Supplementary Committee Agenda

SCRUTINY

Epping Forest District Council

Overview and Scrutiny Committee
Thursday, 11th December, 2008

Place:	Council Chamber, Civic Offices, High Street, Epping
Time:	7.30 pm
Committee Secretary:	Simon Hill, Senior Democratic Services Officer, The Office of the Chief Executive email: shill@eppingforestdc.gov.uk Tel: 01992 564249

10.a Joint PCT Scrutiny in West Essex (Pages 3 - 44)

(Assistant to the Chief Executive) to consider the attached report.

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Joint Report to Overview and Scrutiny Committees for Epping Forest, Harlow and Uttlesford

Date of meetings: 11 December 2008

Subject: Joint PCT Scrutiny in West Essex

Officer contact for further information: Simon Hill (Epping Forest), Mark Sloan (Harlow), Simon Martin (Uttlesford)

Committee Secretary: Adrian Hendry

Recommendations/Decisions Required:

(1) That the Committee consider its participation in a pilot joint scrutiny arrangement for West Essex PCT on the following basis:

(i) the Council having an equal stake in the membership of the group;

(ii) the topic and objectives of any scrutiny being agreed by all three district council's and the PCT;

(iii) the Essex HOSC being informed of the proposed scrutiny, scoping document and objectives of any review;

(2) That, subject to recommendation (1) above:

(i) the Committee put forward ideas for areas of review to be considered further by the Joint Group; and

(ii) the Committee appoint three members to the Group.

Report:

1. Following a review West Essex PCT was created covering the local government administrative areas covered by Uttlesford, Harlow and Epping Forest by combining PCT's previously based on solely district boundaries. The Districts have managed to maintain their strong links with the PCT and from time to time, PCT representatives attend Overview and Scrutiny meetings to discuss matters of both local and strategic interest.

2. At a County level the Health Overview and Scrutiny Committee (HOSC) have the statutory duty for health scrutiny. The work of the HOSC tends however to have a wider strategic remit across Essex rather than having a specific focus on west Essex. Recently HOSC has set up a Task and Finish Review which proposes review the way in which the West Essex PCT plans for and commissions services to meet projected changes in demands and the impact of reconfiguration or change in provision. Its thrust is to look at the strategic commissioning of primary care services, particularly in light of housing growth, development and capacity to ensure robust plans and infrastructure are in place. The full scoping document for the review is attached as Appendix 1.

3. Harlow members have expressed an interest in undertaking a piece of health scrutiny jointly with Uttlesford and Epping Forest on a service level basis. As an example, the recent PCT report into their proposed Strategy for Healthcare for 2008-2012 indicates that people in West Essex suffer from poor access to services including health care, compared to most areas of the country, particularly in Epping Forest and Uttlesford. Additionally, the area is

affluent but there are deprived communities which can adversely affect health and quality of life, this is particularly true for parts of Harlow, Waltham Abbey, Shelley (near Ongar) and Debden. The population age profile also indicates a higher than national average figure.

4. Officers and members from the three authorities have recently met together to discuss how such a review might take place. The issues for such a joint group are:

(i) how to ensure that the participation of the PCT in a worthwhile review can be secured and be mutually beneficial;

(ii) making sure that any review does not duplicate either work undertake by or on behalf of HOSC;

(iii) that the structure does not eventually fall foul of any changes envisaged by the government on joint scrutiny committees following recent consultation which are scheduled for April 2009; and

(iv) that there is capacity to complete the review within a reasonable timeframe.

5. It was agreed by those that met that this report should be made to each of the three authorities to confirm that they would wish to pursue the joint group idea and seek ideas for topics for the review and appoint members to attend meetings on the basis of an equal share of members. Ideally topics suggested for the review should be relevant to all three districts. To give a favour, the Healthcare Strategy is also attached at Appendix 2 which outlines health issues facing the PCT.

6. A further meeting of the authorities will be held early in the new year to discuss the topics and method of review with the PCT. A scoping document will be produced and sent to Essex HOSC to ensure that they are aware of the proposed review.

Policy and Scrutiny Scoping Document

Committee	HEALTH OVERVIEW & SCRUTINY	
Topic	WEST ESSEX HEALTH SERVICES SCRUTINY	Ref:HOSC-SCR-02
Objective	To review the way in which the West Essex PCT plans for and commissions services to meet projected changes in demands and the impact of reconfiguration or change in provision.	
Reasons for undertaking review	Concerns had been raised by the Health Overview & Scrutiny Committee regarding the provision of GP services in West Essex relating to housing growth, development and capacity, particularly in light of a recent closure of a branch surgery and proposal to relocate a surgery. The funding situation had also been raised as an issue with a 2% year on year growth in population, but with delays for the funding to follow the patient, putting a strain on resources. At the meeting of the Health Overview & Scrutiny Committee held on 2 April 2008, the Chairman proposed a review to look at the strategic commissioning of primary care services, particularly in light of housing growth, development and capacity to ensure robust plans and infrastructure are in place. The proposal was agreed by the Committee.	

Method • *Initial briefing to define scope* • *Task & Finish Group* • *Commission* • *Full Committee*	The Review will be undertaken by a Task & Finish Group as agreed at the meeting of the Health Overview & Scrutiny Committee on 2 April 2008. The PCT to be invited to provide the following information to the Group's first meeting: • How the PCT is funded o Amount per capita o Comparison with other parts of the country o How growth is funded • How the cake is currently sliced • Who commissions and who provides o Current and future role of Practise Based Commissioning • Cross border health flows A series of meetings will be held as outlined in the Work Programme section of this document to consider the issues to be addressed and develop findings and recommendations to go into the final report. The final report will be submitted to the Health Overview & Scrutiny Committee to be ratified and then sent to the PCT for a full response to the recommendations and proposed actions.
Membership *Only complete if Task and Finish Group or Commission*	• R Gooding (Chairman) • E Godwin (Co-opted Uttlesford District Council Member) • E Johnson • J Whitehouse - TBC (Epping Forest District Council) • A Naylor Consideration to be given to co-opting a patient representative as voting or non-voting member of the group.
Issues to be addressed	Building on the foundation provided by the background information the Group to investigate, develop findings and recommendations as to how the PCT plans and commissions to meet the following: • Population growth o New housing o Immigration • Changes to services o Reconfiguration, including the Darzi and East of England SHA reviews o Retirements & closures of GP surgeries, dental practises (including removal of NHS lists) • Changes in health needs o Demographics – age, numbers of single person dwellings o Health map • Health Inequalities o LAA targets o Partnership working & pooled budgets • How the PCT engages with the public over potential service changes

	o Pre-consultation engagement on options o Formal consultation o Identification of best practice
Sources of Evidence and witnesses	• PCT representatives & nominees • Local Medical Committee and individual GPs • Royal College of Nursing, Amicus • ECC Adult Care, Health & Wellbeing Service; Schools Childrens & Families; Highways & transport • District Councils • Voluntary Sector • LINk A letter to be sent to potential witnesses and a press release issued inviting interested groups and members of the public to provide oral and/or written evidence. The letter to include a Guide to Providing Evidence document. All sessions, other than briefing and planning meeting, to be "hearings in public" not public meetings.
Work Programme	1st meeting in mid September • PCT requested to provide background papers - at this stage the focus to be on funding and roles rather planning for changes in service • Officer review of the papers to provide a briefing note and suggested lines of questioning • Briefing and planning meeting in private for the Group either the day before or immediately before the first public meeting. • The meeting to consider what other information the Group will require, visits etc before moving into formal evidence sessions • A formal list of questions to be developed to address the issues 2nd meeting October • PCT to respond to the initial list of questions arising from 1st meeting • PCT to consult with the Group on their new strategies 3rd meeting late October • Witnesses session • Group to identify any additional issues to be addressed by the PCT 4th meeting early November • PCT to respond to issues from witness session – separation of this from the witness session to make it clear that the PCT is responding to the Group rather than members of the public/organisations • Group develop findings and recommendations for Governance Officer to include in a draft report 5th meeting end November • Group review draft report

Indicators of Success	The Group will produce a report with findings and recommendations on the future planning and commissioning of health services in West Essex. Success will be demonstrated through the response of the PCT to that report with clear actions and outcomes. Success will also be demonstrated by the response of the Health Overview & Scrutiny Committee to the Review and any recommendations to extend the Review to other PCTs within the county of Essex.		
Meeting the CfPS Objectives • *Critical Friend Challenge to Executive* • *Reflect Public voice and concerns* • *Own the scrutiny process* • *Impact on service delivery*	• Reflect Public Voice & Concerns – Analysis of the way in which West Essex PCT engages with the public over proposed service changes. Inviting Members of the public to provide oral or written evidence to the review. • Impact on service delivery - Consideration of the provision of health services to patients living in West Essex and the effects of changes to services and changes in health needs. Developing recommendations for future planning and commissioning of services.		
Date agreed by Committee	Wednesday 2 April 2008.		
Future Action	The Chairman of the Group to have a preliminary meeting with the Chief Executive of West Essex Primary Care Trust – July 2008.		
Governance Officer	David Moses, Head of Member Support & Governance	**Committee Officer**	Sophie Campion
Service Lead Officer(s)	West Essex Primary Care Trust Adults, Health & Community Wellbeing, ECC Schools, Children & Families, ECC Highways & Transportation, ECC		

West Essex NHS
Primary Care Trust

West Essex Primary Care Trust

Strategy for healthcare

in west Essex

2008 to 2012

Aiming to achieve the best in local healthcare

Foreword

Welcome to the West Essex Primary Care Trust (PCT) Strategy for Healthcare which outlines our plans for health provision across west Essex for the next five years.

This document is the result of an extensive three month consultation with local people; service users; primary care practitioners; health partners both within the NHS and the private sector; social services; local authorities; the parish, district and county councils; voluntary sector; education; the strategic health authority and our staff.

Overall the draft strategy was well received and people noted and welcomed our ambitious and far reaching proposals. This final document recognises those areas that feedback told us needed strengthening, especially around the patient experience and patient safety. In addition people wanted specific priorities and targets so we can be measured over the coming months and years to ensure we are delivering as promised.

We are clear about our goals for improving the health of the population by supporting people to look after their own health by preventing illness and promoting healthy lifestyle choices. When people do require medical help, we are committed to ensuring it is responsive and meets their needs.

The strategy also commits the PCT to working with partner organisations and the public to improve the health and well-being of the people of west Essex and to achieve maximum value from the money we spend. It also takes into account the pledges set out by the East of England Strategic Health Authority in their document Improving Lives, Saving Lives and which support the Our NHS, Our Future review by Professor Lord Ara Darzi.

This document does not deal with issues that are considered to be business as usual or go into operational detail. This is covered by the PCTs business planning processes. However, it does set out our plans and priorities along with what people can expect in the next five years as an outcome of this strategy.

Much of the technical and operational detail will be covered in specific strategies that focus on finance, commissioning and workforce development which will be developed in the autumn of 2007 to underpin this overarching plan.

We thank everyone for their comments and feedback and look forward to working with you in delivering this ambitious health plan for west Essex.

Alan Tobias OBE
Chairman

Aidan Thomas
Chief Executive

Contents

Executive summary

People in west Essex:

- suffer from poor access to services including health care, compared to most areas of the country, particularly in Epping Forest and Uttlesford
- are most often affluent but there are deprived communities which can adversely affect health and quality of life, this is particularly true for parts of Harlow, Waltham Abbey, Shelley and Debden
- Epping Forest and Uttlesford have a higher than average older age range compared to other parts of the country
- in common with many areas people, particularly if they are elderly or suffering from a long-term condition, spend too long in hospital and are often admitted to hospital when alternatives in the community could prevent this
- have good primary care services, but do not feel they can always easily be accessed
- use an NHS which is mostly in financial balance locally but is part of the East of England health community which is in serious financial difficulties
- use an NHS which faces a big challenge to maintain financial balance and meet its national and essential local NHS targets over the next two to three years
- access some hospitals which are under review by neighbouring PCTs in London.

The PCTs strategic aims are to:

- meet the national government and Healthcare Commission targets for the NHS
- move health services into or closer to people's homes wherever this is safe and viable. In particular we will do significantly more to support older people and people with long-term conditions at home, avoiding the need for hospital admission wherever possible
- work closely with our partners in local government, schools and the voluntary sector to demonstrably improve health in the more deprived parts of west Essex
- work closely with GP practices, dentists, pharmacists, optometrists and community staff, to significantly improve access to and the scope of primary care, avoiding the need for hospital based care wherever possible, including mental health and children's services
- establish services that work more effectively and directly with Accident and Emergency (A&E) departments to avoid unnecessary emergency admissions
- ensure we stay within the budgets provided by the taxpayer in three ways:
    1. by limiting investment to essential developments which are critical to national or PCT strategy and those which are demonstrably self funding
    2. by ensuring we commission services effectively by requiring hospitals and primary care providers to be in the top 25% for efficiency in all measures, and monitoring their performance closely
    3. by stopping services which are not cost effective or evidence based.

If this strategy is adopted, within one year we will have:

- consulted on the use of the Walk-in Centre and A&E services in Harlow, and established new primary care based links with A&E
- reduced the need for people to attend A&E by improving access and awareness of alternative and appropriate services
- consulted on the future provision and best use of community hospital beds
- increased direct admissions to urgent and scheduled care teams in the community and community hospitals

- reduced elective referrals to acute hospitals to a level below the current monthly average
- be on target to achieve the national 18 week access target
- implemented major improvements to stroke services
- implemented a new pattern of care for older people with mental health problems
- developed comprehensive strategies for commissioning, finance, workforce, IT, communication, estates, and patient and public involvement
- enabled practice based commissioning (PBC) groups to introduce at least four new primary care based services that are currently hospital based
- agreed plans for the re-provision of GP premises in Stansted, Harlow and Epping
- ensure health is considered as part of planning proposals for housing developments and the second runway at Stansted airport
- planned the introduction of a community based learning disability service for children and young people
- extended the primary mental health service
- rolled out the chlamydia screening programme to at least 15% of the local population under the age of 25.

Within five years we will have:

- addressed areas of inequality identified in our health need assessments
- developed a seamless system for providing services that involve the acute trusts, ambulance trusts, provider organisations and social services for avoiding unnecessary emergency admissions to hospital
- embedded patient experience, patient safety, and infection prevention and control indicators in all our contracts
- achieved year on year improvements in the areas of patient experience, patient safety and infection prevention and control
- reduced levels of adult obesity
- halted the rise in childhood obesity
- increased the uptake of MMR immunisations to national levels as a minimum
- increased the uptake of cervical and breast screening to national levels as a minimum
- increased the availability of primary care based support and in particular self help programmes for people with long term conditions
- measurably reduced the MRSA and clostridium difficile (Cdiff) infection rates in our key providers
- reduced elective referrals to hospital
- reduced emergency admissions
- reduced the incidence of smoking in the overall population to less than 25%
- extended and co-ordinated parenting support in areas identified as deprived
- more flexible opening hours at each GP practice
- developed a clear plan with partner agencies to enhance and mainstream learning disability services
- have delivered new health premises identified in the strategy
- established palliative care and end of life services, and extended the Gold Standard Framework to all areas.

Introduction

West Essex Primary Care Trust (the PCT) was established on 1 October 2006 and brought together Epping Forest, Harlow and Uttlesford PCTs into a single organisation. It serves a population of 270,000 people and has a budget of £360 million.

Our three main functions are:

- engaging with our local population to improve health and well-being
- commissioning a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources, across all service sectors
- directly provide high quality responsive and efficient services where this gives best-value.

We have thoroughly studied health needs in our area. The results of this work are published separately as our first public health report. Using this information and taking into account national initiatives, we consulted with local people and stakeholders. The aim was to establish how health services could be developed to provide better and more equitable care through new models of care that would treat a greater number of patients closer to home. This will give them greater independence as well as better health.

This strategy sets out our overall vision for the future. It does not encompass all of the PCTs business or plans, neither does it go into operational detail. Separate strategies for commissioning, finance, IT, estates, communication, patient and public involvement and workforce are currently being developed to underpin this strategy. The business as usual elements are dealt with by our business planning cycle, ensuring we meet national targets set by the Department of Health and Healthcare Commission.

The Government White Paper, *Our Health, Our Care, Our Say: a new direction for community services*, describes how care could be provided differently – out of hospital into communities and people's own homes – where they can have access to safe and convenient care. This is further supported by the East of England Strategic Health Authority's document *Improving Lives, Saving Lives*, which sets out the overall direction they want PCTs to develop services for the wider East of England population. Whilst they have provided this framework it is not prescriptive. Through consulting with local people and stakeholders about what is needed in west Essex, we have been able to develop this into local priorities and service developments.

We are committed to further review of the strategy from time to time. In the next few months we will be contributing to the national Next Stage Review of the NHS. This may mean that as a result of further consultation with the public and stakeholders, elements of the strategy are revised in line with the outcomes of this national review.

Within the next year we will be consulting separately on plans to improve stroke and rehabilitation services, changes to the Harlow Walk-in Centre and the Princess Alexandra Hospital A&E Department, as well as community hospital services and day hospital services. These are important developments in our plans to improve local care and access.

The PCT strongly supports the valuable contribution community health services make to the health and well being of the people we serve. The existing network of community hospitals, health centres, GP practices, dentists, optometrists and pharmacies has allowed the public to have access to a wide range of health care services without having to travel to hospital. The challenge for the future is to build upon these strengths in order to improve local access whilst ensuring that services are safe and sustainable into the long term.

We are committed to ensuring that local people have an opportunity to work with us in making this a reality and we urge people to get involved and hold us to account for what is set out in this strategy. It has been written with the public in mind however the NHS is a complex organisation and a full glossary of terms is set out in the back of this document. We also ask that local people consider becoming more actively involved in the PCT and if on reading this document you feel you would like more information then please contact us, details are on page 28.

This strategy is not a completed piece of work, just the start of a journey towards better health for local people. We will make yearly reports on where we are with our plans, the benefits achieved and if things have not gone as planned an explanation as to why. We are confident that we can fulfil our plans and look forward to working with you in realising our corporate goal of aiming to achieve the best in local healthcare.

The strategic context

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

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

The national context

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

The planning, purchasing and delivery of health care must change to support this. Instead of focusing solely on treatment in hospital, local health care organisations are expected to reduce the reliance on acute hospitals by providing suitable community based services, particularly those for people with long-term conditions.

Helping people to manage their long-term conditions successfully, can:

- provide high patient and carer satisfaction
- reduce admissions to hospital
- reduce length of stay in hospital
- improve the way services work together
- reduce the costs associated with prescribing drugs.

Community health services have an important role to play in supporting these initiatives. They can mean that patients experience improvements in the way their health care is delivered, at the same time reducing unnecessary admissions to hospital.

Older people use two thirds of the services provided by the NHS. Nationally, the vision for health and social care for older people is one where:

- people should be cared for in their own home whenever possible, consistent with their clinical needs, their wishes and high standards of care
- those who do need an acute hospital bed should be admitted without delay and always within agreed national targets
- inpatients, whose medical condition has been stabilised, should be discharged to more appropriate settings closer to home without delay
- people should benefit from services that promote independence and social inclusion.

The *NHS Plan and NHS in England Operating Framework 2007/8* includes a set of challenging performance targets to reduce waiting times to 18 weeks for elective treatment by December 2008. This will require faster access for patients and a significant redesign of services to achieve improvements in capacity.

This strategy is flexible and may need to change from time to time to reflect new initiatives and changing circumstances. Over the next few months a high level national Next Stage Review will be undertaken looking at the following eight areas of care:

- maternity and newborn care
- staying healthy
- planned care
- mental health
- end of life care.
- children's services
- acute care
- long-term conditions

The PCT is committed to this review, which will involve clinical pathway groups, patient and public consultation, and staff engagement across East of England. Whilst we are confident that most areas of our strategy already reflect potential changes that may come from this review, some parts of the strategy may change as a result of this or other national initiatives as they evolve.

The local context

The NHS is undergoing a period of reform which reflects a basic but fundamental shift of strategy and thinking where the role that public health, health education, prevention and self-care strategies can make is at the forefront. The result has been a major shift in the approach to planning how health care is delivered locally.

Reforming and improving primary and community based services will enable a greater focus on prevention, promoting well-being and delivering services in more local settings which are flexible, integrated and responsive to people's needs and wishes.

Practice based commissioning (PBC) has been the subject of recent Government guidance. This requires the PCT to devolve budget management (not budget responsibility) to groups of GP practices. By putting more decision making power in the hands of primary care clinicians there will be much greater emphasis on the development of alternative provision in primary care, closer to people's homes. Within west Essex the PBC groups are established and have developed work plans to support and promote the work outlined in this document.

A second important development is the complete introduction of a tariff system, payment by results (PbR), as a means of payment for procedures largely in secondary care. This is key to health reform as it both enables and encourages PCT and PBC groups to move services out of hospital wherever it is safe to do so. It is also an incentive to make services attractive to patients as, for the first time, the money will properly follow the patient.

Government policy initiatives now add a clear financial incentive as well as major drivers from primary care to ensure that admission to hospital for anyone, old or young, becomes the last rather than often the only resort.

The White Paper *Choosing Health – making healthy choices easier* establishes a clear agenda for health development setting out the responsibilities of PCTs and other agencies, such as local authorities and schools, to work together to improve the health of the population through a range of interventions. The aim is to set targets for all agencies which encourage and expect public and private bodies to work together, focusing particularly on more deprived communities. This is reinforced in guidance issued to local Government in *Strong and Prosperous Communities*.

Financial context

The approach to moving care to primary and community services means significant investment in community health services over the next two years so that more patients can be treated as close to home as possible. This will mean changing the way we use resources, with more money being spent on services in the community rather than large hospitals. This approach to providing care will require the PCT, working together with its health and social care partners, to utilise the total funding available to best effect.

Whatever the approach to the delivery of services in the future, it is clear that services will need to be financially sustainable.

West Essex population and health

West Essex consists of three district local authorities, each with unique features in its population. It has some of the most affluent wards in Essex. However, by contrast also some of the most deprived.

Harlow was developed as a new town in the 1960s with large population shifts from inner city London. The pattern of primary care is unique having largely been planned alongside the town development. There is significant high tech industry but the resident population suffers from pockets of low levels of educational attainment and relatively high levels of deprivation. Public and other transport links are good within Harlow.

Uttlesford by contrast is largely rural and relatively affluent with the population in small market towns and isolated villages. Primary care is well developed however the area suffers severely from poor public transport and access problems. This is a major contributory factor to isolated cases of deprivation in towns and particularly villages, especially amongst the elderly and those with mental health problems.

Epping Forest also has rural areas similar to Uttlesford. The area south of the M25 is more urban and served by the underground. Some parts of Chigwell and Buckhurst Hill are very affluent. However, by contrast, wards in Waltham Abbey and Debden are among the poorest in Essex and this is reflected in health outcomes. Primary care is well developed in most of Epping Forest, however it is in the lowest 10% of PCTs in the country for MMR uptake.

West Essex is facing a significant population growth over the next ten years of more than 11%. Although housing growth will occur at a large number of sites across the whole of the area, (and in boarder areas such as Hertfordshire), it is likely to be most concentrated north of Harlow and in parts of Epping Forest.

Key health issues are:

Emergency care

Emergency hospital attendances and admissions are increasing across west Essex. The biggest growth, in Epping Forest, takes up proportionately greater numbers of admissions than elective (planned) admissions. The evidence is that large numbers of attendances at A&E are the result of perceived access problems in other parts of primary care and that significant numbers of emergency admissions occur because staff in A&E are unable to access alternative care near to people's homes.

Chronic conditions

Uttlesford has a lower prevalence of chronic diseases. Epping Forest has a higher prevalence for diabetes and hypertension. Harlow has a higher prevalence than the national average for all chronic diseases.

- Deaths from circulatory disease are low in all localities but there is a ten fold difference between wards in Uttlesford and a six fold difference between wards in Epping Forest.
- Death rates are generally low but deaths from chronic obstructive pulmonary disease (COPD) are significantly higher in Harlow than in Uttlesford and Epping Forest.
- Both Harlow and Uttlesford have had high and increasing suicide rates in men in the last few years. Mental health treatment in Harlow and Epping Forest was significantly worse than the national average in recent national indicators.
- Mental health morbidity is generally lower than the national average. However, in comparison with other areas in Essex, Harlow has a higher level of morbidity than most other areas. A recent study carried out by the University of Essex into mental health services in rural areas in Uttlesford, indicates stigma issues hide unmet need.

Health related deprivation

- Teenage pregnancy rates are higher in Harlow than nationally, although some individual wards in Epping Forest are higher than in Harlow.
- The area as a whole suffers from serious deficiencies in public transport. Epping Forest and Uttlesford, with small rural settlements, are among the most deprived in Britain on the measure of access to services.
- Harlow has significant levels of child mental health morbidity.

The population of west Essex is expected to increase by 11% by 2021 (although final decisions on housing growth have not yet been made), with most of the increase expected in the older age (45+) groups. This would result in:

- a 17% increase in hospital admissions if current patterns of use persist
- an increase in numbers of people with chronic diseases, for example a 20% increase in number of diabetics
- an increase in chronic conditions will exacerbate if current lifestyle patterns persist, for example increasing obesity is projected to increase diabetes by 54% by 2030.

A full and detailed analysis of health needs in west Essex is available from the Patient and Public Involvement (PPI) team whose contact details are on page 28 of this document.

Planning healthcare for the future

In this section we identify our strategic proposals to meet the health agenda for the next five years. Having consulted on what was needed locally, what is set out below gives a greater focus on prevention, promoting well-being and delivering services in more local settings which are flexible, integrated and responsive to people's needs and wishes.

These are ambitious but realistic plans and we are confident that while empowering people to take responsibility for their own health needs we can deliver a better and more responsive local healthcare service.

Improving local health

The health service tends to focus on getting people better rather than helping them not to become ill or manage their own health needs so they are in more control. Whilst there will always be medical emergencies we are committed to helping people make healthy life choices and take responsibility for their own care and long term health.

Health equity audits will be undertaken in key clinical areas to ensure marginalised groups are identified so that we can focus on areas of greatest need and inequality. For example GP data has identified a significant problem of hypertension in the Harlow population, combined with evidence of higher stroke admissions and mortality. In response we will develop specific programmes on raising awareness of having your blood pressure measured, initially targeted at men in Harlow.

Other key initiatives are:

- by 2008, roll out the sexual health chlamydia screening programme targeting the under 25's and testing 15% of this age group
- by 2012, increase the uptake of breast and cervical screening, at least up to the national uptake level, particularly in Harlow where uptake of cervical screening is below the target of 80%.
- by 2012, working with practices to ensure GPs routinely assess risk factors in patients such as blood pressure, smoking status, body mass index (BMI) readings etc. are increased to a minimum 70% of all patients measured against the 2006 baseline
- by 2012, ensuring appropriate rehabilitation services are in place for stroke, cardiac and chronic obstructive pulmonary disease (COPD) to reduce readmissions and improve clinical outcomes for patients
- by 2012, reduce death rates from heart disease and stroke by 40% from the 1997 baseline
- by 2012, reduce death rates from cancer by 20% from the 1997 baseline
- working with partner agencies to address the binge drinking culture.

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

- review of GP exercise referral schemes
- development of a locally enhanced service in primary care for reducing obesity
- development of weight management groups and services
- alternative forms of transport such as cycling and walking
- workplace based schemes
- provision of a health trainer service across west Essex (if current pilot proves successful and cost effective).

By the end of 2010 evidence of each scheme will be apparent to the local population.

We will continue to develop work, in conjunction with the LSPs, on reducing the prevalence of smoking from 32% (in 1998) to 26% by 2010 through supporting people to quit by:

- exploring social marketing techniques and through targeting specific groups such as pregnant women, young people and men

- ensuring stop smoking services are accessible and acceptable to patients in the most deprived wards
- supporting local businesses and workplaces in implementing the new legislation on smoke free workplaces
- working with health care partners in redesigning care pathways to help patients stop smoking before treatment and maximising the benefits of surgery.

Children and young people

Children are our future and ensuring they have every opportunity to have a healthy start in life will support them in becoming healthy adults. We are committed to maximising the health, well-being and achievement of all children. In particular by transforming the life chances of the most disadvantaged children under the age of five and the looked after children through involvement in Sure Start local programmes, the development of Children's Centres and partnership working with the Children and Young People Strategic Partnerships (CYPSP). To further support this we will:

- by 2010, engage with local partners to deliver programmes of preventative work on obesity at schools and communities within the wards with most need to halt the rise in obese children
- by 2012, through the commissioning process ensure that maternity services are flexible and individualised giving women and their partners as much control as possible during pregnancy, birth and after their baby is born with additional emphasis on targeting the needs of vulnerable and disadvantaged women
- by 2012, develop clear strategies on supporting children with complex needs, reviewing the need for support to ensure resources are used to maximum benefit for the parents and child
- by 2012, aim to improve uptake of childhood MMR immunisations up to national levels as a minimum
- by 2012, increase opportunities for positive parenting advice through parenting groups
- by 2012, develop parenting services to support families, targeting the most needy.

The focus of health provision for children will be a reduction in hospitalisation and development of more support at home. By 2010 we will:

- increasingly commission children's services out of hospital and in line with the wishes of children themselves and their families
- develop community paediatric nursing services to support the avoidance of children's admissions wherever possible and reduce length of stay to an absolute minimum safe level
- review the significant number of A&E attendances for children under five, refocusing existing services, such as the provision of out of hours support by the health visiting service, to help reduce levels of attendance.

By 2012 we will improve mental health services for children and young people as follows:

- extend behavioural and emotional support for children under five
- extend specialist tier 2 support in all schools
- develop tier 3 support for 16-18 yrs
- develop emergency beds and 24 hour community crisis support.

We fully embrace the Children Act 2004, *Working Together to Safeguard Children (2006)* and partnership working with the Essex Safeguarding Children Board, and will meet our statutory responsibility to establish a Child Death Review Panel by April 2008.

We will, by 2012, build on the success of the young people's services in Waltham Abbey and Harlow, extending this to other areas with high need, for example, Loughton. These services will include access to mental health provision.

Primary care

By 2012 we will ensure that primary care services are measurably better developed in each locality. This will be achieved by:

- commissioning GP practices to have more accessible and longer opening hours
- increasingly including significant alternatives to many medical, and some surgical and diagnostic services currently based in hospital. They will be provided in GP practices, clinics, community hospitals and people's homes
- providing enhanced and more accessible services to help people with long-term conditions to manage their health at home and help avoid hospital admission and attendance
- increasingly providing palliative care in a preferred place of care and ensure other initiatives are standardised across west Essex
- providing better supported discharge with increased rehabilitation after a hospital stay at or near the patient's home
- the provision of modern multi-service centres which meet a full range of health needs at one location
- the development of multi-disciplinary teams, which include pharmacy, district nursing, health visiting, therapy services and case management to provide multi-professional support working closely with GP practices.

Dental services

We will ensure that adequate NHS dental services are accessible to the entire west Essex population by 2012. This will be achieved through commissioning additional dental services from independent contractors as well as from community based service providers. Full details will be outlined in the commissioning strategy.

Pharmacy services

The PCT is one of nine pilot areas across the country for the medicines management project. Working with GPs and other health care professionals, community pharmacists are helping patients to get the most from their medicines so that they suffer fewer symptoms, experience less side effects and understand their treatment better. This is especially important in the management of long-term conditions where up to 50% of patients do not take their medicines as prescribed. We will continue to work with our local pharmacists in this essential project.

The increasing health prevention role for pharmacists will be developed over the five years of this strategy.

We will continue to work with local pharmacies in the roll out of the Electronic Prescription Service to meet the 2008 target.

Long-term conditions

We will commission and develop services which aim to improve the overall support people with long-term conditions receive, helping people to maintain their independence and enjoy maximum health. Within the five years of this strategy these include:

- from 2007, increasing the number of Expert Patients Programmes (EPP) run to a minimum of one per month
- from 2007, the Expert Patients Programme – Looking After Me, aimed at carers, will be targeted to those in need through our own staff and GP surgeries
- from 2007, increasing in the number of Dose Adjustment for Normal Eating (DAFNE) programmes for diabetics run to a minimum of six per year

- from 2007, an increase in the number of X-PERT Patient Programme for diabetes run to a minimum of six per year
- by 2012, increasing the number of Expert Patients Programme volunteer tutors to a minimum of 10
- by 2012, develop and review enhanced services for primary care specialist support for long-term conditions
- by 2012, access to self help groups and voluntary sector support
- by 2012, easier access to specialist advice both in primary and secondary care
- by 2012, easier access to support in managing medication
- by 2012, development of specialist nurses to manage multiple sclerosis and diabetes in the community
- by 2012, working closely with social services to provide easier access to practical support with daily living as necessary.

We will focus on avoiding the need for hospital admission as a result of long-term conditions. We will do this through the provision of focused primary care services and case management for those most likely to be admitted.

The coverage of case management in terms of hours and capacity will be reviewed with the view to expanding the service. A network of specialist advisors including pharmacists, and specialist nursing and therapy staff will support the case managers. The network will reflect local need and is likely be different in each locality.

Community hospitals

We are committed to the provision of services in the communities we serve. In particular we aim to increasingly provide care in people's homes when it is safe and appropriate to do so. If this is not possible, we believe that community hospitals, which are local have a focus on individual care and are supported with diagnostics and expertise in intensive rehabilitation, are a vital fall back for people who might otherwise be admitted to an acute hospital. The business of our community hospitals is to enhance the patient experience by avoiding inappropriate admission to an expensive acute facility and ensuring quicker discharge home.

We therefore propose to review and consult on changes to the configuration of services across west Essex to improve the way we use our community hospitals by making maximum use of those facilities which improve local access, and have access to good diagnostic and clinical support. This will include:

- *Saffron Walden Community Hospital* – where direct admissions will need to be intensively developed
- *Ongar War Memorial Hospital* – where as part of the review we will also need to consider the needs of local people for modern facilities for primary care based medicine
- *St. Margaret's Hospital* – consideration of a combination of potential services, including the development of a stroke unit, and the extension of admission avoidance and support for people with long-term conditions
- *Sydenham House* – we will consider the need for reprovision of older people's mental health services in west Essex and the feasibility of nursing home provision in Harlow, in addition to admission avoidance, when considering its future use.

All this will be the subject of separate consultations.

Mental health

We are committed to de-stigmatising mental illness and will work to ensure that it positively promotes wider acceptance and understanding of mental health problems.

We will continue to commission and support the development of community based services which target severe and enduring mental illness, as well as providing support to prevent admission in crisis. However, we will also consider ways of supporting

the development of primary mental health care services.

The overall approach will be to ensure that resources are targeted effectively at particular needs. For adults this will require:

- by 2008, a fundamental review of current community mental health teams to ensure that people with long-term mental health conditions receive the right level of support and care, and that current gaps in primary care start to be addressed more effectively
- by 2010, provide effective access, treatment and support for people from black and ethnic minority communities
- by 2012, provide an adequate range of primary mental health services for people with less serious conditions
- by 2012, further development of early intervention in psychosis services (target age group is 14 to 35)
- by 2012, develop more appropriate services for people who have multiple problems including those who have a physical and or sensory disability as well as mental health difficulties.

By 2012, develop other specialist services to meet current gaps, in particular:

- eating disorders
- personality disorders
- working with learning disability services for people with Asperger's Syndrome
- younger onset dementia.

By 2012, for older people the aims for community based services will be to:

- retain and develop the current pattern of integrated health and social care community teams
- start to consider how best to provide comprehensive day services across the whole of west Essex
- consider how best to provide home treatment
- ensure that good carer services are in place
- ensuring a good range of psychological therapies.

By 2012, tackle social inclusion by improving employment prospects and opposing stigma and discrimination. A range of initiatives are under way including:

- taking forward the recent review of residential care, rehabilitation and supported housing to ensure that we have the right balance of effective housing support
- completing the review of day services so that they are targeted.

Much of this strategy will need to be jointly provided in conjunction with Essex County Council. We are both are currently working on a joint strategy for older people with mental health problems. This is likely to be published summer 2008.

In addition to these nationally identified programmes there are a number of locally based issues which also need to be highlighted and actions identified. These include:

- developing an effective strategy and range of services for adults under 65 who develop dementia
- providing effective support for people with a personality disorder which in the past has often been a diagnosis of exclusion from mental health services.

Learning disabilities

We are the lead commissioner for learning disability services across north Essex. Although much has been done to improve access to health care for people with a learning disability, there is a strategic imperative to continue to improve that access in the future. The 2006 Disability Rights Commission report, *Equal treatment; Closing the Gap*, found that people with a learning disability are much

more likely than other citizens to have significant health risks and major health problems, particularly obesity and respiratory disease. The key recommendations of the report are:

- improving primary care access and health checks
- tackling diagnostic overshadowing, for example, reports of physical ill health being viewed as part of the learning disability
- improving health by targeting high risk groups in national health inequalities programmes.

The recommendations were reinforced by the 2007 Mencap report, *Death by Indifference* which highlights:

- people with learning disability are seen as a low priority
- many health care professionals do not understand much about learning disability
- many health care professional do not properly consult and involve families and carers
- many healthcare professionals do not understand the law around capacity and consent to treatment
- health professionals rely inappropriately on their estimates of a person's quality of life
- the NHS complaints system is often ineffectual, time consuming and inaccessible.

We accept the recommendations made by these reports and are committed to delivering cohesive action by commissioners, primary care providers and specialised learning disability service providers to address these issues over the lifetime of this strategy.

General hospital services

We will support the provision and development of high quality acute (secondary and tertiary) hospital care for our population. The principle goal of hospital services will be to deliver both planned and unplanned diagnostics, medical procedures, and clinical and surgical interventions as effectively as possible, as well as being within the time limits required by us. In particular:

- to work with key local acute care providers to develop and manage care pathways particularly around cancer services and coronary heart disease
- to improve commissioning of tertiary care.

We will review private and voluntary sector provision in acute care to bolster capacity to achieve the waiting list targets and to provide key specialist care, such as termination services.

Acute hospital services across the East of England and north east London are under review and we will actively contribute to both reviews.

Infection prevention and control, and patient safety

We are committed to working with secondary care partners and within our own services to enhance the patient safety agenda and reduce the incidence of clostridium difficile (Cdiff) and MRSA. In particular we will:

- develop awareness of patient safety issues at all levels within the organisation starting in December 2007
- establish clear infection prevention and control action plans with all providers which will be reported on at board level from April 2008
- work with partners to develop a campaign to improve the awareness of hospital acquired infections amongst patients, carers and visitors starting in April 2008
- ensure robust patient safety reporting and action plans within the PCT that deliver measurable improvement
- develop patient safety, and infection prevention and control indicators for inclusion in all service contracts.

Emergency care

Staff in A&E face significant challenges in accessing primary and community based support for patients at speed. As such services, although often excellent, are disparate and hard to access quickly. They are therefore often left with little choice but to admit patients. For the elderly and those with long-term conditions, the possibility of being admitted to hospital is higher with the potential consequence of reduction in independence and risk of infection.

This must change quickly and we will review and refocus the existing services to ensure greater partnership working and accessibility to prevent admissions to hospital as their primary purpose. This will place an emphasis on high levels of clinical skill, immediate access, and the availability of diagnostic and social care support if these services are to be viable and expand.

We will review the use of the Walk-in Centre to focus its work on preventing attendance and admission at A&E wherever possible. This is subject to a separate consultation.

Elective (planned) care

We are committed to achieving the national target of 18 weeks from referral to treatment for planned care by December 2008. This is challenging and will require major improvements in availability, access to diagnostics and changes to referral arrangements from primary care. The target has significant resource implications, both in terms of money and hospital capacity, which will require us to ensure we adopt the most cost effective approach to elective care. This will include:

- commissioning care from providers on the basis of clinical need and determined by the evidence base
- the review of elective alternatives with all providers of elective care to ensure the most cost effective provision
- wherever appropriate and cost effective, elective care will be commissioned from a primary care alternative, for example moving out-patient follow-up appointments to a GP or community specialist
- working with GPs to expand the existing referral management centre into a clinical assessment service (CAS).

In line with the East of England commissioning framework(s) we will publish proposals for service restrictions where procedures are ineffective in terms of benefit and or cost. Commissioning policy will also conform to NICE guidance.

Palliative care

We will ensure that, wherever possible, palliative and end of life care services will be delivered in accordance with the wishes of patients and their carers.

The Preferred Place of Care scheme will be extended across the PCT area and other key schemes including the carers' scheme (offering practical support to carers), and the emergency drug box scheme will be expanded.

We will develop stronger relationships between the four main hospices and primary care services to ensure greater flexibility of services and less reliance on acute hospital care. Access to specialist palliative care to those in acute care will continue to be provided via the Macmillan team and St Clare's Hospice.

Palliative care services will continue to be developed in line with national initiatives and with an evidence base as identified by the National Institute for Clinical Excellence, the National Council for Hospice and Specialist Palliative Care Services, and the Cancer and Palliative Care Networks. We will extend the Gold Standard Framework, to all areas of west Essex and support the use of the Liverpool Care Pathway throughout.

Monitoring

We will be developing a bi-annual monitoring schedule to report to our Board, to ensure that our progress can be and is monitored, giving local people confidence that these plans are being delivered and improvements are being achieved.

How we will deliver the strategy

In this section we set out how we will deliver the strategy, the vehicles we will use and principles we will apply.

Involving local people

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

Service users will always be involved in planning new or permanent changes to services at an early stage. We will also seek advice from the PPI forums and in the future the LINks, on how best to do this on a service-by-service basis. The only exception to this will be in an emergency when temporary changes may occur.

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

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

We will continue to work with the established user consultative forum and assist the Older People's Advisory Group to become established across the west Essex area.

Practice based commissioning

We will develop practice based commissioning (PBC) as the key lever for change and development of services in west Essex. The PBC groups will be instrumental in the delivery of this strategy.

West Essex has three PBC groups focused around the major hospital providers. We will support these as the focus for GP and primary care professional engagement in commissioning. Individual practices and groupings of practices will also be able to commission services although this will be for much smaller scale developments.

Through PBC we will incentivise practices to:

- provide new cost effective services in primary care to replace secondary care services
- assist in the monitoring of secondary and primary care performance especially with validation of activity reporting
- commission secondary care services for the population
- commission primary care services
- commission health development
- ensure cost effective prescribing.

To do this we will provide PBC groups with financial, commissioning and information expertise to support practices.

The Professional Executive Committee (PEC) will take a lead role on behalf of the Board in examining proposals and setting the agenda for PBC groups.

Partnerships

We will work closely with the three district councils in Epping Forest, Harlow and Uttlesford. There are many common health issues (such as the housing growth) across west Essex. However, each of the three localities has unique health needs. The local councils are critical to successful health development to ensure that planning in each of the districts creates a healthy environment and that individual planning applications take into account health needs and health services.

The public health team will work closely with district councils and co-ordinate the work of provider services, influencing contracts and working with health providers (GP practices, pharmacists,

community nurses, acute hospitals etc.) in addition to other services such as education and housing in focusing on improving the health of the population.

In partnership with the above, we will develop a strategy for improving health based on assessment of needs and to address four key areas:

- diminishing risk factors
- improving disease prevention programmes
- encouraging early detection of disease
- improving access to and treatment of diseases in primary and secondary care.

This will reduce population risk factors by ensuring the public has adequate information about health and disease prevention to help make informed choices to understand and manage their health.

We will continue to meet our statutory responsibilities under the Crime and Disorder Act. We will also work with the Essex Drug and Alcohol Action Team and local Crime and Disorder Reduction Partnership to ensure appropriate commissioning of alcohol and drug treatment services.

We will also continue to work with the three Local Strategic Partnerships (LSPs) within west Essex to drive forward the public health agenda. Key areas to be addressed by the LSPs are:

- educational attainment levels
- public transport that is available and acceptable within Epping Forest and Uttlesford
- alternative forms of transport such as cycling and walking that will not only minimise road congestion and safety but tackle the rising obesity problem amongst the population
- preventative programmes tackling obesity, smoking, poor sexual health practice and emotional health and well-being.

We will work closely with the county council, county LSPs and other Essex PCTs to develop and deliver the Local Area Agreement (LAA). We are committed to adopting the joint targets identified in the LAA in addition to the national targets for health care, and to add value to health and other services provided to local people.

Public health, school nursing and health visiting teams will continue to work closely with schools and colleges in west Essex. They will be involved in planning young people's services through the Children and Young People Strategic Partnership (CYPSP) and LSP.

We will also work closely with social services to establish service delivery for people with long-term conditions, older people and children. Social workers will be part of multidisciplinary teams and we will work jointly with the county council to plan and commission services for adults, people with mental health problems and children.

This will mean establishing and developing clear arrangements for planning and commissioning together with our other partners. This will happen through LSPs, various client specific groups, for example, CYPSP and in the case of health development, through the joint public health arrangements. Wherever possible and appropriate we will seek to develop close practical relationships with social services to reduce the collective costs and improve the effectiveness of commissioning and service delivery. This will include pooling budgets, risk sharing and joint staff appointments.

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

The voluntary sector is critical to our performance. They will influence policy and strategy, both in specific areas of work and in general strategic development. The voluntary sector will also provide some services commissioned by us and crucially provide other services that supplement

those of the statutory sector. They will therefore be supported and recognised as partners of the PCT at all levels.

Service providers such as local acute hospitals (both private and NHS), GP practices, pharmacists, dental practices, optometrists, opticians and mental health providers are also important partners. We will endeavour to foster strong relationships of trust with providers in a managed market in order to ensure mutual benefit wherever possible to ensure service development and quality improvement.

Providers are often a critical source of initiatives and innovation and it will be important that we take a partnership approach wherever possible without compromising our responsibilities in relation to value for money and public accountability.

Improvement in patient satisfaction

Over recent years hospital waiting times have dramatically reduced from years to weeks and more people are being treated with better clinical outcomes. However, now we are moving towards delivering a quicker service we need to put measures in place to ensure that the overall patient experience is as positive as it can be. At its simplest, a better patient experience includes:

- giving patients more control and choice over when and where they are treated
- treating patients with respect and dignity and in surroundings that are fit for the purpose.

We will ensure that specific patient experience indicators are developed and included in our contracts with acute hospital providers, both NHS and private. These indicators will be developed with our patient and public involvement (PPI) and voluntary sector partners and introduced for the 2008/9 contract negotiations.

To complement this we will commission an annual survey of patients' experience of care in our GP surgeries, hospitals, community and mental health services. This will be in partnership with the East of England Strategic Health Authority who will undertake this for all PCTs to ensure that satisfaction improves and enable benchmarking with other services to share and learn from centres of excellence.

We will use the survey to gauge satisfaction with all the factors that contribute to a positive patient experience. This will include assessing whether patients are content with the degree of privacy offered, and whether they are treated with dignity and respect. If we find services fall short of people's expectations, we will act to make improvements.

Working with the local media we hope to ensure that a balanced coverage of health issues is featured. This will be complimented by regular communication through a variety of channels with people on what and how the PCT is doing as well as managing their expectations. A key example of this is GP access whereby many patients feel they have to see their own doctor every time or the visit is wasted. This is not the case and often not possible due to GPs holidays, sickness and working shifts.

This will be set out in our communication and PPI strategy which will be developed within the first year of this strategy.

Patient and public information

We will encourage early detection of disease through the improved availability of patient and public information. The use of community-based initiatives can mobilise communities to raise awareness of symptoms and encourage people to seek professional advice earlier.

For example, differences in cancer mortality and survival rates are often due to the stage at which cancers are treated. People present with symptoms later in England than in other countries in Europe. Some of this is because people are unaware of or scared of symptoms. Improved availability of information about cancer symptoms for patients particularly men, will be a priority and particularly targeted at deprived populations who have the highest cancer death rates.

Our plan is to establish a patient information group which will include a reader panel to ensure that all literature is in clear English and appropriate for the target audience. The panel will include all ages and representatives from all areas of the community including hard to reach and disadvantaged groups.

Patient choice

We will continue to develop the choice agenda in line with government strategy.

We will use Choice to commission better services. Examples will include encouraging GP practices to extend opening hours and access arrangements or offering alternatives to hospital based treatment.

We will continue to work with local practices to ensure the effective roll out of choose and book to assist patients choosing a hospital appointment that meets their needs.

These will be important developments and we recognise that in areas where public transport is amongst the poorest in the country, choice of provider may be less important than the personal choices people make about the quality and nature of their care. We will continue to work with the county and local authorities in the development of improved transport links to all parts of west Essex.

Choice in mental health has been the subject of separate consideration by the Government and is not generally part of the wider choice policy initiatives for other health services. However four areas have been highlighted for development and this strategy aims to help deliver them. These include:

- *life choices* – helping to maintain a quality of life with access to a range of services including vocational support, education and training, suitable housing and the use of direct payments
- *how to contact mental health services* – to include a GP, A&E, Walk-in Centres, NHS Direct telephone help-lines etc.
- *choice when having an assessment* – giving users the ability to choose a time and location
- *a choice of care options* – including access to psychological therapies instead of or in addition to medication.

Principles

As a matter of principle we are not committed to commissioning services from any particular provider. We are committed to commissioning high quality, evidence based, cost effective care that is more accessible to local people than is presently the case.

We will work positively with any providers who are committed to this and to our strategy.

We are also committed to ensuring that clinical quality and continuity of service are paramount.

Procurement

Our vision is to improve the health and well being of the local population through offering a choice of high quality, personalised care in an appropriate setting. To deliver this, we are adopting best practice in the procurement of services and the management of contract and supplier relationships. This aspiration also applies to the commissioning of non-clinical services.

Our strategic procurement objectives are that by the end of 2008 and beyond, the PCT will be:

- working with a wide range of service providers from the private, public, voluntary and social enterprise sectors who can offer diverse and acceptable choices for local service users
- regularly reviewing existing contracts, for both clinical and non-clinical services, to ensure they deliver in accordance with key performance indicators, offer maximum value for money and demonstrate continuous improvement in the quality and range of services on offer
- working with partners to ensure that buying power and economies of scale are maximised through shared procurement departments and initiatives

- conducting service reviews and driving the redesign, innovation and delivery of services through new contracts where public dissatisfaction suggests that changes are needed
- pro-actively supporting existing providers to develop both the quality and range of services.

In delivering these objectives we will work within and take account of:

- our standing financial instructions
- the European Community rules on the procurement of services to reduce the likelihood of legal challenge
- legal requirements which are relevant to employees (such as rules for transfer of staff under existing terms and conditions where appropriate, for example, TUPE)
- regulations that are service specific.

A procurement guide will be published by March 2008 which will set out the processes, common pre-qualification standards and other procedures for inviting competition.

Provider development and market management

We recognise that a mature relationship with key local providers is essential to the success of this strategy. We need strong, effective providers in secondary and primary care and recognise that providers need to develop. We will support those providers who are willing to be flexible and supportive of our strategic goals.

Local knowledge indicates that, in many areas, existing providers in secondary and primary care will remain the provider of choice. However, we are committed to ensuring contestability, cost effectiveness and value for money in commissioning high quality services for local people.

In future we will tender for services, particularly new services, and seek to develop partnerships to support development of pathways of care and innovation in service provision.

Those services currently directly provided are critical to the success of this strategy. We will spend an initial period, whilst shaping our commissioning strategy, refocusing and developing our provider services to enable them to be competitive, whilst establishing appropriate management arrangements for the longer term.

This approach will ensure stability in essential primary and secondary care service delivery while ensuring delivery of the service changes identified in this strategy.

Estate

Our estates function supports healthcare reform by ensuring we have the right environment to provide healthcare in the place it is needed, helping to move services from hospitals nearer to the community and providing easier access.

We inherited a significant number of buildings used for clinical and administrative functions. These are a cost to us that could be spent on other local health services. Therefore the estate needs to be managed as cost effectively and economically as possible.

To this end, within the first year, we will undertake a full estates review of all the building stock we fund directly and indirectly to establish if the buildings are being utilised to maximum effect, are appropriate for health care purposes and comply with national guidance and regulation in terms of utility and access.

As part of this we will review our environmental impact and put plans in place to reduce our carbon footprint by being a cleaner, safer and greener organisation.

In addition the review will re-evaluate the primary care developments planned by the three former organisations, as the balance between the cost of new primary care facilities and the need for space for development of services, will require careful planning due to the significant financial implications.

The key estates projects are:

- primary care facilities in:

Stansted	Osler House
Takeley	Nazeing
Felsted	North Weald
Ongar	Old Harlow

  Ninefields Estate in Waltham Abbey

- resolution of long term use of Sydenham House in Harlow
- resolution of primary care facilities to replace Lister House in Harlow
- accommodation in the Harlow Gateway Project leisure facility
- use of surplus land at Saffron Walden and primary care facilities in town.

The review will lead to a longer-term estates strategy to help to deliver the strategic goals outlined in this document. This will be delivered in the first year of this strategy.

Information technology (IT)

Healthcare reform is about giving patients more choice and control over their own health and care. Creating a health service designed around the patient is at the heart of the Government's vision and key to delivering this is modern technology.

The NHS is currently rolling out the National Programme for IT (NPfIT) which aims, by 2010, to install modern computer systems, fit for the 21st century, to all health professionals in England.

This will ensure that the right information is available to the right people at the right time, with all those involved in the care of a patient having secure access to up-to-date, accurate information for diagnosis, treatment and care. Ultimately, it will also enable patients to have easier access to their own health and care information.

Diagnosis and treatment will be safer and speedier, because professionals will have the right information available to them at the right time, including X-rays and other medical images and information. These will be stored electronically so they can be easily made available at different locations. If required, they can also be forwarded to specialists for their advice.

Key elements of this integrated approach are:

- *NHS Care Records Service* (NHS CRS) – individual electronic NHS Care Records for all England's 50+ million patients, securely accessible by both the patient and those caring for them
- *Choose and Book* – an electronic booking service offering patients greater choice of hospital, clinic and more convenience in the date and time of their appointment
- *Electronic Transmission of Prescriptions* (ETP) – a system to make prescribing and dispensing safer and easier
- *Picture Archiving and Communications Systems* (PACS) – to capture, store and distribute static and moving digital medical images
- the *Quality Management and Analysis System* (QMAS) – giving GP practices and PCTs objective evidence and feedback on the care delivered to patients
- *GP System of Choice* – a national GP computer system with access to NPfIT functionality such as Choose and Book, ETP, GP record transfer and patient summary record
- *SystmOne Community* – an integrated primary care product which uses a single electronic record to enable collaborative working across primary care settings, providing effective management of caseloads and schedules and the reporting and administrative functions required

We are fully committed to delivering the benefits of this new technology and the projects listed above. Within the first year we will develop an IT strategy with timescales and identified resources for all the projects.

Financial management

We are operating in an extremely challenging financial environment and one that is anticipated to be subject to further pressures. The level of growth available to the NHS is set to fall from 2008/09 compared to growth enjoyed over the previous five years.

We need to assess the likely impact of any immediate and future shortfalls of initiatives historically funded by the Department of Health. Remaining funds will be applied in achieving the national targets particularly those associated with access and reduced waiting times.

Against this backdrop of reduced growth funding and national investment targets, a cautious approach must be adopted with regards to investment to ensure that we maintain financial stability, achieve recurrent break even and do not endanger local services.

We will adopt the following principles:

- devolve budget management to the point where decisions on resources are made. This is an important principle but has consequences for the level and quality of budget information supporting our provider services and particularly the PBC groups, which in both cases must be timely accurate and iterative
- we will commission services and implement prescribing policies which are evidence based wherever possible and cost effective
- we will only agree developments which are demonstrably self-funding or which are essential to the achievements of strategic goals or targets
- we will establish no new services without also ensuring their clinical and cost effectiveness is monitored
- we will review existing services for cost effectiveness and discontinue any services which are not cost effective.

Within the first year we will develop a financial strategy to underpin this strategy which will specify the technical and operational plans needed to achieve recurrent break even.

Holding providers to account

We recognise that in order to ensure people receive appropriate services, monitoring what has been commissioned is essential.

Performance management of selected providers is important to us. Providers, whether NHS or not, will be required to comply with appropriate information governance and information sharing standards.

Therefore we will establish increasingly sophisticated performance monitoring of providers.

We will incentivise and properly fund primary care providers for the delivery of high quality evidence based practice in line with our policies. This will encourage research, training and user involvement, both individual and collective, in the delivery of care.

In primary care the Qualities and Outcomes Framework (QOF), prescribing, referral rates and patterns, and other contractual arrangements for primary care contractors will be carefully monitored. Enhanced services and developments established through practice based commissioning will also have clear measures of effectiveness and value for money as a feature. In addition we will monitor access and service quality through service user involvement and secret shopper arrangements.

We will also incentivise general practice and PBC groups to validate secondary and tertiary care information to ensure that the value of the tariff is maximised in west Essex, and to monitor community provision.

These outcomes will be published and providers held to account for their performance.

In secondary care we will fully fund high quality care in line with the tariff and this strategy. We will encourage and incentivise the development of new initiatives and ways of working to ensure that services, and particularly care pathways between providers, operate smoothly, successfully and are

cost effective. We will develop close long-term relationships with key providers to enable service improvement and mutual support, but without compromising our responsibilities for the management of public money and contestability.

We will use all available published data to monitor the performance of acute trusts and will compare data between them. In addition to activity information we will require a range of quality and access information which will tell us about the quality of service, for example information on discharge planning, infection rates and patient surveys.

These outcomes will be published and providers held to account for their performance.

We will encourage innovation and incentivise development in community services (including social care). Community provision, whether or not directly provided, will also be closely monitored. All services will have clearly defined performance targets and be monitored against them. This will require the establishment of more appropriate information systems and better audit of community services.

For mental health, we will establish clear performance monitoring arrangements. These will include the establishment of clear performance standards and the production of regular information.

For all providers, we will monitor the outcome of the Healthcare Commissions analysis and will expect performance to be in the upper levels against all national performance benchmarks unless otherwise agreed.

Workforce

The next five years will see a major transformation in how and where services to patients are provided. We will need to provide leadership on organisational development to support both the commissioning and provision of services in how the workforce will need to change to both deliver and manage these changes.

The workforce directorate will support our strategy by:

- leading the transformation process by involving and engaging staff in the culture and service changes. Developing strong and positive relationships with trade unions is an important part of this transformation as it creates a culture which is open and transparent. Developing policies and procedures which support a business and customer oriented service
- developing the capacity and culture of the organisation to achieve a flexible and efficient workforce which is responsive to changing needs and has a business and customer orientated focus. Over the next 10 years the local demographics will change along with the national trend of an aging workforce. We are developing a workforce model in conjunction with The Princess Alexandra Hospital to test out workforce assumptions to inform strategy on workforce development for the coming years
- developing leadership and management capacity to enable managers to lead through the changes and deliver service improvements
- developing the workforce capacity to empower staff to improve services, encouraging their involvement in service design and creative delivery while maintaining a good worklife balance.

A workforce strategy will be developed within the first year with internal and external stakeholders utilising opportunities and joint leadership development with East of England Strategic Health Authority.

How to get involved

West Essex PCT is committed to involving patients, carers and the public in the planning and decision making process around the services we provide and purchase (commission).

We are actively seeking participation from people of all ages in our local community to become involved in the PCT as lay members.

This could include visiting our premises to help carry out a monitoring visit, attending a meeting regularly on a given area or being a member of the reader panel for patient information.

You can be involved as:

- an individual regarding your care
- a user of local health services
- a carer
- part of a community
- representative of an organisation with an interest in health care.

This will not be an onerous task involving lots of your time and we will advise you what is appropriate depending on how much time you can offer. In return we will provide an induction to the PCT, training should you have to attend meetings and reimburse travel expenses.

We also have number of regular open forums which you can receive the papers from and attend as you wish.

By being involved you can help shape future local NHS services. It will also give the PCT a better understanding of the needs of local people.

If you are interested and wish to discuss this further then please contact us by any of the methods below.

Post: Patient and Public Involvement Team,
The Laurels, St Margaret's Hospital,
The Plain, Epping, Essex CM16 6TN

Phone: Freephone 0800 7833396

Email: mail@westessexpct.nhs.uk

Patient Advice Liaison Service (PALS)

If you would like help, advice, information and support about any of our services, this is available through the Patient Advice and Liaison Service (PALS), who offer an independent and confidential service to all patients, carers, families and friends.

How to contact the PALS

The PALS managers can be contacted by:

- Phone: Freephone 0800 7833396 (answerphone out of hours)
- Fax: 01279 827622
- E-mail: PALS@westessexpct.nhs.uk
- Post: Patient Advice and Liaison Service (PALS)
  The Laurels, St Margaret's Hospital
  The Plain, Epping, Essex CM16 6TN

Glossary of terms

Appendix 1

Accident & Emergency (A&E)	The term for a group of rooms within a hospital that is designed for the treatment of urgent and life threatening medical emergencies.
Acute care	Medical or surgical treatment usually provided in a general hospital.
Body Mass Index (BMI)	Body mass index (BMI) is a measure of body fat based on height and weight that applies to both adult men and women.
Care homes (residential)	Establishments which provide accommodation, meals and personal care (such as help with washing and eating) for people who can no longer live independently. Also referred to as residential homes. The majority of establishments are run by private companies but some are managed by local authorities
Care pathway	An agreed and explicit route an individual takes through health and or social care services that detail the activities and professionals involved at different times and stages.
Case managers	Highly experienced professionals who work closely with patients and their GPs to plan and organise an individual's care. They act as a single point of contact for a patients care.
Chlamydia	Chlamydia is the most common sexually transmitted infection (STI) in the UK. It affects both sexes, although young women are more at risk. It can be treated, but it often has no symptoms in either men or women, so remains undetected. Infection may only be diagnosed once chlamydia has led to complications, when treatment can sometimes be too late to stop permanent damage.
Choice (also known as patient choice)	Giving patients more choice about how, when and where they receive treatment is one cornerstone of the Government's health strategy. Another is giving members of the public a bigger hand in shaping local care systems.
Choosing Health – making healthy choices easier	This White Paper was published in November 2004 and sets out the key principles for supporting the public to make healthier and more informed choices in regards to their health.
Chronic Heart Disease	A general term which covers one or more specific diseases of the heart which are long-term conditions affecting a patient's life and do not respond to treatment.
Chronic Obstructive Pulmonary Disease (COPD)	Persistent or recurring disease of the lung which also affects the heart.
Clinical	Literally means 'belonging to a bed' but is used to denote anything associated with the practical study or observation of sick people
Commissioning	A continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring.

Community care	Care or support provided by social services departments and the NHS to assist people in their day-to-day living.
Community hospitals	Local hospitals serving relatively small populations (less than 100,000) providing a range of clinical services but not equipped to handle emergency admissions on a 24/7 basis.
Community health services	Treatment provided to people outside of hospitals, together with preventative services such as immunisation, screening or health promotion.
Connecting for Health	This is delivering the National Programme for IT to bring modern computer systems into the NHS which will improve patient care and services.
Creating a Patient Led NHS	This document, published in March 2005 by the chief executive of the NHS, explains how the NHS Improvement Plan will be delivered. It describes the major changes underway and how some of the biggest changes will be carried forward for a patient-led health service.
Crime and Disorder Reduction Partnership	The 1998 Crime and Disorder Act established partnerships between the police, local authorities, probation service, health authorities, the voluntary sector, local residents and businesses. These partnerships are working to reduce crime and disorder in their area. West Essex is linked to the Epping Forest, Uttlesford and Harlow LSPs.
Children and Young Peoples Strategic Partnerships (CYPSP)	CYPSPs are multi-agency partnerships involving the responsible statutory and voluntary agencies that commission and or provide services to children and young people aged 0 to 19 (or in some cases to 25). These include education, social care, the police, leisure and health.
Diabetes	A condition characterised by a raised concentration of glucose in the blood due to a deficiency in the production and or action of insulin, a pancreatic hormone.
Diagnostics	Procedures used to distinguish one disease from another e.g. laboratory tests, x-rays, endoscopies.
Elective care	The assessment and treatment of non-urgent conditions. At present this may require a hospital out-patient visit, diagnostic tests and possibly an operation.
Electronic prescription service (EPS)	A system to make prescribing and dispensing safer and easier.
Enhanced services	There are services not provided through essential or additional services, or essential and additional services delivered to a higher specified standard. They were negotiated into the general medical services (GMS) contract as a key tool to help PCTs reduce demand on secondary care. Their main purposes are to expand the range of local services to meet local need, improve convenience and choice, and ensure value for money. They were designed to provide a major opportunity to expand and develop primary care, and give GP practices greater flexibility and the ability to control their

	workload. There are three types of enhanced service: • directly enhanced services (DES) – must be provided by the PCT for its population, eg. the childhood immunisations programme • local enhanced services (LES) – locally developed services designed to meet local health needs.
Essex Safeguarding Children Board (ESCB)	This is a statutory multi agency organisation which brings together agencies who work to safeguard and promote the welfare of children and young people in Essex.
GP (General Practitioner)	Doctors who look after the health of people in their local community and deal with a whole range of health problems. They also give health education and advice on things like smoking and diet, run clinics, give vaccinations and carry out simple surgical operations.
Health equity audit	This looks at the specific health needs of the local population taking into account social and economic factors such as demographics, disease indicators and age ranges.
Hypertension	Also known as high blood pressure. Persistent hypertension, if untreated puts you at greater risk of having a heart attack (myocardial infarction) or stroke.
Independent Sector	Private and voluntary organisations providing health and social care services to the community.
Independent Sector Treatment Centre (ISTC)	Private health services that offer NHS patients free fast, pre-booked day and short stay surgery, and diagnostic procedures in specialties such as ophthalmology, orthopaedics and a range of other conditions.
LINks (Local Involvement Networks)	From April 2008, the Government plans to replace Patient and Public Information Forums with Local Involvement Networks (LINks). LINks are being introduced to help strengthen the system that enables communities to influence the care they receive. Backed up by certain powers, LINks will: • provide everyone in the community – from individuals to voluntary groups - with the chance to say what they think about local health and social care services – what is working and what is not • give people the chance to influence how services are planned and run • feedback to services what people have said about services so that things can be improved. There will be a LINk in every local authority area that is responsible for social services.

Local Area Agreements (LAAs)	These are made between central and local government in a local area. Their aim is to achieve local solutions that meet local needs, while also contributing to national priorities and the achievement of standards set by central government.
Local Authority	Local authorities are democratically elected local bodies with responsibility for discharging a range of functions as set out in local government legislation. They have a duty to promote the economic, social and environmental well being of their geographical area. This is done individually and in partnership with other agencies, by commissioning and providing a wide range of local services.
Locality	Areas into which the total geographical area of the PCT is divided. There are three localities within the West Essex PCT – Epping Forest, Harlow and Uttlesford.
Local Strategic Partnership (LSP)	This is a single non-statutory, multi-agency body, which matches local authority boundaries and aims to bring together at a local level the different parts of the public, private, community and voluntary sectors
Long-term conditions	Those conditions (e.g. diabetes, asthma and arthritis) that cannot, at present, be cured but whose progress can be managed and influenced by medication and other therapies.
Managed care	Patients with complex needs are identified and supported by skilled practitioners working for an integrated care system.
MMR	MMR is the combined vaccine against measles, mumps and rubella
Models of care	Guidance on ways of treating patients that are based on clinical evidence.
Multi Disciplinary Team (MDT)	Describes when professionals from different disciplines work together.
National Programme for IT (NPfIT)	See Connecting for Health.
NHS Trust	Public bodies providing NHS hospitals, community and mental health care, and ambulance services.
National Institute of Health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
National Service Frameworks (NSFs)	National service frameworks (NSFs) are long term strategies for improving specific areas of care. They set measurable goals within set time frames.
NHS (National Health Service)	The NHS provides the majority of healthcare in the UK, from general practitioners to A & E Departments, long-term healthcare and dentistry. It was founded in 1948 and has become an integral part of British society, culture and everyday life.

NHS Plan	The NHS Plan was published in July 2000. It outlined a new delivery system for the NHS, and changes for social services and NHS staff groups. It also set out plans for cutting waiting times, clinical priorities and reducing inequality by 2010.
Nursing homes	Residential establishments which provide the same care as in a care home (see above) but which also have registered nurses who can provide care for more complex health needs.
Our Health, Our Care, Our Say	The Government's listening exercise with the public about what their priorities are for future health and social care services. It comprised four regional events, a range of local events and other activities including questionnaires. The process culminated in a national Citizens' Summit. The events were deliberative, with a Citizens' guide given to participants beforehand to introduce the key issues.
Out of hours service	Medical cover provided outside the normal working hours of community health care professionals, usually from 6pm-8am Monday – Friday and 24 hours during weekends and Bank Holidays.
Operating Framework	The document, published annually by the Department of Health, is designed to help local NHS staff shape services around the needs of their local communities.
Palliative care	Supportive service for those who are living with disease that is not curable e.g. cancer or multiple sclerosis.
Pathways of Care Patient Pathways	Structured, multi-disciplinary plans of care designed to support the implementation of clinical guidelines and protocols. They provide detailed guidance for each stage in the management of a patient (treatments, interventions etc) with a specific condition over a specific period of time. They aim to improve, in particular the continuity and co-ordination of care across different disciplines and sectors.
Patient choice	See Choice.
Planned Care	Treatment as part of an agreed clinical pathway which is planned in advanced.
PPI (Patient and Public Involvement)	For health to fulfil its potential, members of the public should take a substantial role in shaping development. Patients and service users should be kept well informed of clinical processes and decisions.
PPI Forums	Patient and Public Involvement Forums PPI forums exist in all NHS trusts (including Foundation trusts) and PCTs to improve the quality of NHS services by bringing to trusts and PCTs the views and experiences of patients, their carers and families. They will be abolished under legislation in 2008 and replaced with local involvement networks (LINks).

Practice Based Commissioning (PBC)	A process that engages GP practices and other primary care professionals in the commissioning of services. Front line clinicians are provided with the resources and support to become more involved in commissioning decisions and gives clinicians greater freedoms and flexibilities to tailor services to the needs of the local community.
Practice Based Commissioning Groups	Forums established in each of the PCT's localities which include GPs and other health professionals. The groups have a critical role in taking forward the NHS reform programme, particularly in relation to practice based commissioning.
Primary care practitioners	Health professionals such as family doctors, dentists, pharmacists, optometrists, ophthalmic medical practitioners and therapists, together with community nurses such as district nurses and health visitors who care for people in community settings or in their own homes.
Primary care	Services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic practitioners together with district nurses and health visitors, with administrative support.
Primary Care Trusts (PCTs)	Free-standing statutory NHS bodies with responsibility for delivering health care and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.
Procurement	The acquisition of goods and or services at the best possible total cost of ownership, in the right quantity and quality, at the right time, in the right place for the direct benefit or use of organisations or individuals, generally via a contract.
Professional Executive Committee (PEC)	The PEC is made up of GPs, nurses and other health professionals. Its role is to work closely with the PCT board and other senior managers to help develop and plan the future direction of the PCT. They make sure that the PCT takes into account professional developments and clinical governance requirements.
Providers	Organisations providing healthcare services.
Public sector	An umbrella term which includes all organisations and functions that affect or are likely to affect the public or a section of the public. They are funded by central Government.
Quality Outcomes Framework (QOF)	The QOF rewards practices for the provision of quality care, and helps to fund further improvements in the delivery of clinical care.
Referral	This is when a GP feels you need to see a specialist about a particular problem or condition.
Rehabilitation	A programme of therapy designed to restore independence and reduce the effects of a disability.

Scheduled care	When care or treatment is planned in advance.
Secondary care	Specialist health care services that treat conditions which normally cannot be dealt with by primary care practitioners (i.e. GPs, therapists, community nurses etc) or which are as the result of an emergency. It covers medical treatment or surgery that patients receive in hospital following a referral from a GP. Secondary care is made up of NHS foundation, ambulance, children's and mental health trusts
Stakeholder	Organisations and individuals with an interest in the activities of the PCT. Stakeholders are involved in partnership working and are involved in PCT consultations.
Strong and prosperous communities	The aim of this White Paper is to give local people and local communities more influence and power to improve their lives. It is about creating strong, prosperous communities and delivering better public services through a rebalancing of the relationship between central government, local government and local people.
Tariff	The (national) tariff is a schedule of prices. It covers admitted patient care, (day-cases, elective in-patients and non-elective in-patients), outpatients and accident and emergency services.
Teams Around Schools, Children and Communities (TASCC)	TASCCs are multi disciplinary teams from across health, social services, education, the police and community groups to provide a focus on preventative services for children and young people.
Tertiary care	Specialised care usually undertaken in specialist centers away from District General Hospitals
Urgent care	Short term intervention (usually up to six weeks) by a multi-disciplinary team, provided in a patients' own home or a care environment, aimed at preventing hospital admissions or facilitating hospital discharge.
Voluntary and community sector	An umbrella term referring to registered charities as well as non-charitable non-profit organisations, associations, self-help groups and community groups who work for public or community benefit.
Walk-in Centres	Centres staffed by nurses that offer fast and convenient access to treatment and information without needing an appointment.
White Paper	Documents produced by the Government setting out details of future policy on a particular subject
Your Health, Your Care, Your Say	This consultation asked the public, patients, service users, and staff for their views on how to improve the services provided in the community by the NHS and social care. These views helped to shape the resulting Our Health, Our Care, Our Say White Paper.

West Essex NHS
Primary Care Trust

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