivering care. To do this **we will create managed Palliative and End of Life Care Networks that use the Marie Curie Delivering Choice Programme, or a similar model**, which has been shown in Lincolnshire to improve outcomes in preferred place of care and admission avoidance at the same time as reducing costs.

Raising Awareness

Death is not often openly discussed and there are many fears about death and the dying process. We need to make both the public and professionals more aware of the challenges faced by individuals and families at the end of life, and the support available to them. **We will deliver targeted communications campaigns for the public and raise awareness for all health and social care professionals through appropriate education and training to address end of life issues.**

This will help improve the identification of individuals entering the last year of life and ensure that a holistic approach to care is taken rather than one that focuses just on physical problems. It should also help address the cultural shift that is needed to recognise that, for many, death does not represent failure and that enabling people to die well is a core function of health and social services.

Assessment and Care Planning

To make end of life care effective we need to recognise and assess the needs of patients and their families or carers. **All patients identified as entering the last year of life will have a holistic needs assessment, including consideration of physical, psychological, social and spiritual domains. All carers should also have a full assessment to identify their needs.**

We will then begin an advance care planning process. This plan needs to be accessible to all appropriate health and social care staff to share information and decisions, for example as part of an end of life care register.

This process will be based on the **Preferred Priorities for Care** (PPC) document which records patients' key preferences and goals for care. It is not currently used systematically across the region, which is why **we will ensure it is available to all through all providers of end of life care**.

Case Study

In west Essex the Preferred Priorities for Care document was introduced in 2006 to record people's preferences and choices about end of life care. It provided the opportunity to record:

-The patient's thoughts about their care, their choices and preferences, including where they would like to die

-Family profiles and carers' needs

-The services available in the locality and being accessed by the patient

-Changes in care needs.

The system follows the patient through their path of care and information is shared with all relevant health and social care professionals. Of the first 100 patients to use the document, 88% of those who have died achieved their preferred place of death.

Another area where best practice is not being applied for the benefit of our whole population is in the use of the **Gold Standards Framework** (GSF) or an equivalent. This should provide a systematic approach to the community care of patients in the last year of life and act as an end of life care register. It is not being used by all providers, especially by GP practices and care homes with no end of life facilitator or Macmillan GP facilitator. **We will specify that all providers follow this best practice**.

Supportive and Palliative Care Delivery

Whilst we have areas in our region providing excellent **supportive and palliative care services**, this is not available everywhere. Not all health and social care professionals currently have the skills to provide generalist palliative care and access to specialist palliative care is not available in all settings 7 days a week. **Out-of-hours services are an area in particular need of development**.

Generalist Palliative Care from both medical and nursing staff should be available to all patients in all settings 24/7, including appropriate medicines and equipment. When out-of-hours or ambulance services are involved, communication and handover mechanisms should be in place for patients on end of life care registers.

Specialist Palliative Care services should:

- Meet the NICE criteria for multi-professional team composition, providing face to face assessments, 9am-5pm, seven days a week as a minimum with specialist advice available 24/7
- Ensure access to the full range of specialist palliative care services including hospital support teams, inpatient services, day therapy services, outpatient services and community teams
- Ensure that transitional services for children and young adults are developed in line with the Better Care, Better Lives guidance[54].

Supportive care should underpin palliative and end of life care provision, including assessment of need for and, if needed, referral to psychological; social; spiritual; and family and carer support services. **Carers should have access to support** through an expert carers programme and a carers forum which delivers on the feedback we got from the *Improving Lives; Saving Lives* consultation about the role of carers.

We are not currently delivering these levels of care and support across the whole region. This vision says we will invest in and develop services to address these unmet needs.

Care of People who are Dying
To ensure a good death, and minimise distress to patients and their families and carers, we need high quality co-ordinated care in the last days of life. What constitutes a good death can vary significantly between individuals, and a key role of assessment and care planning is to identify personal priorities and wishes.

For many, a good death will include:

- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in the company of close friends and/or family.

The majority of patients would also prefer to die at home. **We will ensure that the east of England delivers world class standards in choice of place of death**.

It is important to recognise that people's views may change over time because of negative experiences or disease progression. It is therefore essential that, as the patient is identified as entering the last days of life, a further review is carried out to establish current wishes.

The **Liverpool Care Pathway for the Dying Patient** is a multi-professional integrated care pathway for the last days of life and provides an evidence based framework of best practice to enable staff to deliver high quality holistic care. **Again, this is not being used universally across the region but we will ensure it is, especially by care homes and primary care services**.

Care after Death
End of life care does not stop at death, but extends to the provision of practical and bereavement support for families and carers. All care settings need to provide streamlined verification, certification and registration of death in line with national guidance and have clear policies for referral of deaths to the coroner and post-mortem examinations. **We will also ensure that bereavement services are available for families and carers if they need them**.

To ensure we deliver this new pathway universally, **we will set up a Palliative and End of Life Care Board** who will set out the framework to be followed by commissioners and providers, and will then monitor delivery against agreed outcomes. This Board will also ensure all PCTs have end of life care registers, to help the sharing of information between service providers, and an effective training programme for all staff, allied to effective workforce planning for the future.

Conclusion

To raise the level of all end of life care in the region to that of the best, there are a number of important areas that need to be addressed. These include, working in partnership with the public and professionals to increase awareness of end of life issues; identifying individuals' wishes and making them central to the care planning process; and ensuring access to high quality personalised services for both patients and carers. These will help more people achieve their goals, including preferred place of death. Central to this is the development and training of a competent and compassionate workforce to support patients and their carers throughout their journey.

This pathway places end of life care where it belongs; an equal partner with other parts of the NHS. It sets out how partnership across organisational boundaries and with the patient and carers are needed to deliver better care; it delivers better outcomes for families, and greater choice for the patient; and it treats people as individuals through the provision of personal plans. This, the final pathway, meets the principles for change and addresses an area that has remained hidden for too long.

Pen Portrait After

Sheila is 78 years old and has chronic heart failure. Doctors have told her that this is now very advanced. Sheila wants to die at home and her key worker draws up an end of life plan that is shared with the family and available to healthcare workers who may need it. The plan is very personal as Sheila is clear about wishing to die at home, not wanting to be resuscitated, and who she wants with her at the end. Having lived in the same house for forty years her neighbours and friends are very important. The daily visitors have meant a great deal to Sheila and Ron. One night Sheila has problems breathing and Ron calls the contact number given by the key worker. A team member arrives who is trained and experienced in end of life care, consults Sheila's personal electronic record, and administers medication to help Sheila become more comfortable. Sheila dies at home with her family and close friends present. Comprehensive bereavement support is provided for Sheila's family after her death.

"You matter because you are you. You matter to the last moment of your life. We will do all we can, not only to help you die peacefully, but to live until you die."
Dame Cicely Saunders, founder of the modern hospice movement

Conclusion

In many respects the core of the NHS will be little different as a result of this vision. The vast majority of people will continue to see their local GP for most of their healthcare needs. Community hospitals and community teams will continue to be important local facilities and trusted providers of care. And, all Acute Trusts will continue to have A&E departments and inpatient obstetric units.

But, in the experiences of those who use the NHS, services will be better, more personal, more integrated and more accessible. This vision makes sure best practice is available to all across the east of England, from maternity care and core standards for IVF, through to better services for those who are dying.

This vision makes a series of guarantees never before made by the NHS about access to services; reduction in waiting times; and choice of place of birth.

It increases choice across the system and the integration of services across organisational boundaries and creates effective partnerships with patients, carers and others in the public and private sector.

It creates new bodies in end of life care and children's services to set core standards and measure their implementation as well as imbedding cross NHS processes for delivering programmes that will benefit from economies of scale.

It promises new staff and better training to deliver on the guarantees and improvements we propose.

It meets the case for change and the aspirations of our population, as well as delivering against the principles for progress. It also points the direction to delivering the pledges we made in *Improving Lives; Saving Lives*.

The vision is clinically driven, evidence based, patient centred and delivers better outcomes that will be measured systematically and communicated to those we serve.

It is the product of thousands of hours work by hundreds of people, including clinical staff, who came together and said the case for change showed action needed to be taken. We are not delivering well enough for enough people. They agreed to recommend change to create a better NHS, and to ensure we, in the east of England, deliver on our vision to be the best health service in England.

In all, this vision is a journey, *Towards the best, together*.


my life story

How we Move Towards the Best

In previous chapters we have described the population and health and healthcare needs of the region; we have outlined a case for change and the principles that underpin that change; we have set out our pledges for a better NHS in the short term and a concrete and detailed vision for the NHS over the next decade. So far, seven chapters of what we plan to do, but now we must answer the question of how we will move from plans to action. This chapter does that.

Moving Towards the best, together will not be easy. It will mean removing old boundaries, and working across organisations and silos to create change. It will mean throwing away old approaches where they don't work to look at how different ways of working can deliver better outcomes. And it will mean focussing on issues and services that too often have been bottom of the pile in terms of investment and priority.

This section highlights how we have already started work to deliver our *Improving Lives; Saving Lives* pledges, and how, if this vision is agreed after consultation, further specific work will help drive us on our journey *Towards the best, together*.

This section highlights a series of cross cutting support mechanisms that will each help shape how the NHS moves forward. These are:

- Leadership
- Quality and Safety
- Innovation and Improvement
- Patient and Carer Experience
- Workforce and Training
- Information
- Commissioning and System Management.

Each, in their own way, will build the vital infrastructure that the NHS and its partners will need to refocus and realign to deliver change.

We then outline 30 first steps; actions that are already in train; actions that we will initiate in preperation for the outcome of this consultation; actions that we will be ready to initiate if the proposals in this division are supported. This is not in any way intended to pre-empt the outcome of the consultation but to ensure that the NHS is ready to move forward quickly once decisions have been taken.

Leadership

Change requires leadership, from the top and from every level of the service. Clinicians need to lead from the front, standing up for change and bringing their colleagues with them on the journey. Managers need to move beyond the day-to-day tasks into leading staff and engaging partners in change and progress. Stakeholders will also need to lead, shaping the vision and delivery around their priorities, but also playing their part in understanding and contributing towards the bigger picture. And patient leadership will also be important to ensure that the patient voice is strong, is heard and is acted on.

Our Talent and Leadership Plan will build on the existing work of the Breaking Through and Gateway programmes, to increase the opportunities for people from Black and Minority Ethnic Groups, and people not currently working within the NHS, to become NHS leaders. Our aim is to identify, support, develop and position talented individuals so that we are 'spoilt for choice' when making senior leadership appointments.

Clinical Leadership

Our NHS is recognised across the national system as being at the cutting edge of identifying and developing leaders. In the past two years we have delivered training and development programmes for nearly 1,000 clinical leaders, including front line staff and consultants.

We are now committed to investing £3 million in each of the next three years, significantly raising our game, to shape and prepare the next generation of leaders, giving them the confidence and skills they will need now and in the future. This new investment will see over 350% more clinicians and other leaders benefiting from leadership development over the next three years as we identify and build leadership skills of 5,000 clinicians and other individuals. These will be leaders at all levels with training provided to meet the needs of them and their teams.

This training and talent programme will be directly aligned to this vision, using the challenges and proposals here to shape our programmes and test our leaders. These practical applications will benefit these leaders when they go back to their organisations and put their new skills and confidence to work.

We have also put clinical leadership firmly at the heart of our own organisation, the SHA. Building on the clinicians that already sit on our Board we have recruited a new Medical Director and four Associate Medical Directors with experience of the acute, primary care, public health and mental health sectors. These new leaders will all continue clinical practice alongside their duties at the SHA, ensuring that real front line experience and knowledge is integral to every decision we take.

That is why we will not allow the Clinical Pathway Groups to wither on the vine now they have delivered their proposals. We will change them into Clinical Programme Boards and charge them to influence and ensure delivery of the visions they created.

Management Leadership

We have created and invested in, Talent and Aspiring Director programmes. We have cast our net wide across the region and identified a group of people who will lead the NHS, alongside their clinical colleagues, within the lifetime of this vision. These managers have been enrolled on year-long Aspiring Directors' programmes which test their skills and knowledge of the NHS, and then identify where they need to improve and develop. These programmes have been made available to every NHS organisation in the region, and again the training is aligned to and driven by the delivery of this vision.

We have also aligned the managerial leadership of the NHS to the delivery of this vision. The Chief Executives of all our PCTs now sit alongside the Executive Team of NHS East of England on the East of England NHS Management Board. This board will shape and monitor the delivery of the vision, spreading best practice and learning lessons where appropriate, and pooling resources where it will deliver a better deal for the NHS and its patients. There has never before been this level of co-operation across our NHS.

Also, within the SHA, the personal and directorate priorities of the whole Executive Team have been aligned to the delivery of the vision. The success or not of individual directors will be judged on how they have helped the vision become real. Staff have also been given permission to tell managers where work they currently do does not contribute to the delivery of the vision and then change focus so that the effort of every member of staff is about delivery.

Stakeholder Leadership
NHS East of England is the first, and so far only, Strategic Health Authority to invest in building partnerships through the appointment of a specific Director of Strategic Partnerships. This post was identified in recognition that we could not deliver our pledges or the rest of this vision on our own – we need to work with stakeholders and partners across the region.

Work has already begun to build these relationships. We have identified a joint programme of priorities with the East of England Development Agency which will bring economic, environmental and health benefits to the region. This includes the work on sustainability and the *Staying Healthy in the Workplace* initiative outlined in the Staying Healthy section.

Further work has also been carried out locally to align Local Area Agreements to this vision, including identifying marginalised groups; supporting smoking cessation; and ensuring we take a full partnership approach, using all the levers available, to deal with the problems of alcohol. We will build on these partnerships to better align community health services with other services provided by local government.

We will also work, with the voluntary sector, like Marie Curie Cancer Care and the regional Carers Forum to ensure their expertise, experience and outlook are drawn upon effectively.

Local authorities and elected local councillors are probably the single most important group of partners the NHS has. Whether through LAAs, aligning local services to create one-stop community centres, or carrying out their legal function to scrutinise proposals for change from the NHS, local authorities are key to delivering progress. That is why we have supported the establishment of a regional Overview and Scrutiny Committee, which brings together all the councils in the east of England that have a scrutiny function, to consider this vision.

These partnerships, and many more, have required leadership and a change of focus by our stakeholders and by the NHS. We have worked to align agendas where possible, and negotiated change where necessary. This is the sort of leadership and partnership building we will need more of over the next decade.

Patient Leadership
Patients have told us that they want to be more involved in their own care and treatment and they want the NHS to meet their expectations more consistently. To do this effectively patients need to continue to make their views known, whether it is ensuring their GPs offer choice, or asking staff to make sure they have washed their hands between treating patients. This is leadership at the sharp end, personal leadership, standing up for your own rights and those of fellow patients.

There also needs to be better organisational leadership by patients. We have already committed ourselves to working with local authorities to ensure our Local Involvement Networks (LINks) which are designed to represent patients are the most effective in the country. We have made clear that we expect these organisations to have adequate resources and have started to create a regional LINks Hosts Network similar to the regional OSC we work with.

We have also started to create a Regional Carers Forum. This body will support and advise the NHS, whilst monitoring our promises to carers, thereby increasing the quality of life of both carers and those they care for.

Finally, the expert patient programme will make sure that patients are leaders in their own care. This programme institutionalises patient leadership, making it central to the delivery of better care.

Quality and Safety

This whole vision will improve the quality of NHS services. Whether by centralising stroke and specialist heart attack treatments, or investing in new clinical staff, the whole thrust is delivering a better quality service to patients and the public.

However a quality service that is not a safe service is not worth having. That is why we have pledged to create the safest health service in England. Do no harm is lesson number one for aspiring clinicians and it must flow through everything our NHS does for everyone who works in it.

We will be investing in quality and safety to underpin the delivery of this whole vision. Currently there is variation in basic standards and best practice is slow to filter through systems. These failings can lead to unsafe services.

We will change this through the leadership programmes and through embedding quality and safety into the business planning, operational delivery and monitoring of every NHS organisation. And we will measure the outcomes, making safety a fundamental driver of choice and a mark of performance.

Our focus on reducing Healthcare Associated Infections has already delivered reductions of 58% in *C.difficile* infections and 32% in MRSA bacteraemias this year, amongst the best in the country, but we are not going to stop there.

We are in the process of establishing an East of England Patient Safety Faculty which will bring together clinicians, patients, staff and managers to facilitate a focus on safety, fighting infection, reducing medication and clinical errors and improving clinical leadership around patient safety, across the whole health system. This Faculty, under the leadership of the National Patient Safety Champion, will establish a patient safety programme that will:

- Be focused on high performing clinical teams with excellent clinical leadership, identifying, improving and measuring the quality of care
- Ensure strong clinical ownership of service performance, alongside patient and family involvement
- Measure quality more rigorously than ever before; with some indicators measured across all services and others developed specifically within individual teams.

This Faculty will spread best practice, provide learning, and intensively support organisations that need it. We will set tough system-wide targets and institute measurement of safety and quality through a bespoke east of England patient safety scorecard for all organisations. One of the measures will be evidence of deep cleaning as an ongoing process across all NHS organisations and facilities, year on year, every year.

We will also hold organisations and individuals accountable for safety, recognising that mistakes happen but having zero tolerance for avoidable mistakes and infections – ensuring proper reporting, responding to serious failures robustly and learning from near misses.

We have already agreed to spending up to £3.75 million over the next five years on an external partner to drive and support system wide patient safety work, learning from results in NHS Scotland. We will also ensure that PCTs reflect not just national priorities but also local priorities for patient safety and quality in contracts with providers.

This focus on quality and safety will be allied to the leadership programmes, be system wide and operate at all levels of every NHS organisation. It is only through delivery on the basics of patient safety that we can hope to hold the confidence and support of our patients, staff and public as we move towards the long term delivery of this vision.

Innovation and Improvement

Elsewhere in this vision we point out that 30% of medicine changes every decade. That is one of the drivers of change and reform. This progress is by design, through the innovation of healthcare professionals and others constantly searching for new and better treatments and processes.

We, in the east of England, have already made our mark, winning three of the four national health innovation awards handed out in 2008. We will build on this by encouraging funding and supporting innovation and improvement ideas from wherever they come.

This need to support innovation has already been recognised at a national level through the establishment of the Health Innovation Council. As well as supporting innovation, this body will lead work in an area where the NHS is not good enough: systematically testing ideas and then adopting system wide the ones that are proved to work. That is why a Health Innovation Challenge Fund is also being created at a national level.

In the east of England we want to build on our reputation for innovation and improvement, going beyond the national drivers. NHS East of England will work in partnership with Health Enterprise East to offer prizes for innovation which help to achieve our pledges. This year we are sponsoring a prize for the best innovation in tackling childhood obesity. The prize will support the development of the idea into practice through our new innovation fund.

Resources will also be available to undertake a critical and health economics appraisal of research evidence and innovation to support our priorities. This will be developed and implemented by Health Enterprise East and the East of England NHS Management Board who will use commissioning practice to encourage, support, test and roll out innovation across all NHS organisations.

Areas for innovation that we want to encourage are: technologies (devices, equipment); drugs (taken forward nationally); clinical processes (improvement of a clinical process within e.g. A&E); and management systems (how services are managed and co-ordinated together).

The east of England is host to a wide range of universities with health or health related faculties, many of which have international reputations in research and development in health related fields. Of particular note is Cambridge University's international reputation for innovation and excellence in biomedical science, including the specialist MRC-funded epidemiology unit, with particular expertise in nutrition and obesity. The University of East Anglia also has an international reputation for research on the impact of climate change. In addition, the east of England is home to one of only five national Biomedical Research Centres, a number of large pharmaceutical companies and many biomedical science and technology companies.

The opportunities that this creates to develop research that links fundamental biomedical science to improvements in patient care are considerable which is why we will be working with our academic colleagues and some of the brightest and best in business through the Research, Development and Innovation Alliance. We will identify areas where we know the problem, but don't know the answer and ask these people to support us in the search for those answers. We will also consider whether creating an Academic Health Sciences Centre should be explored and tested out.

We will not limit our sights to our own backyard. We will work with the PCT Support Unit for Evidence Based Practice to identify and systematically implement best practice and innovation from across the country and the world. We are not, and never will be, ashamed of learning from other countries, cultures and health services.

To support this we have held for the first time this year regional Health and Social Care Awards. These awards reward best practice, innovation and improvement across our local NHS. The winners of these awards this year will each receive £10,000 to help communicate and spread best practice across the region. These awards will now be an annual event and we will add two new awards. One will be for innovation from across the NHS in England; the other will be for innovation from across the globe that we have implemented for the benefit of our people. We will also explore whether the East of England NHS Bank (see below) could establish a small fund to encourage the development of early stage innovations into service delivery.

Improving the Experience of Patients and Carers

Pledge one is to deliver year on year improvements in patient experience. We will set up a monitoring and measurement process for this that will be more sophisticated than any used currently: using real time patient experience trackers; public research; partnership with LINks and expert charities; and an analysis of NHS complaints to create one single measure of experience and confidence in the NHS. This approach to patient satisfaction and public confidence as a core function of ensuring the NHS gets better year on year will be allied to a programme of work that will explore new ways of making PCTs more accountable and responsive to local populations.

We have already taken steps to create a Regional Carers' Forum. This will be supported by the Expert Carers Programme and the Pathway for Carers; identified in the Mental Health section but referring to all carers whoever they care for. We will also ensure that all PCTs have a Carers' Commissioning lead and that all identified carers are offered an annual review of their own health needs and a discussion on the health of the person they are caring for, subject to the consent of that person.

We will carry out and publish a local annual public survey across the east of England to determine local views on NHS services and the organisations that provide them. This survey will support World Class Commissioning and the performance management of PCTs in the region, but will also be a powerful tool for directing change and improvement where need is identified. In addition, we will expect all Trusts to be in the top half of national patient survey findings.

We are also committed to improving the patient experience through better access and more choice, and by reducing waiting times through the introduction and management of waiting time guarantees in services where guarantees have not previously been offered by the NHS. We have already begun this work by managing a region-wide procurement for a new 8am-8pm, 7 days a week GP led health centre in each PCT area to provide more integrated services at more convenient times to local people. If these waiting time guarantees are supported in the consultation we will ensure they are clearly set out in service contracts and will then performance manage the delivery of these targets.

Workforce and Training

The proposed service changes, set out in our vision are radical and will require significant changes to and for our workforce. Essentially, we need to do three things:

- Ensure that we have the right numbers of staff in the workforce, recruiting more if we need to;
- Ensure they are properly trained in skills and competences which will enable them to respond flexibly to the needs of patients and carers, including in perhaps unfamiliar areas like promoting healthy living and recognising patients entering their last year of life;
- Ensure that the workforce is deployed and organised in the places where care will be delivered in the future, breaking down organisational and geographical boundaries where necessary.

We have already begun this work, 18 months ago, in the workforce technical group that supported *Looking to the Future*. More recently we have carried out a risk and needs assessment around the delivery of this vision. This work has identified some of the workforce changes, which we will need to make and, in some areas, we have taken early steps to address them.

More Staff
We have already commissioned an extra 55 training places for midwifery in 2008/09 and will build up the midwifery workforce over the next three years adding at least 160 more midwives to our maternity and new born services.

Similarly, in mental health we are currently tendering contracts with local universities to train and recruit at least 350 more psychological therapists over three years to deliver the specific changes envisaged in psychological therapy services.

Developing Current Staff
However, it is not just about recruitment, it is about developing and improving our current workforce. To do this we have created a regional partnership with the Learning and Skills Council and Skills for Health - the first in the country. This will receive investment of £21 million over the next three years and be specifically aimed at training our support staff. This will enable us to develop new roles to support clinicians such as care assistants and health trainers. That is why we have created an innovative Strategic Workforce Investment Fund for all east of England staff of £20 million for each of the next three years, a total investment of £60 million over the lifetime of the pledges. We have also committed ourselves in the Staff Commitment to ensuring that all funds allocated to the SHA over the lifetime of the pledges for training and development are ring-fenced for that purpose. In addition, we will explore how we could create incentives so that Trusts who provide a good education experience for students would be rewarded accordingly.

Community Services
We need to enhance the skills and capacity of our community workforce. This vision calls for more care to be provided in the community, some of which will be different to that currently provided. This change of focus will require investment, training and support of the existing workforce and identification of where relevant skills and capacity may exist in the acute sector.

Flexibility
We will also need to increase the flexibility of our staff, recognising that staff may now need to travel where before we expected patients to do that. Some of the proposed changes will require staff to work, think and respond to patients and carers very differently to the way they do now. Far more services will be provided by managed clinical networks that cross organisational boundaries and staff will be encouraged and supported to change their working practices accordingly. Many staff will see this as a welcome opportunity to improve their clinical practice and the quality of care which they are able to deliver.

Personalisation
In the future services will be more personalised. Patients and carers want to be more involved in decisions about their care and therefore need more information about their condition and how to manage it and more support when making decisions about treatment. This will place new and challenging demands on staff, sometimes challenging an entire career's approach and outlook to treating patients. This is particularly true in needing to use every clinical engagement to promote prevention and well-being.

All of this will have a major impact on training, whether through changing and improving training programmes or simply buying more training places. This will be a particular issue in ensuring staff are ready and trained to support both the expert patient programme and the expert carer programme.

Managing Change
Change of this magnitude needs to be carefully planned and well managed, involving staff every step of the way.

PCTs as commissioners will need to assess their current position, determine their local priorities and develop local strategies to deliver the vision. Identifying changes needed in the workforce and making those changes happen will be an integral feature of local strategies. To achieve this, we are setting up six County Workforce Groups across the region. Each County Workforce Group will be led by a PCT, with representation from clinicians, service providers, social care, Higher and Further Education, the Learning and Skills Council and Skills for Health. These groups will be responsible for aligning local workforce plans to service and financial strategies and ensuring that resources are invested appropriately.

A Timetable for Workforce Change
Delivering the changes required by, and for, our workforce should not be underestimated, so we have set out a three stage process that will ensure we get it right first time.

June 2008
We will carry out workforce risk assessments which we will share and agree with each of the Clinical Pathway Groups. We will also pilot our future approach to modelling workforce options with children's services and develop a model education and training investment plan with the End of Life group.

September 2008
We will develop options for the future workforce required to deliver each of the clinical visions, in conjunction with the Clinical Pathway Groups.

October 2008-March 2009
We will then enter the delivery and implementation phase, where we will work with both the Clinical Pathway and County Workforce Groups to implement our plans, including the commissioning of new education and training.

All of this work will be underpinned by the Staff Commitment which ensures we work in partnership with staff and their representatives to deliver change sensitively, provide appropriate time, access and support for training and development, and that we measure staff satisfaction year on year.

Information

Access to accurate, timely and integrated patient information is key to the delivery of these changes. Developing this vision has strengthened our understanding of where the gaps are and what we will need to do to fill them. Implementing systems provided by the National Programme for Information Technology (NPfIT) effectively, supplemented by other local systems where necessary, will be essential to achieve our objectives.

This will include online booking services such as Choose and Book; prescription services; summary care records; primary care records; fully integrated primary and secondary records; and the PACS system which allows images such as X-rays and scans to be shared electronically. Integrated primary care records are already available across all community and child health services, and over 25% of our GP surgeries have joined the programme. We intend, where possible, to roll it out to all GPs.

Similarly Choose and Book is already used in 44% of referrals but we will ensure this number is raised to 90% recognising that some clinical reasons will mean not every referral will be via this route. However, we will go further and use Choose and Book to reduce more of our waiting times by extending the technology to other areas where we make waiting time guarantees. We will also promote the use of NHS Choices as a means of giving the public more information about healthy lifestyles as well as choices about treatments and providers.

Much of the current IT investment programme has been about improving the access to, and exchange of, information within the NHS. As we move care closer to home, the use of portable devices and mobile communications will become even more important, so we will ensure that training and policies are in place to protect and encrypt data held like this.

PACS is already revolutionising the way X-rays and other information is passed between clinicians, allowing expert opinion and diagnosis in near real time across organisational boundaries. We will further develop and invest in this technology to guarantee the safety and quality of the clinical networks we will establish as a result of this vision. This will include building on our South West Essex pilot of summary care records and rolling out Lorenzo (full clinical records shared across organisations) over the next four years.

One key strand to information is improving the awareness of what services are available and how to access them. There are a variety of different ways in which this can be achieved, but the role that 'Patient Navigators' could play is one that we will explore more fully. We will also investigate the use of patient-held records.

We will also make use of new real-time Patient Experience trackers which allow information about patient experience to be collected, analysed and acted upon from local wards to cross-regional action.

One area where information is particularly poor is public health data for mental health. Working closely with the Eastern Region Public Health Observatory, NHS East of England will put in place a programme of data development and capture to address this important area.

We will also increase the information and understanding we have of our population through an annual lifestyle survey which will help us direct interventions more effectively to where they are most needed. This will be supported by the work we carry out to measure public confidence and the broader patient attitudes to the NHS via public research on an annual basis.

Commissioning and System Management

This vision sets out a commissioning framework for PCTs. They will need to drive local delivery by ensuring they commission the right services and manage the system and the performance of their providers effectively. Some of this will be driven by local need and local conditions, but in other areas co-operation across the region will deliver better results for patients and the public. That is why the East of England NHS Management Board will be a cornerstone of delivery.

World Class Commissioning, currently being developed by the Department of Health, identifies a set of key competencies for PCTs that will be used to develop them and measure their performance. All 14 PCTs in the east of England will take part in a World Class Commissioning assurance exercise later this year to support the development of NHS commissioning to world class standards.

Alongside the development of their commissioning capabilities, all PCTs have set up, or are in the process of setting up, their provider functions as separate stand alone parts of their organisations. Discussions are continuing as to how best to develop these functions to ensure that the organisational arrangements are sustainable in the long term and will support the provision of the best levels of care.

Co-operation does not end with agreeing joint agendas and priorities. It will need to extend to commissioning joint services with social care. This will be particularly important in children's services; mental health services; long term conditions; end of life care; and the whole area of prevention and well-being. We will also need to devise and implement a programme to get secondary care clinicians more involved in commissioning along similar lines to the potential of Practice Based Commissioning in primary care.

Another aspect of partnership that we wish to explore is that between PCTs and their populations. We would like to develop concepts that build participation, for example PCTs having members, similar to Foundation Trusts, to encourage greater engagement and give the public a greater voice on local priorities.

We also want to explore the potential for creating new ways for ensuring more integrated care between primary and secondary care. We believe that this may be particularly relevant where acute hospitals are located in more rural or remote locations

We are committed to supporting change by reforming the way we pay for and incentivise services. The national tariff, Payment by Results, is actually Payment by Activity. It is too blunt a tool to deliver the complexity of service we propose. We will ensure payment systems are developed to become sophisticated enough to support our changes. This will include unbundling the tariff to recognise that current payments for say, hip operations, include payments for the operation and the recovery, but if more recovery becomes community focussed then we will need to ensure money follows the patient.

The SHA will also take its new responsibilities for managing the system of NHS-funded care very seriously. We will ensure, through effective communication that patients are aware of all the options open to them for choice of care, including independent sector providers who will carry out NHS procedures, free at the point of use, at NHS prices.

We will also set up a regional competition and disputes panel to ensure that those providers who wish to treat NHS patients are playing by the rules, putting patients and care first. This will include closer working with the independent sector, bringing them into the NHS family so that they know providing NHS services comes with responsibilities to ensure safety, quality and service improvement. All providers will be required to report an agreed range of outcome measures in an agreed format that allows direct comparison between providers. We will begin this work by analysing and producing an effective map of all local and regional service providers and then assessing the public's attitudes to using these services effectively.

On a broader front, we will consider what other partnership and liaison groups we might usefully establish. These could include groups with local government; key employers; the Learning and Skills Council; higher education; or the East of England Development Agency (for example), as well as with voluntary and third sector partners or with organisations with specific interests in helping us deliver our pledges. We would welcome any comments on what groups might usefully be established, as part of this consultation process.

All of these changes need to be paid for. We know that the decisions over the last two years to reduce and then abolish debt have been tough, but they put our regional NHS in a strong position to plan and invest. We recognise that some of these changes will require up-front investment and probably some double running costs in the early stages. To help support these strategic decisions we have created the East of England NHS Bank, a pooling of funds from both the SHA and PCTs to support cross border initiatives and pilots of new ways of working or delivering treatment. This supports our assertion that the NHS in our region has the financial stability to pay for the delivery of the vision.

Conclusion

These support mechanisms, from more effective and inclusive training to better collection and use of information show that we are willing and able to start the journey *Towards the best, together*.

Below we lay out our first 30 actions, some already in train, some we will put in train but some awaiting the results of the consultation, ready to go if you agree with our proposals.

1. We are already procuring new GP led health centres in each PCT area that will be open 8am-8pm, 7 days a week by December 2009.

2. PCTs are commissioning to ensure that at least half of their GP practices offer extended hours this year.

3. We have set a target for each PCT to increase the number of people using an NHS dentist and we are supporting this through research to identify areas underprovided with dentists.

4. We are commissioning an east of England public research company who will support measuring patient and public confidence and experience as well as delivering the annual lifestyle survey.

5. We are pushing ahead with the recruitment and development of skills to deliver effective social marketing programmes that will target advice and support on staying healthy, where it will be most effective in reducing unfairness in health.

6. We will invite expressions of interest from east of England providers for providing a range of stroke services and we will assess their ability to meet the relevant quality standards.

7. We will carry out a similar preparatory exercise for the potential designation of heart attack centres and a major trauma centre for the east of England.

8. We are agreeing a set of improvment targets for each PCT to increase the proportion of people dying at home over the next threee years.

9. We are seeking a partner to provide £3.75 million worth of patient safety activity across the whole region.

10. Our cardiac networks are refocussing their work on the priorities set out in this vision; in particular expanding their remit to include stroke and also to focus on heart failure, cardiac rehabilitation and the primary and secondary prevention of coronary heart disease.

11. We have similarly asked our cancer networks to refocus their work on the national Cancer Reform Strategy, including further reducing waiting times for cancer care and preparing plans to increase radiotherapy provision, as well as reviewing the development of services at The Mount Vernon Cancer Centre.

12. We are seeking to identify a pilot for the proposed urgent care number, working with a local PCT, the Ambulance Trust, acute hospitals and NHS Direct to test this idea.

13. We have already started work to recruit at least 350 more psychological therapists.

14. We will ask our Maternity Matters Group to work with our Neonatal Networks to set up Perinatal Networks, taking responsibility for planning uniform pathways of care in the region in addition to planning maternity services for high risk mothers and neonatal care.

15. We will carry out a detailed stocktake of surgical services to identify how change could be carried out for vascular surgery, peadeatric surgery and others before coming forward with detailed proposals.

16. We have already commissioned another 55 midwife training places and will then recruit at least 160 new midwives over the next three years.

17. We have set up an East of England NHS Bank to provide support to the delivery of this vision.

18. We have created the East of England NHS Management Board to monitor and drive implementation of the vision.

19. We have created a £60m Strategic Workforce Investment Fund.

20. We are investing over £9m in a Clinical Leadership Programme.

21. We are establishing an East of England Patient Safety Faculty.

22. We are setting up an Innovation Fund for new approaches to staying healthy.

23. We have already signed the first Workforce Development Programme for support staff in partnership with Skills for Health supported by £20m investment.

24. We are establishing a Regional Carers' Forum and a Regional LINks Host Network.

25. We have already held and will now hold annually regional Health and Social Care Awards to support innovation and reward and recognise staff.

26. We have asked the East of England Specialised Commissioning Group to prepare plans in a number of areas. These include a designation process for neonatal care centres across the east of England, preparing a strategy to increase the provision of renal dialysis and establishing a single set of eligibility criteria for IVF so patients will have the same entitlement wherever they live in the region.

27. We will recast the Clinical Pathway Groups as Clinical Programme Boards to oversee and support the implementation of the vision in their respective areas.

28. We are preparing for a major assurance exercise during 2008 to strengthen commissioning in all our PCTs and are tendering for an external partner to work with PCTs on developing their local strategies later this year.

29. We will roll out the Productive Ward - Releasing Time to Care initiative across the region over the next two years. This initiative aims to reduce paperwork, increase direct patient care and develop and strengthen the roles of ward and community sisters.

30. We will pilot the introduction of patient held budgets for people with long term conditions who have personal health plans.

Consultation and Next Steps

Join us on our journey *Towards the best, together*. Your views are important to us; they will help us ensure we have the right vision for the future. This is your opportunity to make your views known and help shape the NHS across the whole of the east of England, now and for the next decade.

Te consultation runs from 12 May 2008 to 4 August 2008 and you can make your views known in a number of ways:

- You can complete the response form included with this document
- You can write giving us your views using the freepost address below
- You can log on to our website at www.eoe.nhs.uk and complete the online response form or email us via the website

Written responses should be sent to:

Towards the best, together
NHS East of England
FREEPOST
Victoria House
Capital Park
Fulbourn
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We will then carefully review the views expressed during the consultation and present a report to the SHA Board on 25 September 2008 for them to take decisions on the content of this vision.

The next stage after this will be for PCTs to prepare their local strategies. These will set out the PCTs' intentions to improve local services and how this will be achieved. These local strategies will be built on this vision as well as any local priorities. The SHA will work with PCTs to support the preparation of these strategies and will formally sign them off at the end of 2008.

The implementation of this vision will begin once consultation is complete and the final version has been agreed. Any specific service change involving reconfiguration will also be subject to its own specific consultation before changes are made. These consultations will be led by either the SHA or the local PCT, depending on the nature of the proposed service change.

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Glossary of Terms

Acute Care
Medical and surgical treatment usually provided by a hospital. Commonly, care for diseases or illnesses that progress quickly, feature severe symptoms or have a brief duration.

Acute Services
Medical and surgical interventions usually provided in hospital. Specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

Acute Trust
An NHS body that provides hospital based healthcare services from one or more hospitals.

Antenatal
Before birth.

Aortic Aneurysm
The swelling and weakening of the wall of the aorta, the major artery supplying oxygenated blood to the body, which can leak or burst.

Cancer Reform Strategy
Sets out the next phase of the government's commitment to delivery of world class cancer services.

Cardiac
Relating to or affecting the heart.

Cardiovascular system
Effects the circulation of blood around the body.

Cardiothoracic Surgery
The field of medicine involved in surgical treatment of diseases affecting organs inside the thorax (the chest).

Cataract
Any opacity in the lens of the eye that results in blurred vision.

Catheter
A tube that can be inserted into a body cavity, duct or vessel.

Clostridium difficile (C Diff)
An anaerobic bacterium that is present in the gut of up to 3% of healthy adults and 66% of infants. When certain antibiotics disturb the balance of bacteria in the gut, Clostridium difficile can multiply rapidly and produce toxins which cause illness.

Chemotherapy
Refers to treatment of disease by chemicals that kill cells, specifically those of micro-organisms or cancer.

Choose and Book
System that allows patients to make their first consultant outpatient appointment, at a time, date and place that suits them.

Chronic Obstructive Pulmonary Disease
An 'umbrella' term for people with chronic bronchitis, emphysema, or both.

Cleft Lip
Commonly known as hare lip, it is where the skin and tissue do not develop normally below the nose of a fetus during pregnancy.

Clinical Network
A group of health professionals from different NHS organisations working together across institutional and local boundaries.

Clinical Pathway Groups
The eight clinically led groups set up under Our NHS, Our Future to produce a vision of how clinical services should be delivered in the future.

Chlamydia
A sexually transmitted infection (STI) caused by a tiny bacterium, Chlamydia trachomatis.

Commissioning
The process in which health service and local authority agencies identify local needs for services and assess them against the available public and private sector provision. Priorities are decided and services are purchased from the most appropriate providers through contracts and service agreements.

Coronary Heart Disease
Narrowing of the coronary arteries that supply blood to the heart.

CT scanner
A computerised tomography scanner is a special kind of X-ray machine.

Deliberative Event
When the public, patients, service users, and staff become actively involved in the shaping of policy through interactive consultation events.

Dementia
The loss (usually gradual) of mental abilities such as thinking, remembering, and reasoning.

Diabetes
A condition in which there is too much glucose in the blood.

Diagnostics
Diagnostics are tests or procedures carried out in order to reach a diagnosis that is a decision on the nature of a patient's condition.

Emergency Care
Emergency care is provided to patients suffering a medical or surgical emergency, such as a stroke, heart attack or severe injury.

Endocrinology
Endocrinology is the science of the endocrine glands, including the thyroid glands, pituitary glands, pancreas, ovaries and testicles.

Euroqol
The EuroQol Group has developed a standardised non-disease-specific instrument for describing and measuring quality of life.

Exacerbations
An exacerbation is the worsening of a condition. In medicine, exacerbation may refer to an increase in the severity of a disease or its signs and symptoms.

Feto-maternal services
Feto-maternal services focus on the health of the mother and fetus, and offer screening and diagnostic tests to identify any problems during pregnancy.

Forensic
Forensic medicine combines knowledge of the law with that of various branches of medicine; a forensic practitioner within medicine is someone who provides medical evidence for court proceedings.

Foundation Trust
Foundation Trusts were introduced in 2004 and have been given much more financial and operational freedom than other NHS Trusts. Foundation Trusts are run by local managers, staff and members of the public, which are tailored to the needs of the local population.

Gold Standards Framework
The Gold Standards Framework is a framework to enable gold standard care to all those in their last year of life and improve the quality of life for both patients and carers.

GP
General Practitioners are doctors who work from a local surgery or health centre providing general medical advice and treatment to patients who have registered on their list.

Gynaecology
Gynaecological medicine relates to disorders affecting the female reproductive organs, i.e. ovaries, uterus and vagina.

HCA
Healthcare assistants (also known as nursing assistants and nursing auxiliaries), support healthcare professionals with the day-to-day care of patients, either in hospitals or in patients' own homes.

Healthcare Associated Infections
Healthcare associated infections are infections, such as MRSA or Clostridium difficile that are acquired in hospitals or as a result of healthcare interventions.

Healthcare Commission
The Healthcare Commission is an independent inspection body for both the NHS and independent healthcare providers.

Holistic Care
Holistic care can be described as care of the whole person, taking into account physical, psychological, social and spiritual needs.

Hypertension
Hypertension is more commonly known as high blood pressure – a patient will be diagnosed as hypertensive if they have a sustained blood pressure of 140/90 mmHg or over.

Intensive Care
Intensive care medicine or critical care medicine is a branch of medicine concerned with the provision of life support or organ support systems in patients who are critically ill and who usually require intensive monitoring.

IVF
In vitro fertilization (IVF) is a technique in which egg cells are fertilised by sperm outside the woman's womb, in vitro.

Learning and Skills Council
Learning and Skills Council has a single goal: to improve the skills of England's young people and adults to ensure England has a workforce of world-class standard.

Local Area Agreement
Three year agreement that sets out the priorities for a local area in certain policy fields as agreed between government, local authority and other partners.

Local Involvement Networks (LINks)
Local Involvement Networks aim to make it easier for citizens to say what they want from health and social care services, to talk with the people who run them and to hold them to account. Run by local individuals and groups, a LINk is being established in every area in England.

Lorenzo
An electronic system that will create single, standard electronic records and therefore remove the need for paper records.

Maxillofacial Surgery
Oral and maxillofacial surgery is surgery to correct a wide spectrum of diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the oral and maxillofacial region.

Mental Health Trust
Provides treatment and care for patients who are mentally ill. The services may be provided from a hospital or in the community.

Minor Injury Unit
Minor injuries units (MIUs) are used for less serious injuries, such as sprains, cuts and grazes. Many people go to accident and emergency (A&E) when they could be treated just as easily, and sometimes quicker, at a minor injuries unit.

MRI Scanner
A magnetic resonance imaging (MRI) scan is a special technique that uses magnets and radiowaves to produce two and three-dimensional pictures of the inside of the body. These images can help clinicians to make a diagnosis about a number of conditions.

MRSA
Bacteria that can cause infection in a range of tissues such as wounds, ulcers, abscesses or bloodstream.

Multiple Sclerosis
Multiple sclerosis (MS) is a neurological condition that affects the transfer of messages from the central nervous system to the rest of the body. As there is no cure, medical treatment concentrates on symptom relief.

National Institute of Clinical Excellence (NICE)
An independent organisation that provides national guidance on the promotion of good health and the prevention and treatment of ill health.

Neonatal
Pertaining to the first four weeks after birth.

Neurology
Diagnosis and treatment of diseases and disorders of the nervous system.

Neuroradiology
The clinical subspecialty concerned with the diagnostic radiology of diseases of the central nervous system, head, and neck.

NHS Direct
A service providing 24 hour access to health information and clinical advice, via telephone, the NHS Direct website or the NHS Direct Interactive digital TV service.

Optometrist
Trained professionals who examine eyes, test sight, give advice on visual problems, and prescribe and dispense spectacles or contact lenses. They also recommend other treatments or visual aids where appropriate.

Orthotics
The science and technology of braces, especially when supporting weak or injured joints and muscles.

Orthodontics
Orthodontic treatment is a way of straightening or moving teeth, to improve the appearance of the teeth and how they work. It can also help to look after the long-term health of the teeth, gums and jaw joints, by spreading the biting pressure over all the teeth.

Outpatient
A patient who is not an inpatient (not hospitalised).

PACS
In medical imaging, picture archiving and communication systems (PACS) are computers or networks dedicated to the storage, retrieval, distribution and presentation of images.

Paediatrician
A doctor who specialises in treating babies and children.

Palliative Care
Palliative care is any form of medical care or treatment that concentrates on reducing the severity of disease symptoms, rather than halting or delaying progression of the disease itself or providing a cure.

Pancreatic Cancer
The pancreas is responsible for producing digestive enzymes and a substance known as insulin. Tumours can be benign (not cancerous) or malignant (cancerous).

Parkinson's Disease
A degenerative disorder of the central nervous system that often impairs the sufferer's motor skills and speech, as well as other functions.

Perinatal
The perinatal period commences at 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500 g), and ends seven completed days after birth.

Perineum
The surface region in both males and females between the pubic symphysis and the coccyx. The perineum is the region of the body inferior to the pelvic diaphragm and between the legs.

PET Scanner
A nuclear medicine imaging technique which produces a three-dimensional image or map of functional processes in the body.

Plastic Surgery
Plastic surgery is concerned with repairing and restoring skin and tissue, whether present from birth (congenital) or caused by disease aging or injury.

Podiatry
A field of healthcare devoted to the study and treatment of disorders of the foot, ankle, and the knee, leg and hip.

Postnatal
Of or occurring after birth, especially during the period immediately after birth.

Practice Based Commissioning
This sets out proposals for involving GP practices in commissioning health care services such as a greater variety of services, from a greater number of providers in settings that are closer to home and more convenient to patients.

Primary Care
Primary care is the care provided by people you normally see when you first have a health problem. It might be a visit to a doctor or a dentist, an optician for an eye test, or just a trip to a pharmacist to buy cough mixture. NHS walk-in centres and the NHS Direct phone line service are also part of primary care. All of these services are managed by the local primary care trust (PCT).

Primary Care Trust
An NHS Body responsible for identifying from within their available resources the healthcare needs of their relevant population, and for securing through their contracts with providers a package of hospital and community health services to reflect those needs. PCTs have a responsibility to ensure satisfactory collaboration and joint planning with local authorities and other agencies.

Pulmonary
The pulmonary arteries carry blood from the heart to the lungs.

Quality and Outcomes Framework
The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004.

Radiotherapy
Radiotherapy is a common treatment for many cancers. It is often used with other treatments, such as surgery or chemotherapy. However, there are some benign conditions that can be treated, such as thyroid disease or bone formation around a hip replacement.

Respiratory Disease
Respiratory disease is an umbrella term for diseases of the respiratory system. These include diseases of the lung, bronchial tubes, trachea and pharynx. There are many such conditions ranging from mild and self-limiting (e.g. the common cold) to life-threatening (e.g. bacterial pneumonia or pulmonary embolism).

SENCO
Special educational needs coordinators (SENCOs) have responsibility for managing the effective delivery of the education psychology service, learning support, behavior support, special educational needs assessment and administration, and parent support.

SGRQ
St George's Respiratory Questionnaire is a standardized self-completed questionnaire for measuring impaired health and perceived well-being ('quality of life') in airways disease.

Socio-economic
Socioeconomics or socio-economics is the study of the relationship between economic activity and social life.

Statin
The statins (or HMG-CoA reductase inhibitors) are form of drugs used to lower cholesterol levels in people with or at risk of cardiovascular disease.

Strategic Health Authority
Strategic Health Authorities are responsible for developing plans for improving health services in their local area. Strategic Health Authorities manage the NHS locally and are a key link between the Department of Health and the NHS.

Strategic Needs Assessment
Strategic Needs Assessment in partnership with the local community identifies priorities for action that will improve the health and wellbeing of the population. Assessment will improve access to data about the needs of the population by those who, now and in the future, plan and deliver services.

Thrombolysis
The main treatment for heart attack is the administration of clot dissolving drugs (thrombolysis) which help to restore blood supply in the coronary arteries to the affected part of the heart.

Urgent Care Centre
The Urgent Care Centre (UCC) is a new service designed to treat patients who have minor injuries or minor health problems. You will be seen by a range of professionals, who are qualified to manage minor injuries and minor illnesses.

Urology
Urology is the branch of medicine that focuses on the urinary tracts of males and females, and on the reproductive system of males.

Vascular Surgery
Vascular surgery is a subspecialty of general surgery in which diseases of the vascular system, or arteries and veins, are managed, largely via surgical intervention.

Vitreoretinal Surgery
Retinal and vitreous surgery address problems such as Retinal Detachment and Intraocular Infection. Retinal and vitreous problems can cause severe loss of vision or even blindness.

0*Walk In Centre*
Walk-in centres provide nurse led care for minor injuries and illnesses and general health advice. The pilot centres are located in major towns and cities throughout England.

Consultation criteria

This consultation document has been drawn up in accordance with the key consultation criteria as laid out in the cabinet Office Code of Practice on Consultation.

The consultation criteria are:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.

2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.

3. Ensure that your consultation is clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced the policy.

5. Monitor your organisation's effectiveness at consultation, including the use of a designated consultation co-ordinator.

6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The code states that these criteria must be reproduced in all consultation documents.

It is also important to bear in mind Cabinet Office consultation guidance which says… "When analysing responses, remember that consultation is not a public vote: you should afford most weight to the most cogent ideas and argument."

And finally, please note that the patient stories contained in this consultation document are simply narrativ examples. They are not real stories. Patient confidentiality prevents us from using real life examples butthese are typical case studies of patient care. Any resemblance to any real person is entirely coincidental.

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Panel Date	Decision	Action	Response	Date for Future Action
	Town Centre Cleaning Regimes			
1/11/05	Cleaning regimes in town centres added to the programme of studies.	Scoping report requested.		
3/10/06	Presentation by Head of Operations. Working Group formed to look at Sunday cleaning and enforcement.	Meeting of Working Group held on 13th November 2006. Further meeting to be held to consider a possible pilot of new cleaning arrangements in St Ives.		
3/07/07	Further update requested.			
6/11/07	Update received from Head of Operations.			
8/01/08	Report requested giving details, including costs, of providing a full cleansing service on every day of the week.	Report requested.	Report submitted to Panel's July meeting and Panel's concluding report to Cabinet's September meeting. The matter is raised elsewhere on the Agenda.	**7/10/08**
	Disability Access			
7/11/06	Preliminary report considered. Further information requested on the Council's existing policies on disability equality and access and on research in this area.	Further reports submitted.		

Panel Date	Decision	Action	Response	Date for Future Action
	Disability Access (Cont)			
5/12/06	Disability Equality Scheme and Action Plan endorsed. Further research to be undertaken within Members' wards and officers of the County Council and of the Police requested to attend future meetings to discuss the study.	Representatives of the County Council and of the Police invited to future meetings.		
6/02/07	Panel met with representatives of Speaking Up and G Morris. A number of matters were identified for further consideration. – improved enforcement of disabled parking bays, extending bus pass hours for disabled users, Council paperwork, advertising of disabled facilities at leisure centres and advocacy services at Council offices.	Report submitted to the Cabinet on high dependency toilets on 28/06/07.	The Cabinet decided to approach Papworth Trust for their advice on the need for high dependency facilities for people whose disabilities are so severe as to prevent them from using conventional toilets designed for the disabled and in particular on the possibility of extending the availability of facilities at Saxongate, Huntingdon for such use.	
5/06/07	Meeting attended by County Council's Access Officer. A number of avenues identified for further investigation. Cabinet to be requested to consider providing high dependency toilets.	Survey sent to Town and Parish Councils and District Councillors. Returns received.		
4/12/07	Findings of survey considered. The Panel requested: • further consultation with Town and Parish Councils on dropped kerbs and parking, the findings of which will be forwarded to the County Council	Further consultation documents despatched.		

Panel Date	Decision	Action	Response	Date for Future Action
	Disability Access (Cont) and police respectively for action/comment; • that views on the need for more low liner buses and training for employees on the needs of those with disabilities be forwarded to bus operators; • that a suggestion that carers be provided with free bus passes be forwarded to the County Council; • details of potential consultees on Council policies and services representing local disability groups. • that a representative of Directions Plus be invited to a future meeting to discuss the study; • further investigation of the existence of the Disability 'Blue' Route scheme implemented by the Council; and • that investigations be made on the use of Blue Badge parking permits, to include the procedures involved in applying for a permit.	Letters sent to bus operators. Carers UK consulted. List submitted to meeting in January 2008.	Presentation received at Panel's April 2008 meeting. Advised that the Papworth Trust did not have Disability 'Blue' Routes in the District. The Council's Supervising Inspector reported that very little enforcement action is taken towards Blue Badge Holders.	

Panel Date	Decision	Action	Response	Date for Future Action
	Disability Access (Cont)			
4/03/08	Suggestion made to invite a representative from Hunts Forum of Voluntary Organisations to a future meeting to discuss the study.		Presentation received at Panel's July 2008 meeting.	
1/07/08	Working Group established comprising Councillors Mrs M Banerjee, S J Criswell, Mrs K E Cooper and Mrs J A Dew to review the findings of the study.	Meeting held on 8th September where a number of issues have been raised for further investigation. Further meeting to be held on 9th October.		
	Adoption of Roads and Sewers			
5/12/06	Study to be undertaken into the processes and procedures involved with the adoption of roads and sewers.	Information requested.	Scoping report to be submitted to a future meeting. Representative of the Anglian Water to be invited to attend a future meeting to discuss the study.	
5/06/07	Report deferred to next meeting.	Meeting to be arranged.	First meeting held on 22/10/07.	
3/07/07	Working Group established comprising Councillors J D Ablewhite, D A Giles, Mrs C A Godley and P K Ursell, to undertake a review on the process of adopting			

Panel Date	Decision	Action	Response	Date for Future Action
	Adoption of Roads and Sewers (Cont) estate roads and sewers with an aim to put measures in place that will streamline the process and make the procedures more transparent, initially by an investigation of introducing a District-wide register of un-adopted roads and sewers.			
4/12/07	Working Group held meeting with the Principal Building Control Officer.			
5/02/08	Further meeting to be held with Head of Planning Services, Projects and Assets Manager and representatives Highway authority.	Meeting arranged.		
4/03/08	Councillor Mrs P A Jordan appointed onto the Working Group in place of the late Councillor Mrs C A Godley.	Meeting held on 11/04/08.		
03/06/08	Owing to their interests in the study, Councillors M F Shellens and J S Watt were appointed on to the Working Group.	Meeting held on 24/07/08.	Various information sought from DEFRA, Anglian Water and the County Council. A further meeting will be arranged pending the receipt of this information.	

Panel Date	Decision	Action	Response	Date for Future Action
	Grant Aid			
5/12/06	Study to be undertaken into the processes in applying for grant aid and the effectiveness of grant schemes.			
	Details of all grant schemes requested.	Information requested.		
	Review of Small Scale Environmental Improvement Schemes to be undertaken.		Meeting held on 24/10/07 to plan further study work.	
3/4/07	Details of all grant schemes considered. With the exception of Shopmobility, the Working Group undertaking the review of the Small Scale Environmental Improvements scheme was requested to examine the schemes' criteria, publicity, application process, officer involvement and approval process.	Meeting arranged.		
4/12/07	Review of Small Scale Environmental Improvements Scheme completed. Working Group awaiting further information on other grant schemes administered by the Council.	Meeting held on 1/02/08.		
	Details of grant schemes circulated. Meetings to be held with various Heads of Service to discuss capital and revenue grant schemes falling within their remits. Investigations nearing completion.	Meetings held on 20/03/08, 26/03/08, 7/05/08 and 24/07/08.	Final meeting of the Working Group anticipated late October.	

Panel Date	Decision	Action	Response	Date for Future Action
03/06/08	**Great Fen Project** Discussed at the Panel's June meeting as a potential study area. Some concerns raised regarding the present financial situation that the project was facing.			
01/07/08	Update received by Councillor P G Mitchell at Panel's July meeting. Chairman reported that the Service Support Panel would be undertaking a study on the matter and invited Members to nominate themselves to partake in the study. In that light, Councillors E R Butler, P G Mitchell and J S Watt expressed their interests in the study.	A presentation on the Great Fen will be received at the Service Support Panel meeting on 11th November 2008. All Service Delivery Panel Members will be invited to attend the meeting.		**11/11/08**
03/06/08	**Impact Of The New A14 In Terms Of Air Quality And Noise Pollution** Suggestion made by Councillor M F Shellens to review the impact of the new A14 in terms of air quality and noise pollution in light of the problems being experienced within his Ward.	Information sought from the District Council's Environmental and Community Health Services Division.	Advice received. Councillor M F Shellens to report back thereon at a future Panel meeting.	**07/10/08**

Panel Date	Decision	Action	Response	Date for Future Action
2/09/08	**Call Centre Monitoring** Following recent changes to the Panel's remit (with effect from 1st September 2008), Call Centre Monitoring has now been transferred over from the Service Support Panel to the Service Delivery Panel. Quarterly performance reports to be circulated informally to Members of the Panel (June and November of each year) and an Item included on the Agenda every 6 months in future (February and September of each year). Since the formation of the Customer Service Team in February 2008, quarterly performance reports for the Customer Service Team are now produced, incorporating Call Centre statistics. Requests made for future performance reports to incorporate additional information relating to the number of unanswered telephone calls received by the Call Centre and the number of enquiries that were not the responsibility of the District Council.	Formal report to be considered at Panel's September 2008 meeting. Next performance report expected November 2008 – to be received informally.		**04/11/08**

Panel Date	Decision	Action	Response	Date for Future Action
2/09/08	**ICT Developments** Remit transferred over from the Service Support Panel in September 2008. Update on Flexible Working Strategy to be received at October Panel meeting. Report on the outcome of the home working project in the Revenues and Benefits and Environmental and Community Health Service Divisions to be submitted to a future meeting.		On October Panel Agenda – presentation to be received by the Head of Information Management. Report anticipated at Panel's November meeting.	**7/10/08** **4/11/08**
14/05/08 **02/09/08**	**Corporate Plan – Growing Success** Councillors Mrs M Banerjee, S J Criswell and P G Mitchell appointed to Corporate Plan Working Group. In considering the Review of Growing Success the Corporate and Strategic Framework Panel decided to extend the Corporate Plan Working Group's remit by	Meetings held in June and July to review the Corporate Plan. Bi-annual reports to be submitted to Overview and Scrutiny Panels in March and September of each year. Financial information to be considered at future Working Group meetings.		

Panel Date	Decision	Action	Response	Date for Future Action
	Corporate Plan – Growing Success (Cont) requesting it to investigate the cost implications of each priority area identified within the Corporate Plan.			
1/07/08	**Forward Plan** **Sub-Regional Housing Strategy** Requested that report should be considered at a future Panel meeting. **Community Engagement** Requested that the report should be circulated informally to Panel Members as soon as it becomes available.		To be included on Agenda for November meeting. Expected early October 2008.	**4/11/08**