Shaping a healthier future

NHS
Harrow
Clinical Commissioning Group

HARROW

Summary of progress under Shaping a healthier future

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www.harrowccg.nhs.uk

Shaping a healthier future

SHAPING A HEALTHIER FUTURE

NHS

Shaping a Healthier Future (SaHF) will transform services for 2 million people across North West London

Why the system needs to change

- We have a growing and ageing population with more long-term conditions
- One in four patients find it difficult to see a GP when they need to and many end up in A&E
- We have more A&E departments per person than other parts of the country
- There are too few specialists in hospitals to provide high-quality round-the-clock care
- We are working from inadequate NHS facilities
- We are working within an increasingly tight budget.

North West London's five year plan

- Design a system which better supports patients and gives them more control and input over their own care
- Prevent people from dying prematurely
- Enhance quality of life for people with long-term conditions
- Help people to recover from episodes of ill health or following injury
- Ensure that people have a positive experience of care
- Treat and care for people in a safe environment and protecting them from avoidable harm

Five year plan to date

2012-2014
- Consultation and decision making

2014 - 2019
- Year 1 of implementation

Mental health and wellbeing

Improving mental and physical health through integrated services.

- Transformation of services to be responsive to patients needs and easy to access and navigate.
- Care provision as close to home as possible, with GPs at the heart of care, where and when it is needed.
- Improves the lives of users and cares, promoting recovery and delivering excellent health and social care outcomes, including employment, housing and education.

Whole systems integrated care

Coordinating care across commissioning bodies and providers

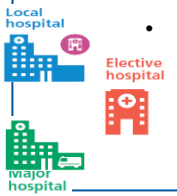
- People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems and processes will enable and not hinder the provision of integrated care.

Primary and community care

Transforming out-of-hospital services and improving access to GPs

- Provides more local input into primary care commissioning; improves access to GPs whilst being able to move money around the health economy more quickly.
- Puts the right support in place to nurture and grow GP networks so they are able to deliver sustainability in the long term.
- Develops a primary care estates strategy that takes into account hub and GP estate requirements and support implementation of plans to deliver the required estates changes of need.

Hospital reconfiguration



- Delivers a major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes. The concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

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INTRODUCTION TO HARROW

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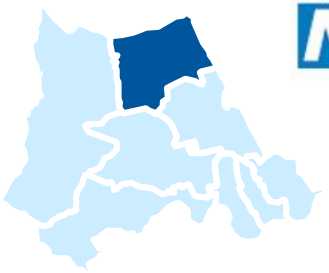
Harrow's population is growing and ageing; it has one of the highest proportions of those aged 65 and over amongst the boroughs that form the North West London cluster.



Population demographics

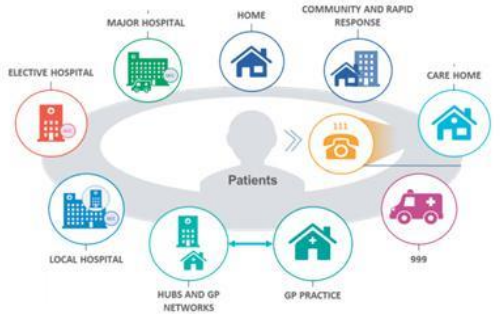
- Harrow's population is estimated to grow over the next 10–15 years, particularly amongst the 0–15 age group, and the over 65s. There will also be a decline in the number of residents aged 15–44. Currently, the north of the borough has a greater proportion of older people than the south.
- The population is ageing: Harrow has one of the highest proportions of those aged 65 and over compared to the other boroughs in North West London.

- More than 50% of Harrow's population is from Black and Minority Ethnic (BAME) groups. The biggest of these is the Indian ethnic group who make up over a quarter of the Harrow population.
- Less than half of the children speak English as a first language. The second most commonly spoken language is Gujarati.

- Harrow residents generally have better than average health and life expectancy compared to England and London. However, there are also health inequalities in Harrow that reflect socio-economic inequalities.
- Residents in the poorest parts of Harrow live on average 7 years less than those in the richest areas. Residents in the poorest areas will also spend up to 17 more years living with poor health.

Care provision

- **34 GP** practices
- **45 General Dental** practices and 2 Orthodontic practices
- **69 pharmacies**
- **65 care homes**



- **London North West Healthcare NHS Trust** and **Imperial College Healthcare NHS Trust** are the main providers of acute services.
- **London North West also** provides community services
- **Central and North West London NHS Foundation Trust** provides mental health services in and out of hospital.

Overview

239,000
Local resident population

£263m
Health commissioning budget 2014/15

£9m invested in community and integrated services

Health challenges

- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease.
- Harrow has particular challenges around circulatory disease and if mortality rates from coronary heart disease in the most deprived parts of Harrow were to reduce to the rate seen in the most affluent, life expectancy would increase by over 1 year in males and over nine months in females. Tackling chronic obstructive pulmonary disease (COPD) in both sexes would make a significant difference to life expectancy.

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CURRENT OUT OF HOSPITAL PLANS

NHS

Harrow CCG has invested £9m[1] in 13/14 and 14/15 on increasing the number of community services and joining up health and social care.

Whole systems integrated care

- **Short Term Assessment Rehabilitation and Re-ablement service (STARRS):** by providing care in the community and in patients' homes, this service helps avoid stays in hospital. If you do need a hospital stay, it will also help you get safely back home sooner. In 2014/15 STARRS helped over 3,000 patients.
- **Ambulatory care:** currently helping 50 patients a week, this service helps reduce unplanned short stays in hospital.
- **Integrated Care Planning**: patients with long term conditions get care that brings together all their health and social care needs so they stay healthy for longer and don't need to go to hospital. So far, we have agreed 6000 care plans with patients in order to deliver better more coordinated care.

Mental health and wellbeing

- **Psychiatric liaison service** supported by a **single point of access** and a **supported discharge service** providing better care for people with mental health illnesses at the right time in the right care settings.
- **Harrow Dementia Action Alliance:** a partnership of local organisations established to plan and improve dementia services.
- **Integrating Mental Health**: ensuring people receive the most appropriate care, that is more responsive to people's needs, improves wellbeing and is delivered closer to home.
  - 50% of Community Mental Health services shifting to general practice (excluding *Child & Adolescent Mental Health Services*, Mother & Baby community services, specialist teams and memory services).
  - 20% of mental health appointments will be provided by GP surgeries.
- **Memory Assessment Service** in primary care has reduced waiting times from 37 to 13 weeks and improved the diagnosis of dementia.

Additional one off investments

New primary care IT system: we have improved the IT systems in Harrow GP surgeries allowing patient data to be shared across practices more easily; to support GPs working in groups to provide better more care to local people. All practices will move onto a single IT system which will link up to acute and community services so patients get more joined up care and a better experience.

Community Out of Hospital services

- **Urgent Care Centre enhancements:** we have improved the service offering minor injuries and illness management which runs alongside the A&E service and is open 24 hours a day, 7 days a week. The service now treats over 300 patients per day from an initially commissioned 190 patients per day.
- **Gynaecology, cardiology and ophthalmology** services have been redesigned more care is available in the community rather than hospital based settings. This should help reduce waiting times and provide a more responsive and accessible service.
- **Community Walk-In Centres / Hubs**: our two walk in centres will become *out-of-hospital hubs* offering a wider range of community-based services. A third hub is to be developed to serve the east and north east of the borough. The aim is to offer up to 36,000 walk in appointments from an existing baseline of 22,000 contracted appointments.
- **End of life care:** With our three key providers of end of life care we are developing an integrated care model for end of life care, with a shared palliative care single point of access pilot so patients get an agreed care plans that supports them to die in dignified settings.

Primary care transformation (including OOH hubs)

- **Prime Ministers Challenge Fund** (PMCF) is helping all 34 GP practices in Harrow to deliver better support to patients for urgent, continuous and convenient care.
- **Six GP Peer Groups** established to provide clinical leadership and drive up the quality of GP services available to all patients by sharing best practice.
- **Weekend & evening GP appointments:** Two practices offer weekend and bank holiday access to patients across Harrow. The Pinn Medical Centre offers 8:00 a.m. to 8:00 p.m. access seven days a week; and Alexandra Avenue offers weekend access to patients from 9:00 a.m. to 4:00 p.m. Twenty practices also offer extended access during the week.
- **Efficient appointments:** 28 practices offer telephone consultations and one practice is offering email consultations. 25 practices offer online appointment booking and 24 offer longer appointments to those that need them.

Investment note: Additional expenditure on 'out of hospital' services and infrastructure, spent since the start of SaHF. This is expenditure on primary and community care services, provided outside of acute, intended to reduce demand on the acute sector, i.e. to reduce non-elective or elective admissions, in-hospital outpatient appointments, and A&E attendances. Also includes investment in supporting infrastructure. Project costs are excluded.

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FUTURE OUT OF HOSPITAL PLANS

NHS

Whole systems integrated care

- We have worked with our partners to submit our **Better Care Fund Plan**, which has now been approved. We aim to transform community services, integrate care fully and support social services so people can stay healthy and in their own homes for longer, only go to hospital if they need to and, if they do need a stay in hospital, get the right support when they leave.
- We are working as part of the North West London CCG collaboration to develop innovative approaches to whole systems integrated care as one of the **National Integrated Care Pioneer Partnerships.**
- We are continuing to roll out and develop our successful **Whole Systems Integrated Care Programme** to provide better services for people over 65 with one or more long term condition.
- We will pilot and roll out weekly **virtual ward** meetings to provide better care for patients considered at high risk of hospital admission. Consultants will be available to assess patients and provide expert advice, as well as carrying out home visits if necessary. This will be piloted in one area from March 2015 and rolled out across the borough over the course of 2015/16.
- We will **re-commission and reconfigure our community nursing services.** Six multi-disciplinary teams – bringing together staff from the NHS and social care – will work across the borough so patients get more joined up care between GP, hospital, community and social care.

Primary care / General Practice

- **Improving primary care and access to it**: we are supporting our 34 GP practices to work in networks to deliver integrated care services and work more closely with community and acute services. This means more appointments will be available at more convenient times. Patients will also be able to contact their GP in new ways such as via email.
- We will continue to make it easier to see a GP with three **Walk In Centres** GP practices providing appointments 08:00–20:00, seven days per week, so all patients can access both urgent (within 4 hours) and non-urgent (within 48 hours) appointments. In time the walk in centres will be expanded to form community hubs.

Mental health and wellbeing

- We have commissioned, reconfigured and expanded the **Memory Assessment Services (MAS)** so that it is community based, co and located within practices. All investigations are completed prior to first attendance at the MAS. Access to specialist services by multi-disciplinary teams is also provided.
- As part of **Improving Access to Psychological Therapies (IAPT),** Harrow is one of the pilot sites for the "Big White Wall" initiative where people can self refer - or be referred from a relevant service – for IAPT support so Harrow residents can get help early to maintain their psychological well being.
- We have established the **Harrow Primary Care Mental Health Service (PCMHS)** providing screening, assessment, comprehensive and evidence based interventions, advice and sign posting for people aged 18 years and above who are experiencing a range of mental health problems.
- Harrow has re-configured the **Roxbourne Service** which provides active mental health rehabilitation to Harrow residents - reducing delayed discharges, and length of stay.

Community Out of Hospital services

- **Increasing Outpatient and Elective Services in the Community:** we intend to continue our work moving of services into community settings where safe and in the best interests of patients.
- Through our Primary Care Transformation Plan, Whole Systems work and the reconfiguration of community services we will continue to deliver our vision of establishing three **Community Hubs** across the borough.
- We will **re-commission and reconfigure our community nursing services**. Six multi-disciplinary teams – bringing in staff from community, primary, hospital and social care – will work across the borough so patients get a more responsive service.
- We are investing in a **Enhanced Nurse Pilot Project** to increase nursing capacity within the community and provide better care management and coordination for our most vulnerable patients.