NHS
Harrow
Clinical Commissioning Group

Commissioning Intentions 2016-17

DRAFT

Personalised	Localised	Integrated	Centralised

Date: Tuesday 28 October 2015,

Contents

Section 1: Introduction and Overview

Harrow Clinical Commissioning Group (CCG) is the public agency responsible for purchasing the bulk of health care services in Harrow.

It is a GP led organisation tasked with working in partnership with other statutory and community organisations including Harrow Council, NHS England, Healthwatch and key health providers like London North West Hospital Trust and the Central North West London Healthcare Trust to deliver the best healthcare outcomes for Harrow residents with resources available.

Harrow CCG: Organisational Vision

Harrow CCG's has a clear organisational vision. It is:

'To work in partnership to ensure that Harrow residents receive high quality, modern, sustainable, needs-led and cost effective care within the financial budgets available.'

The aim of these commissioning intentions is to set out clearly how the CCG will utilise its resource allocation in 2016/17 to deliver its vision and to highlight any significant changes it is planning to the services that it commissions during that time.

In particular the purpose of Harrow CCG's local Commissioning Intentions is to:

- Notify our providers as to what services the CCG intends to commission for 2016/17.
- Provide an overview of our plans to commission high quality health care to improve health outcomes for

  Harrow registered patients for 2016/17.
- To engage with our member practices in commissioning a model of high quality health care for the residents of Harrow.

Document Overview

- Section One provides an overview of our intentions, our approach and key priorities. It also identifies how we will work to deliver these priorities and report on progress throughout the year
- Section Two sets out the strategic context, nationally, at a North West London level and in Harrow. In particular it highlights the importance of ensuring quality services, achieving financial stability, delivering a whole systems, community based transformation and seven day services
- Section Three sets out the key findings from the stakeholder engagement exercise undertaken to inform these commissioning intentions and the proposed actions as a result of this
- Section Four sets out our detailed commissioning intentions by service area
- Appendix One provides an overview of health needs and trends in Harrow.

- To engage partners, patients and the wider public in shaping the way in which we respond to the health needs of Harrow residents and the way we commission the appropriate services to meet local needs.

The Commissioning Intentions provide a basis for robust engagement between the CCG, partners and providers, and are intended to drive improved outcomes for patients and to transform the design and delivery of care, within the resources available. Whilst developing the Commissioning Intentions for 2015/16 last year, the CCG undertook an extensive engagement programme with a variety of stakeholders. The range of feedback received resulted in the following changes termed as 'You Said, We Did'":

You Said	We did
Engage more with Harrow patients and other stakeholders	• Increased number of engagement events CCG team attend and facilitate • Involved stakeholders in wheelchair and community services procurement • Increased engagement around 2016/17 Commissioning Intentions
We need better and more integrated community nursing services	We have developed a new integrated community services model and undertaken a procurement exercise to identify a provider to deliver it
The CCG needs to work better with your partners	Worked with Harrow Council to agree a Better Care Fund Plan to deliver better integration between health and social care and to refresh and renew the Harrow Health and Wellbeing Strategy
Focus on improving respiratory and hone oxygen services	Have incorporated this requirement in new community services specification
Carry on and accelerate your work on integrated care	Focussed on care planning for people with long term conditions and the roll out of virtual wards

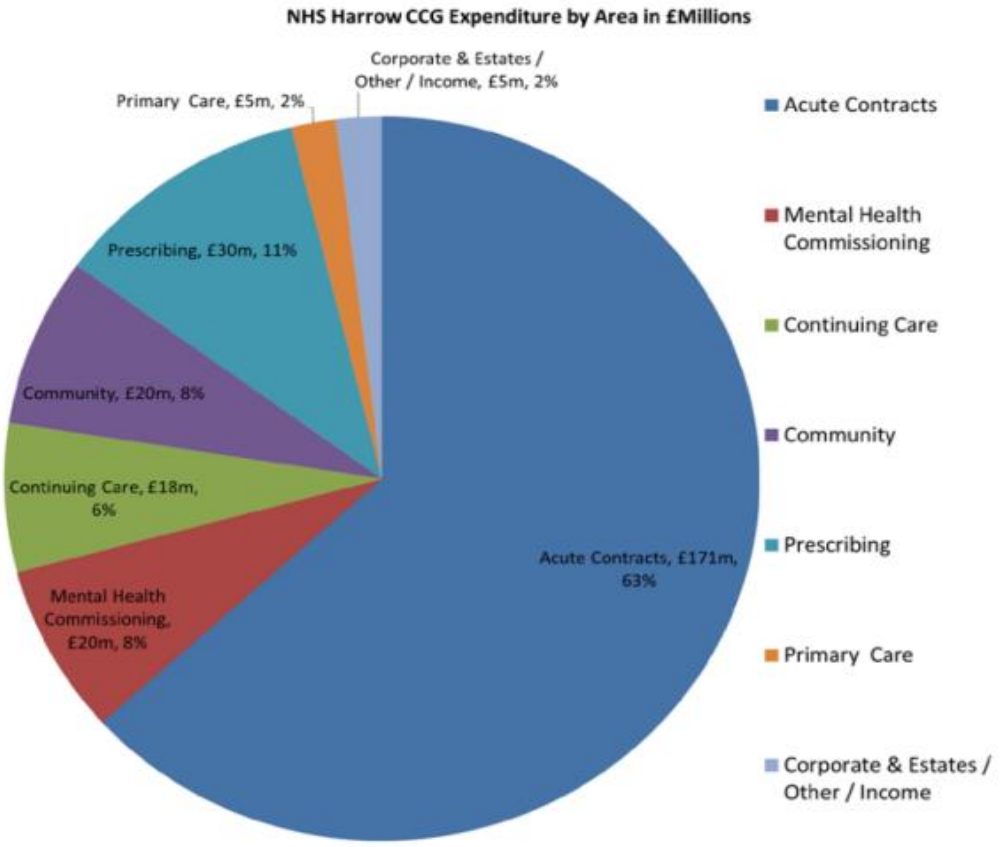
In developing the 2016/17 Commissioning Intentions an extensive programme of stakeholder engagement has been undertaken following the original publication of the draft document. In particular engagement sessions with representatives from Mind, HAD, Age UK, Harrow Patient Participation Network, Healthwatch Harrow, each Harrow GP Peer Group and the Harrow GP Forum have taken place. In addition a stakeholder engagement event attended 181 people was facilitated on Thursday 22 October. Set out in section 3 of this document are the key findings from this stakeholder engagement and CCG proposals for taking this work forward.

Harrow – the financial context

The CCG received a recurrent resource allocation of £269m for the 2015/16 financial year, which it utilises to commission healthcare services for Harrow residents.

Harrow CCG is a financially challenged organisation and while it achieved break even in 2014/15, it has an underlying deficit of £12million and is currently the beneficiary of financial support from other CCGs within the North West London Collaboration. Harrow CCG is working hard on finalising a Sustainability Plan aimed at clearing the underlying deficit, which will need to be agreed with NHS England. A key priority for the CCG in 2016/17 will be delivery of the QIPP efficiency plan.

The chart below provides an overview.



Our Values and Key Priorities

As part of the North West London Collaboration of CCGs Harrow has a very clear view as to the model of care that it wishes to commission. That model of care is based around four key values:

- Personalisation
- Localisation
- Integration
- Centralisation

To support the delivery of these Values we have developed 10 Key Priorities to inform our Commissioning Intentions in 2016/17. These are presented below.

Values

Key Priorities for 2016/17

Personalised

1. We will work with patients and other key stakeholders to ensure that we best meet the diverse needs of Harrow residents. (Governing Body, Engagement and Equalities Sub Committee, Joint Health and Wellbeing Executive).
2. We will promote self care and better health care education, focussing on prevention (All Services, Education Forum)
3. We will develop better patient pathways for Diabetes and MSK services

Localised

4. We will reduce hospital attendance by commissioning more elective procedures outside of hospitals and investing more in community and primary care capacity in the borough *(All)*
5. We will work with GP Practices to increase access to primary care services and provide more services out of hours (Primary Care & Community Care Workstream)

Integrated

6. We will transforming services to deliver whole systems, community based care focussing on providing joined up support for people at risk of hospital admission or with long term conditions. (All)
7. We will leverage the benefits of technology to provide more timely, joined up services, better and more consistent treatments and the more optimum use of resources (Information Management Workstream)
8. We will work with partners in NW London to improve urgent care and out of hours care pathways to ensure more responsive care and to reduce pressure on A&E and LAS services (Unplanned Care Workstream)
9. We will work with other commissioners and providers to develop better and more integrated mental health and children's services (Childrens, Mental Health Workstreams)

Centralised

10. We will reduce the amount of time spent by patients in hospital by increasing the availability of community beds and developing better and more efficient care pathways out of hospital and into the community (Unscheduled Care Workstream)

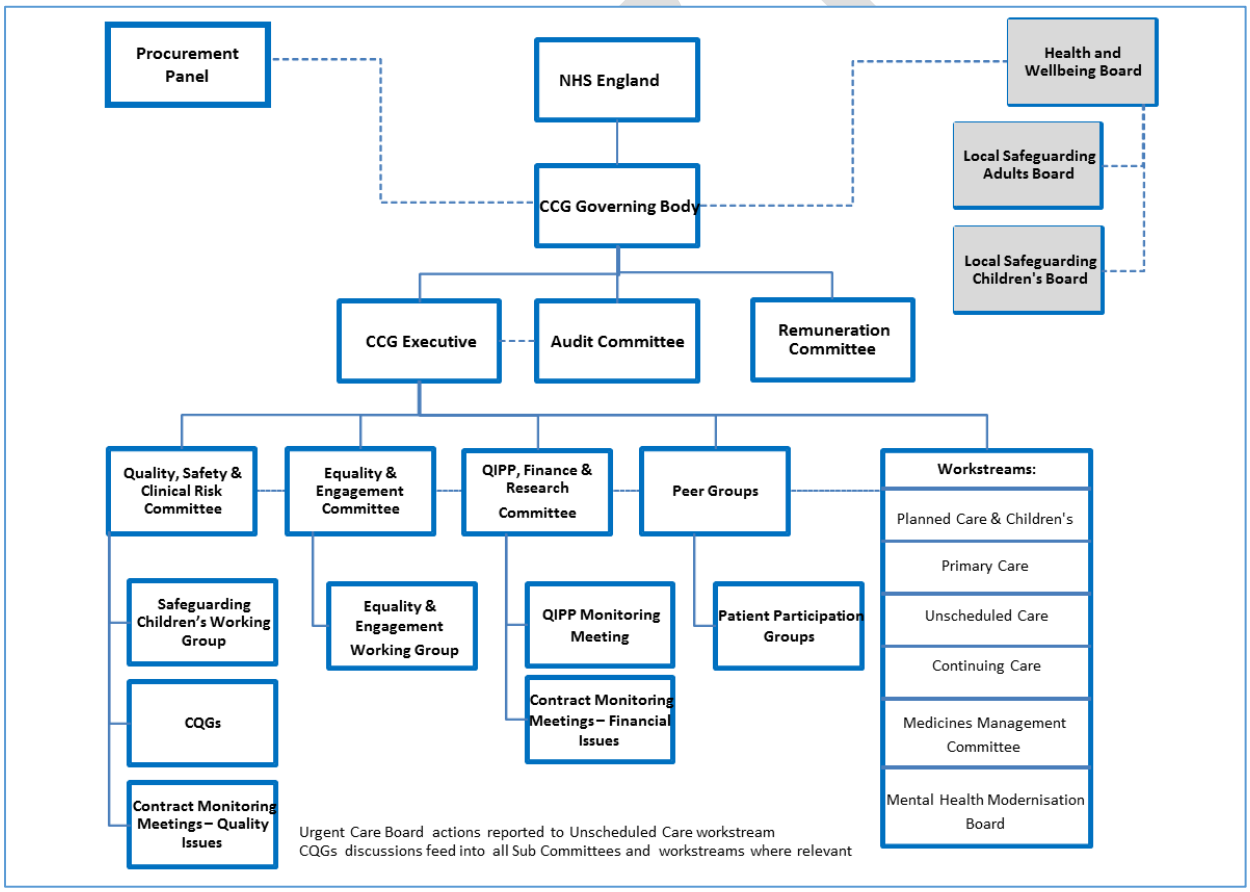
Health Landscape in Harrow

These commissioning intentions have been informed by a comprehensive analysis and understanding of the Health Landscape in Harrow and an overview is provided in appendix 1.

Delivering our Key Priorities

To deliver our key priorities we will utilise our existing governance structure and workstream as presented in the diagram below.

We have set out clearly which group will be accountable for each of our key priorities and which Clinical Director and Management Lead will be responsible for each of our commissioning intentions



We will also seek to strengthen our strategy development and delivery process by investing more resources in patient co design and engagement, in particular where work is underway to develop new care models or pathways.

We will also work to strengthen delivery by promoting a systems leadership approach to health transformation across the borough. We have made good progress in working effectively with our partners through the Better Care Fund initiative, through the Health and Wellbeing Board and through our collaborative work

around Winter Resilience. We recognise though that the challenges required over the next five years require commissioners, providers and patients to work better together and that is why this is our number one priority.

Measuring Progress during 2016/17

We will measure progress against the delivery of our commissioning intentions in 2016/17 by:

- Presenting a review of progress against each of the 10 key priorities at each meeting of the Harrow CCG Governing Body and the Harrow Health and Wellbeing Board
- Engaging with GP Practices through Peer Group Meetings and the GP Forum on progress with implementing our Commissioning Intentions on a quarterly basis
- Facilitating a Patient and Stakeholder Commissioning Intentions Stock Take Event in March 2016
- Working with Harrow Health Watch and the Harrow Patient Participation Network and affiliate groups to update on progress and focus on particular priority areas

Engage with NHS England on progress with delivering the Commissioning Intentions and the Sustainability Plan through the on-going assurance process

Section Two: Strategic Context

Our commissioning intentions and our key priorities are informed and shaped by the national, regional and local strategic context. An overview is presented below.

National Strategic Context

In developing our local Commissioning Intentions, Harrow CCG needs to consider the national strategic context. The on-going financial restraint requires public organisations to reduce costs and whilst the health budgets are 'protected' there are knock on effects that increase the pressure on healthcare services when budgets are cut elsewhere in the public sector.

Summary of the NHS Five Year Forward View

The national strategic context is laid out in the NHS document "The Five Year Forward View". Highlights from this document are provided in the following section.

The Five Year Forward View

Published in October 2014 sets out the need for the NHS to align the quality of care for all, address health inequalities, focus on reducing the level of preventable disease and cope with growing demand. It estimates that if growing demand for healthcare services is not met by further annual efficiencies and flat real terms funding then there will be a mismatch between resources and patient needs of c. £30bn by 2020/21.

This can only be addressed by tackling demand, efficiency and funding.

In 15-16 additional £2bn of recurrent funding was announced in the Autumn Budget statement following publication of the Five Year Forward view.

A summary of the Five Year Forward View is provided in the following section.

The NHS has dramatically improved over the past fifteen years. Cancer and cardiac outcomes are better; waits are shorter and patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread and health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients.

The first argument we make is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded and the NHS is on the hook for the consequences.

The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

Second, when people do need health services, patients will gain far greater control of their own care including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

Third, the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

England is too diverse for a ‘one size fits all’ care model to apply everywhere. But nor is the answer simply to let ‘a thousand flowers bloom’. Different local health communities will instead be supported by the NHS’ national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care through a Multispecialty Community Provider. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

A further new option will be the integrated hospital and primary care provider – Primary and Acute Care Systems – combining for the first time general practice and hospital services, similar to the Accountable Care Organisations/Partnerships (ACPs) now developing in other countries too.

Across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. Smaller hospitals will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the maternity services they offer. The NHS will provide more support for frail older people living in care homes.

The foundation of NHS care will remain list-based primary care. Given the pressures they are under, we need a ‘new deal’ for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

In order to support these changes, the national leadership of the NHS will need to act coherently together, and provide meaningful local flexibility in the way payment

rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology – radically improving patients' experience of interacting with the NHS. We will improve the NHS' ability to undertake research and apply innovation – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch.

In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance – compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period – provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending per person would take account of population growth. Flat NHS spending as a share of GDP would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could – if matched by staged funding increases as the economy allows – close the £30 billion gap by 2020/21. Decisions on these options will be for government and will need to be updated and adjusted over the course of the next five year period.

NHS Outcomes Framework

Whereas the NHS Five Year Forward View document sets the strategic direction for all NHS organisations, Harrow CCG also need to consider the NHS Outcomes Framework which provides a national overview of how well the NHS is performing. The Outcomes Framework was first developed in December 2010 and has been updated annually since then which enables it to remain a tool which reflects the current landscape of the health and social care system. In preparing HCCG's Commissioning Intentions for 2016/17 we therefore need to consider the latest edition of the Outcomes Framework (2015/16) and the indicators that are outlined within it.

The NHS Outcomes Framework requires NHS organisations, including Harrow CCG, to consider performance indicators that are grouped together into the following five domains:

Domain 1: Preventing people from dying prematurely.

Overarching Indicators:

- Potential Years Life Lost (PYLL) from causes considered amenable to healthcare
- Life expectancy at 75
- Neonatal Mortality and Stillbirths

Improvement areas under Domain 1 include focusing on Cardiovascular Disease, Respiratory Disease, Liver Disease, Cancer, Mortality in Adults with Serious Mental Illness, Infant Mortality and reducing mortality rate in adults under 60 with a Learning Disability.

Domain 2: Enhancing quality of life for people with Long Term Conditions (LTCs).

Overarching Indicators:

- Health-related quality of life for people with Long Term Conditions (LTCs)

Improvement areas under Domain 2 include focusing on the proportion of people who feel supported, employment of people with LTCs, reducing time spent in hospital by patients with LTCs, enhancing the quality of life for carers, those with mental illness and those with dementia as well as those with multiple LTCs.

Domain 3: Helping people to recover from episodes of ill health or following injury.

Overarching Indicators:

- Emergency admissions for acute conditions that should not usually require hospital admission.
- Emergency readmissions within 30 days of discharge from hospital.

Improvement areas under Domain 3 include improving outcomes from planned treatments, preventing lower respiratory tract infections in children from becoming serious, improving recovery from injuries and trauma, stroke and fragility fractures,

helping older people to recover their independence after illness or injury and dental health.
Domain 4: Ensuring that people have a positive experience of care. Overarching Indicators: • Patient experience of primary care. • Patient experience of hospital care. • Friends & Family Test. • Patient experience characterised as poor or worse (primary and hospital care). Improvement areas under Domain 4 include improving people's experience of outpatient care and accident and emergency services, improving hospitals' responsiveness to personal needs, improving access to primary care services, improving women and their families' experience of maternity services, improving the experience of care for people at the end of their lives, those with mental illness, for integrated care and for the experience of healthcare for children and young people.
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidance harm. Overarching Indicators: • Deaths attributable to problems in healthcare. • Severe harm attributable to problems in healthcare. Improvement areas under Domain 5 include reducing the incidence of avoidance harm (such as deaths from venus thromboembolism (VTE) events, incidence of healthcare acquired infection (HAI), hip fractures and category 2, 3 or 4 pressure ulcers), improving the safety of maternity services and improving the culture of safety reporting.

Better Care Fund

A key requirement of Central Government was the development and agreement of a Better Care Fund Plan between the CCG and Harrow Council. The plan was agreed in January 2015 and is fully assured. Progress continues to deliver its priorities.

The Better Care Fund plan will play a key role in delivering the CCGs wider vision

In particular it focuses on real people and delivering three key schemes:

- Whole Systems Integrated Care
- Transforming Community Services; and
- Protecting social care in Harrow.

Progress on delivering our BCF continues. It is a key priority for the CCG and we will continue to monitor and make progress with its delivery.

High Impact Actions for Urgent & Emergency Care

In addition to the NHS Five Year Forward View and the NHS Outcomes Framework, Harrow CCG also needs to consider the 8 High Impact Actions for Urgent & Emergency Care that have been recommended by NHS England, Monitor and Trust Development Agency. These 8 Actions have been reviewed and agreed by the Harrow System Resilience Group (SRG) and are summarised below:

1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

4. SRGs should ensure the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support the management of falls patients without conveyance to hospital where appropriate

6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on

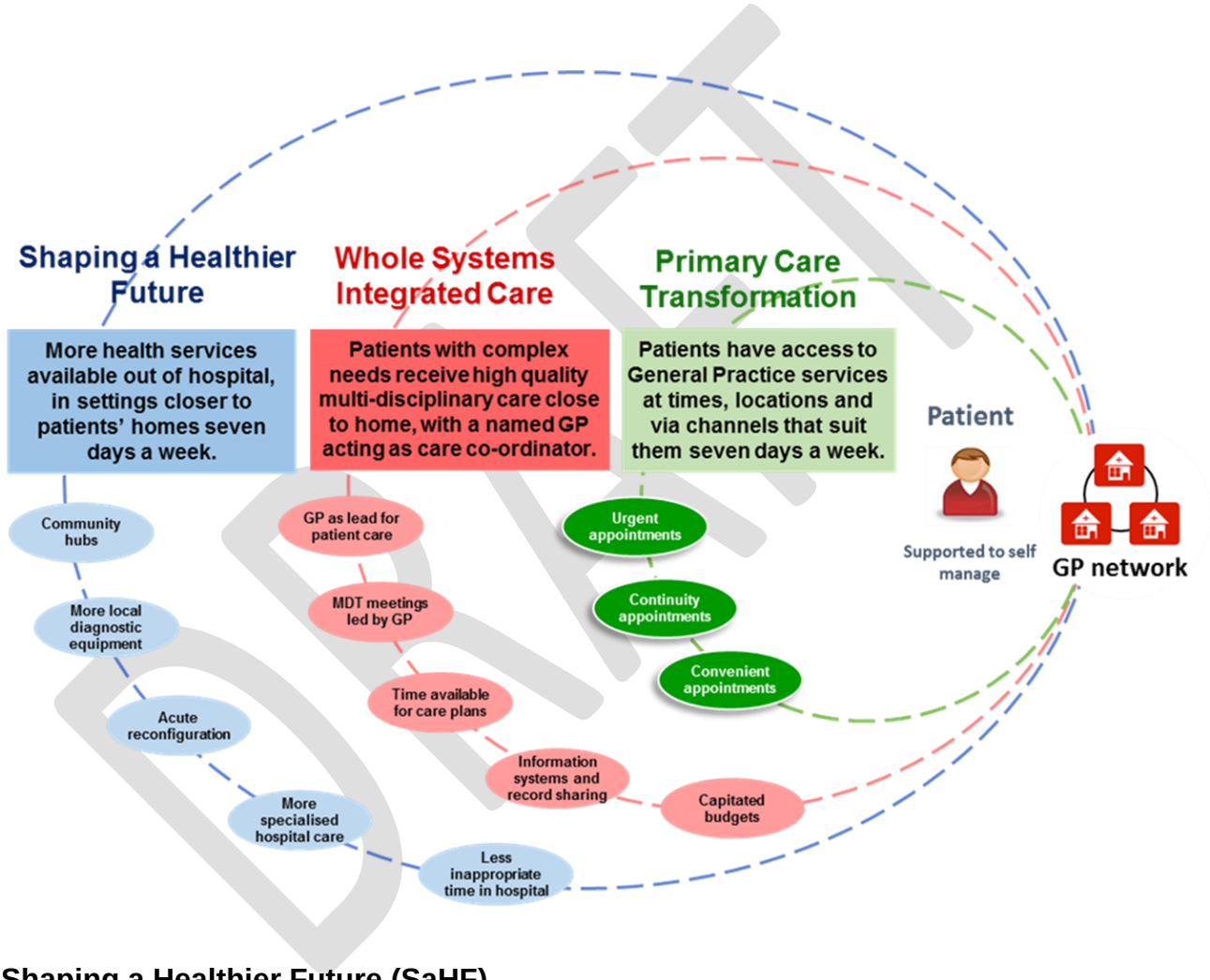
7. Daily review of in-patients through morning ward or board rounds, led by a consultant/senior doctor, should take place seven days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

The North West London Strategic Context

Harrow is part of the North West London Collaboration of CCGs and together they have worked closely to develop a long term vision for the delivery of health and social care in North West London. The key aims of this transformation vision is to provide more care closer to home, reduce pressure on acute services, invest in whole systems care and reconfigure acute services to deliver better outcomes and to release resources for investment in the community.

The diagram below provides an overview of the North West London Healthcare Vision.



Shaping a Healthier Future (SaHF)

To deliver the North West London Healthcare vision we need to transform how health and care services are delivered both in hospital and in the community. In 16/17 the SaHF Reconfiguration programme will continue to oversee the re-configuration of the existing hospital landscape of nine hospitals to provide five Major Acute Hospitals. This will involve the following fundamental changes.

- Ealing and Charing Cross sites redeveloped, in partnership with patients and stakeholders, into local hospitals;
- Hammersmith Hospital established as a specialist hospital;
- Central Middlesex Hospital will be redeveloped as a Local and Elective Hospital.

Outline Business Cases (OBCs) are being developed and centrally reviewed for all sites in 2015/16 (major and local hospitals) additionally the programme is also developing an Implementation Business Case (ImBC) to ensure that the refined solution for NWL remains affordable and aligned with the clinical vision. OBCs for Major and Local Hospitals are expected to be approved by NHS England, NHS Trust Development Agency, Department of Health and Her Majesty's Treasury in 2015/16, and following this Full Business Cases will be developed to allow the redevelopment of sites to continue.

Harrow Local Strategic Context

There are a range of local strategies and plans which inform the CCGs commissioning intentions – in particular the Harrow Health and Wellbeing Strategy and the Better Care, Closer to Home – the NHS Harrow, Out of Hospital Strategy.

Harrow Health and Wellbeing Strategy

The vision of the local Harrow Health and Wellbeing Strategy is

"To help each other to start, live, work and age well."

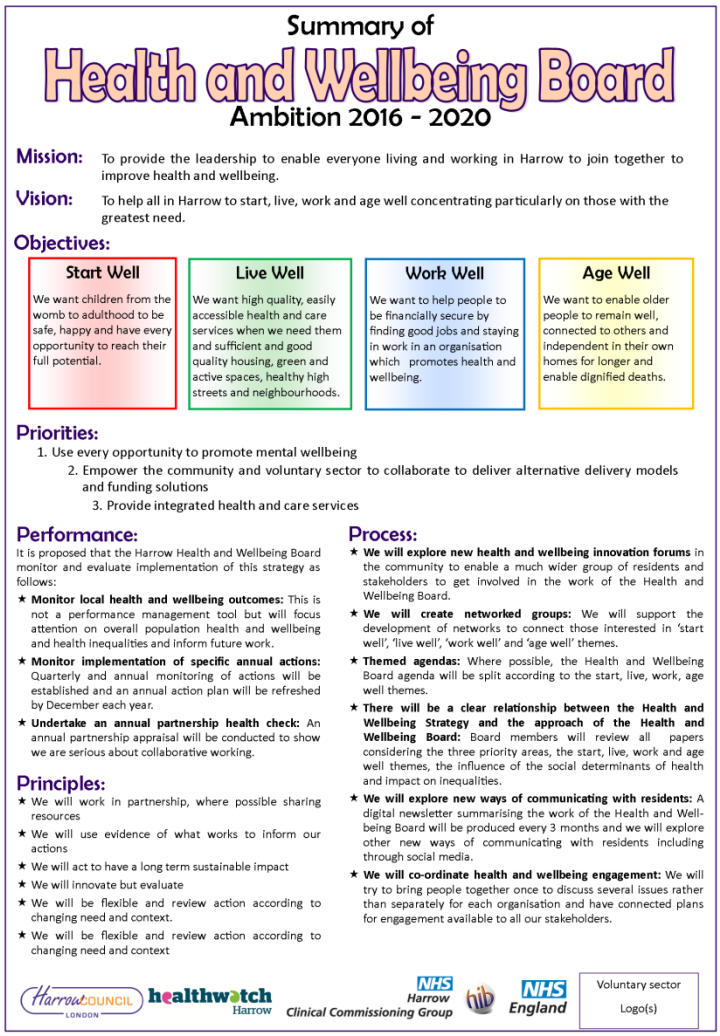
This means:

- Start well – we want children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential
- Live well – we want high quality, easily accessible health and care services when we need them, sufficient and good quality housing, green and active spaces, healthy high streets and neighbourhoods
- Work well – we want to help people to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing
- Age well – we want to enable older people to remain well, connected to others and independent in their own homes for longer and enable dignified deaths

The key priorities are:

- Use every opportunity to promote mental wellbeing
- Empower the community and voluntary sector to collaborate to deliver alternate delivery models and funding solutions
- Provide integrated health and care services

The focus of Health and Wellbeing partners in the future will focus on how they can contribute to making Harrow a better place to live and reduce the differences in life expectancy and healthy life expectancy between communities.



Summary of

Health and Wellbeing Board

Ambition 2016 - 2020

Mission: To provide the leadership to enable everyone living and working in Harrow to join together to improve health and wellbeing.

Vision: To help all in Harrow to start, live, work and age well concentrating particularly on those with the greatest need.

Objectives:

Start Well
We want children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential.

Live Well
We want high quality, easily accessible health and care services when we need them and sufficient and good quality housing, green and active spaces, healthy high streets and neighbourhoods.

Work Well
We want to help people to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing.

Age Well
We want to enable older people to remain well, connected to others and independent in their own homes for longer and enable dignified deaths.

Priorities:

1. Use every opportunity to promote mental wellbeing
2. Empower the community and voluntary sector to collaborate to deliver alternative delivery models and funding solutions
3. Provide integrated health and care services

Performance:

It is proposed that the Harrow Health and Wellbeing Board monitor and evaluate implementation of this strategy as follows:

- ★ **Monitor local health and wellbeing outcomes:** This is not a performance management tool but will focus attention on overall population health and wellbeing and health inequalities and inform future work.
- ★ **Monitor implementation of specific annual actions:** Quarterly and annual monitoring of actions will be established and an annual action plan will be refreshed by December each year.
- ★ **Undertake an annual partnership health check:** An annual partnership appraisal will be conducted to show we are serious about collaborative working.

Principles:

- ★ We will work in partnership, where possible sharing resources
- ★ We will use evidence of what works to inform our actions
- ★ We will act to have a long term sustainable impact
- ★ We will innovate but evaluate
- ★ We will be flexible and review action according to changing need and context.
- ★ We will be flexible and review action according to changing need and context

Process:

- ★ **We will explore new health and wellbeing innovation forums** in the community to enable a much wider group of residents and stakeholders to get involved in the work of the Health and Wellbeing Board.
- ★ **We will create networked groups:** We will support the development of networks to connect those interested in 'start well', 'live well', 'work well' and 'age well' themes.
- ★ **Themed agendas:** Where possible, the Health and Wellbeing Board agenda will be split according to the start, live, work, age well themes.
- ★ **There will be a clear relationship between the Health and Wellbeing Strategy and the approach of the Health and Wellbeing Board:** Board members will review all papers considering the three priority areas, the start, live, work and age well themes, the influence of the social determinants of health and impact on inequalities.
- ★ **We will explore new ways of communicating with residents:** A digital newsletter summarising the work of the Health and Wellbeing Board will be produced every 3 months and we will explore other new ways of communicating with residents including through social media.
- ★ **We will co-ordinate health and wellbeing engagement:** We will try to bring people together once to discuss several issues rather than separately for each organisation and have connected plans for engagement available to all our stakeholders.

Harrow Council LONDON | healthwatch Harrow | NHS Harrow Clinical Commissioning Group | hlb | NHS England | Voluntary sector Logo(s)

Cancer

Cancer has a significant impact on wellbeing and quality of life of people with cancer and their family and carers. Although many cancers are treatable and have a good and improving survival rate, cancer is the second highest cause of death in Harrow. Lung cancer and breast cancer are two specific cancers that drive the health inequalities gap. Effective prevention and early detection will have a long term impact on incidence of some cancers and deaths from other cancers. As with long term conditions, there is a significant role for ill health prevention and early detection and there are considerable employment issues for people with LTCs and impact of disease on local economy. Standard of living is affected impacting on the individual with the condition and their family. In 2012, London Clinical Commissioning Groups (CCGs) identified early detection as a priority area to transform cancer services and that an important way to achieve this is to raise GP awareness of quality and timeliness of referral routes, symptoms of cancer and access to diagnostics. Every year more than 30,000 Londoners will be diagnosed with Cancer.

The aim is to improve the early detection of cancer and referral management of cancer cases, both factors known to influence survival rates. This work also has

relevance for the CCG's efforts towards meeting the NHS Outcome Framework Domain 1 target to, and to reduce deaths in the people aged under 75. The CCG aims to reduce the proportion diagnosed through the emergency referral route, which will usually have a more advanced cancer, poorer survival chances and higher care costs for the CCG.

The CCG will continue to work closely with Secondary Care to meet the national targets for the diagnosis and treatment of cancer conditions. In order to manage emergency presentations of cancer related symptoms in acute settings, the CCG is working with Secondary Care partners to enhance the current Acute Oncology Service (AOS).

To achieve these outcomes working in closer partnership with public health and voluntary groups is essential. Partnership working will improve uptake in screening, especially for patients in marginalised and seldom heard groups. Public Health messages will help all cancer outcomes as they emphasise healthy lifestyles which will improve outcomes in cancer and all other disease areas.

NHS Harrow Out of Hospital Strategy - Better Care Closer to Home

In 2012/13 NHS Harrow consulted on its Out of Hospital Strategy, which sets out the intention to commission services which reduce reliance on hospital based care through strengthening the range and focus of services delivered in primary and community settings.

The 'Out of Hospital Strategy', Better Care Closer to Home - Our strategy for co-ordinated, high quality out of hospital care, sets out five strategic goals:

- Easy access to high quality, responsive primary care.
- Clearly understood planned care pathways.
- Rapid response to urgent needs within 2 hours.
- Social and Healthcare Providers to work together, with the patient at the centre, to proactively manage people with long term conditions, the elderly and end of life care patients out of hospital.
- Patients will spend an appropriate time in hospital.

Harrow CCG has identified that there are significant opportunities to improve the quality of out of hospital services through the implementation of a whole systems approach to out of hospital services and in particular the re-commissioning of its existing community services.

Partnerships

Harrow CCG considers partnerships with patients, carers, the public and its members as integral to successfully delivering its vision.

NHS Harrow CCG continues to work in partnership with Carers and plan to jointly enhance this work with Harrow local Authority. The local Carer organisations provide a significant role to ensure carers get the support they need to undertake the complex, personal and often challenging role they deliver to their families, love ones and friends.

Working to the following objectives:

- Engage relevant stakeholders in a timely and appropriate manner during all phases of the commissioning cycle
- Ensure that all stakeholders receive, clear, coherent and consistent information regarding CCG activities
- Increase local awareness of, interest in and engagement with clinical commissioning
- Develop strong working relationships with partners and stakeholders that enable appropriate joint decision making and information sharing
- Establish a mechanism and feedback loop that supports the CCG in actively building upon the input it receives from key partners and stakeholders

Harrow CCG Mental Health Engagement Groups:

- Harrow Youth Parliament
- CNWL service users forum
- Harrow Health Watch
- Harrow BAME Carers Group
- Harrow Advocacy Groups (Mencap, Voice ability, MIND)
- Rethink- Young people's group
- Harrow Users Group (HUG)
- London Healthy Partnerships

Section Four: Outcome of stakeholder engagement

Following publication of the draft commissioning intentions an extensive programme of stakeholder engagement has been undertaken to test and inform the CCGs proposed commissioning intentions.

The draft Commissioning Intentions document was circulated as follows:

- Publication on CCG website
- Circulation and review by Patient Participation Groups
- Circulation and review by GP Practices Local Medical Committee
- Circulation and review by Harrow MPs and Councillors
- Submission and review by NHS England
- Scrutiny and review by Harrow Healthwatch and affiliated organisations
- Circulation and review to community organisations and other stakeholders
- Circulation and review by existing and prospective providers
- Scrutiny and co-design at stakeholder engagement event on 22 October

Accompanying this document is a report summarising the conclusions of the stakeholder engagement event facilitated on 22 October 2015. This was attended by 181 individuals with a wide range of interests and representing a wide range of organisations. Of those completing an event satisfaction survey 94% said they were satisfied or very satisfied with the topics discussed on the tables at the event.

Set out below by service area are the key findings from the stakeholder engagement and the proposed next steps. Please note that the tables below incorporate the findings from all of the engagement events that have taken place and are not drawn exclusively from the stakeholder engagement event on 22 October.

Integrated Care

Integrated Care			
No	**Key Finding**	**Action**	**Change CI**
1	Need to focus much more heavily on Prevention and Self Help	Incorporate and monitor Prevention KPI is all major contracts	Y
2	Quality of existing Falls Service needs to be improved	Service being re-procured as part of Community Services project	N
3	Much greater promotion of existing whole system programme required	To be incorporated into WSIC Business Case 2016/17	Y

4	Care Planning process should be simplified and made more accessible	Review approach to care planning ahead of WSIC Business Case 2016/17	Y
5	Widespread patient expectation that patient records should be shared to support effective integrated care	Interoperability and patient record sharing to be identified as key CCG priority	N
6	Considerable GP frustration with limited progress with patient record sharing	Interoperability and patient record sharing to be identified as key CCG priority	N
7	Greater opportunities for system-wide approach to support 5000 most vulnerable Harrow Patients	To be incorporated in planned discussions on establishing Accountable Care Partnership	Y
8	Greater opportunity for aligning incentives amongst providers and commissioners to improve the hospital discharge pathway	Existing key priority and to be incorporated in discussions on establishing Accountable Care Partnership	N

Primary Care

Primary Care			
No	**Key Finding**	**Action**	**Change CI**
1	Positive patient experiences with on-line prescriptions and appointment booking	Set target of all GP practices to provide on-line prescriptions and appointment booking by April 2016?	N
2	Positive patient experience with telephone triage arrangements – should incorporate a guaranteed ring back standard	All GP practices to be encourage to provide telephone triage by April 2017?	Y
3	Significant patient frustration that care records not routinely shared when referred to community or acute service	Interoperability and patient record sharing to be identified as key CCG priority	N
4	Significant patient frustration about continuity of care and use of locum GPs	To be addressed through Increasing access to primary care programme	N
5	Patient perception that average wait for routine GP appointment in Harrow is 2 weeks	To be addressed through Increasing access to primary care programme	N
6	Patient perception that standard appointment length insufficient to deal effectively with complex or	To be addressed through Increasing access to primary care programme	N

	multiple conditions		
7	Better communication and marketing of community services required	To be addressed through re-procurement of community services	
8	CCG needs to prioritise re-procurement and reconfiguration of walk in centre services	To be addressed through Increasing access to primary care programme	N
9	Walk In Centre or Walk In tariff to be established at Northwick Park Hospital	To be addressed through Increasing access to primary care programme	N
10	Benefits of Consultant telephone Advice Service for GPs to be considered	Further investigation required; partly addressed through community services procurement	
11	Greater coordination is required between GPs and community nurses	To be addressed through community services re-procurement	
12	Positive patient perception of use of text messaging to confirm appointments	To be addressed through Increasing access to primary care programme	N
13	Sit and wait service should be available in all GP practices	To be addressed through Increasing access to primary care programme	N
14	Increased promotion required to raise awareness of early and late appointments available	To be addressed through Increasing access to primary care programme	N
15	Considerable frustration at lack of walk in service in East Harrow	To be addressed through Increasing access to primary care programme	N
16	Better training for reception staff required and receptions to be made more welcoming	Training currently underway through Education Forum	N

Planned Care

Planned Care			
No	**Key Finding**	**Action**	**Change CI**
1	Should incorporate within planned care contracts KPI to measure DNAs	Consider as part of 2016/17 contractual framework	N
2	Clinical and business case for	Planned Care workstream to	?

	investment in Sleep Apnoea Service	consider requirement	
3	Clinical and business case for investment in Obesity Clinic	Planned Care workstream to consider proposal provided	?
4	Clinical and business case for investment in Spinal Pain Service	Planned Care workstream to consider requirement	?
5	Insufficient capacity within the community for COPD and Respiratory Services	Addressed as part of Community Services re-procurement	N
6	Additional capacity required to provide Pulmonary Rehab services	Addressed as part of Community Services re-procurement	N
7	Insufficient speech and language services available in the community	Planned Care workstream to review service requirement	?
8	Significant opportunity to improve MSK care pathway	Identified as a priority are for 2016/17	N
9	Better data sharing between GPs and other clinical services should be a number one priority for the CCG in 2016/17	Identified as a key priority for 2016/17; ICT interoperability work to be prioritised	N
10	Greater opportunity for integrated services – currently a disconnect between diagnostic tests, GP and acute referrals; not helped by poor record sharing	Care pathways to be systematically reviewed by Planned Care workstream	
11	Currently long waits for secondary care appointments at LNWHT	To be addressed as part of existing contract management arrangements	N
12	There is a clear need for more self help groups and clarity about access and referral arrangements to these services (eg Diabetes prevention Programme	??	??

Mental Health

Mental Health			
No	**Key Finding**	**Action**	**Change CI**
1	More effort is required to follow the protocols for Shifting Settings of	Review and improve the monitoring of this programme	Y

	Care.		
2	Training for GPs and staff caring the patients with mental health conditions	Ongoing training and updates for GPs and Staff on mental illness	Y
3	Greater promotion and information around translators/interpreters services, Advocacy and PALS	Review and improve current provision	Y
4	Stigma and lack of respect remains evident	More promotion on reducing stigma improving dignity and respect	Y
5	Limited information in Practices concerning mental health	Promote and improve the level of communication and information displayed in practices, libraries and newspapers	Y
6	Culturally for Harrow a significant number of people in the community rely only or firstly on their community or spiritual leaders	Involve community and spiritual leaders through voluntary and community organisations to reach and educate communities on mental health and dementia	Y
7	Services users and carers require more time with their GP when describing their symptoms	Increase the number of specialist mental health nurses attached and based at GP Practices.	N
8	GP practices and providers are not always aware of the cultural backgrounds and behaviours of their carers and users	Produce information describing the countries, cultures, language and barriers to treatment associated with the multicultural make-up of Harrow.	Y

Unscheduled Care

Unscheduled Care			
No	**Key Finding**	**Action**	**Change CI**
1	Better signposting required to set out difference between Urgent Care Centres and Walk In Centres	Unscheduled Care WS and Communications team to review	N

2	Access to specialist care through local GPs difficult	To be addressed through community services re-procurement	N
3	Physical pathway to A&E is difficult, traffic and access to other parts of hospital	To be referred to LNWHT	N
4	Greater opportunity to work with and educate frequent attenders at A&E	?	N
5	Patients should have their health data available wherever they go – but should not be provided to external agencies	Identified as a key 2016/17 priority. To be addressed through ICT and Interoperability plans	N

End of Life Care

End of Life Care			
No	**Key Finding**	**Action**	**Change CI**
1	CNS team should move to a 7 day working schedule to better align with other services and address the delayed transfer of care	Consider as part of 2016/17 contract round	N
2	Need to align the acute palliative care team	Consider as part of 2016/17 contract round	N
3	Planned discharge should not be left until late on Friday	Consider as part of 2016/17 contract round	N
4	Should be a timely evaluation of the End of Life SPA incorporating a wide range of stakeholders	Review of End of Life SPA to be scheduled	Y
5	Potential for greater education and training between palliative care teams and district nurses	Refer to Education Forum	N

Equality and Engagement

Equality and Engagement			
No	**Key Finding**	**Action**	**Change CI**
1	CCG to undertake more targeted work with young people utilising different methods of communication and engagement	Equality & Engagement Committee to develop next steps	N

2	Young Persons Ambassador to be appointed to Governing Body	Governing Body to consider benefits of proposal	
3	Insufficient focus on healthy eating and prevention, particularly within schools	Approach to promoting Health Eating to be considered by CCG seminar	
4	Greater focus on support for Carers (particularly working carers) required	??	
5	Greater opportunity to utilise volunteers and partnership working	??	
6	Culturally for Harrow a significant number of people in the community rely only or firstly on their community or spiritual leaders	Involve community and spiritual leaders through voluntary and community organisations to reach and educate communities on mental health and dementia	Y
7	Services users and carers require more time with their GP when describing their symptoms	Increase the number of specialist mental health nurses attached and based at GP Practices.	N

Health and Wellbeing Priorities

Health and Wellbeing Priorities			
No	**Key Finding**	**Action**	**Change CI**
1	Insufficient focus in existing commissioning intentions on Cancer	To be strengthened prior to presentation to Governing Body	Y
2	Insufficient focus on healthy eating and prevention, particularly within schools	Approach to promoting Health Eating to be considered by CCG seminar	
3	Greater focus on support for Carers (particularly working carers) required	??	
4	Greater opportunity to utilise volunteers and partnership working		

Section Three: Commissioning Intentions:

Set out on the following pages are our commissioning intentions within specific service areas. These should be considered alongside our key priorities set out on page 6.

1. Integrated Care
2. Unplanned Care
3. Planned Care
    a. MSK (incorporating spinal, trauma, orthopaedics, rheumatology, physiotherapy and pain management)
    b. Community cardiology, gynaecology, ophthalmology and diabetes
    c. Dermatology, Neurology
4. Mental Health
5. Children & Young People (CYP)
6. Medication Management
7. End of Life
8. Community Services
9. Primary Care
10. Continuing Health Care (CHC) & Complex Care
11. Safeguarding
12. Information Technology

Service Area 1	Integrated Care
Service Lead	CL: Dr Amol Kelshiker ML: Dylan Champion
Overview	**Whole Systems Integrated Care (WSIC)** means……. **building care and support around individuals** rather than organisations, and providing more care outside of hospitals and in the community. It also means **tailoring different care solutions for different population groups** and re-prioritising the use of resources so that more is spent on **prevention and proactive long term support** and less is spent on reactive emergency and unplanned care.
Need	The CCG has identified over 65s with one or more long term condition as its priority group because it believes there is the greatest opportunity to improve the quality of life and to reduce the likelihood of hospital admission for this group through the implementation of a whole systems integrated care approach to health and social care.

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Ensure named GP and identified case manager for every patient in the borough at high risk of hospital admission • Ensure every patient at high risk of hospital admission has the opportunity to agree a care plan • Support employment of Enhanced Practice Nurses at practice level to support GPs in providing effective case management and coordination for patients	• Better care for people with long term conditions or at high risk of hospital admission • Overall reduction in hospital admissions • Better utilisation of resources available

Personalised	Localised	Integrated	Centralised

Localised	• Embed and establish GP led multi-disciplinary teams to coordinate primary and community care at a sub network level • Embed and establish Virtual Wards at a sub network level to coordinate intensive community based support for patients at high risk of hospital admission	• Greater continuity of care for patients as increased collaboration between agencies at local level • Additional targeted support for patients at highest risk of hospital admission
Integrated	• Embed and establish GP led multi-disciplinary teams to coordinate primary and community care at a sub network level • Embed and establish Virtual Wards at a sub network level to coordinate intensive community based support for patients at high risk of hospital admission • Continued investment in protecting social care through existing Section 75 Agreement (Better Care Fund Plan) • Invest in additional social care resource to provide better coordination between health and social care at a sub network level as part of multi disciplinary teams	• Greater continuity of care for patients as increased collaboration between agencies at local level • Additional targeted support for patients at highest risk of hospital admission • Continued investment in protecting social care and better alignment of resources at a sub network level
Centralised	• Establish Shadow Alternative Care Partnership bringing together local health and social care partners to work together to provide better care • Successful development and submission of Better Care Fund Plan 2016/17	Establishment of a partnership organisation will improve patient experience by reducing care pathway fragmentation, reduce costs

Service Area 2	Unscheduled Care
Service Lead	CL: Dr Amol Kelshiker ML: Mark Featherstone
Overview	Harrow CCG is responsible for commissioning most of the boroughs urgent and unscheduled care facilities including A&E services at Northwick Park, the Urgent Care Centre, NHS 111 Service and the support provided for patients when they are discharged from hospital following admission
Need	Through the Shaping a Healthier Future Programme North West London CCGs have invested significantly improving A&E Services at Northwick Park; performance levels need to improve and the CCG needs to invest resources in providing alternative pathways and ensuring patients utilise the most appropriate support available. Work is also required to improver hospital discharge pathways.

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Ensure that all Harrow patients are aware of the options available to them when they have an urgent care need • Work with NWLHT to improve the patient experience in A&E at Northwick Park • Continue to invest in Rapid Response Service to provide more urgent care at home and in the community • Develop patient champions at UCC and A&E to support awareness and patient flow • Developing pharmacists to work proactively within the new Emergency and Urgent care pathways	• Better patient care experience • Reduction in demand A&E and NEL admissions • Patients are aware of the options available to them • Patient satisfaction with the services available improves

Localised	• Investment in community beds to provide step down support from hospital as close to patients home as possible • Continued investment in Walk In Services (open 8-8, Monday to Sunday) and establishment of 3 community hubs • Continued investment in Rapid Response Service to provide support at home within 2 hours of GP referral	• Better Patient Experience • Reduction in demand for A&E Services • Increase access to unscheduled care services out of hours
Integrated	• Develop with Brent and Hillingdon an integrated strategy for delivering urgent and out of hours clinical services • Review and reconfigure hospital discharge care pathway (including implementation of community beds reconfiguration) • Ensure effective operation and development of Rapid Response Service	• Better Patient Experience • Reduction in demand for A&E Services • Better utilisation of resources available
Centralised	• Establish Shadow Alternative Care Partnership bringing together local health and social care partners to work together to provide better care • Review of End of Life SPA pilot • Continued multi-agency approach to providing winter systems resilience	• Better Patient Experience • Reduction in demand for A&E Services • Better utilisation of resources available

Service Area 3 (a)	Planned Care- MSK Services encompassing Spinal Services, Trauma & Orthopaedics, Rheumatology, Physiotherapy and Pain Management
Service Lead	CL: Dr Kanesh Rajani ML: Sue Whiting
Overview	Re-development of MSK pathways inclusive of Trauma and Orthopaedics, Rheumatology, Physiotherapy and Pain Management services. Development of seamless and personalised care pathways enabling effective and holistic management of range of MSK conditions.
Need	The demand for MSK services have been increasing. Between 13/14 and 14/15 there have been over 17% increase in number of referrals. There is a clear need for development of clear specialist led clinical pathways ensuring patients timely access and discharge from the services as well as appropriate after care.

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Improve the pathways, referral and hand off processes for MSK services across primary, community and secondary care • Develop of IT provision for MSK services • Development of patient self-management programmes, including chronic pain self-management training • Psychology support for failed outcomes in spinal care	• Patients managed in primary care • Patients are able easily access secondary care MSK services when necessary • Improved levels of patient satisfaction
Localised	• Development of a Single Point of Access covering MSK services • Development of consultant led community CATS/CAS services • Development of shared care rheumatology service	• An increasing proportion of MSK patients are managed in the local community

Integrated	• Develop a consultant led MSK triage service • Develop clearer points for transferring patients across primary and secondary care • Develop a clinically led aftercare model • Create a spinal multi-disciplinary team	• Multidisciplinary model of care ensures that patients are seen by a clinician from the most appropriate clinical discipline

Centralised	• Develop a preferred provider list for CATS/CAS services
	• More clearly defined direct access criteria for complex cases – i.e. those requiring the Royal National Hospital for Orthopaedics
	• Improvements to community spinal services including provision for:
	  ○ Specialised extended physiotherapy
	  ○ Therapeutic injections
	  ○ Appointments with a spinal surgeon for discussion about surgical management
		• Improved oversight and management of patients throughout whole MSK/ spinal pathways
		•

Service Area 3 (b)	Planned Care- community cardiology, gynaecology, and ophthalmology
Service Lead	CL: Dr Amol Kelshiker (cardiology and gynaecology) and Dr Kaushik Karia (ophthalmology) ML: Sue Whiting
Overview	Harrow CCG is seeking to move a broad range of activity currently delivered within outpatient Cardiology into a community setting. There will be greater integration with other providers in primary, secondary and tertiary care to reduce the risk of duplication or discontinuity of services. QIPP 2015/16 gynaecology savings are linked to reaching an agreement with London North West Hospital Trust about the provision of community services. There is an intention to move appropriate areas of the gynaecology service into community settings during 2015/16. Key proposals for the ophthalmology service include: • A referral management service and a single pathway for patients whether they enter within the community based service (CBS) or hospital eye service (HES) • Community based services will be delivered by primary care level practitioners where possible • Safe and sustainable shift of appropriate activity from HES to CBS • Expand the community ophthalmology service to include management of first and follow up appointments for Cataracts, Glaucoma and General Ophthalmology conditions within community service.
Need	The Harrow cardiology service model is not sustainable when considering current referral trends, population profile and expected service demands. This generates a case for a service redesign process. Within gynaecology patients do not always need to receive hospital based care and alternative community based services can often be delivered to a better standard and be more cost effective. Capacity within acute hospital providers is constrained and this is adversely impacting referral to treatment waiting times for patients Similar trends are affecting the ophthalmology service model.
Key Actions for 2016/17	

Theme	Action	Outcome
Personalised	• Provide a 'one stop' (same day) community cardiology service for patients registered with Harrow general practices with quick access to diagnostics offering consultant led clinician consultations with minimum follow-up. • Improve the availability of diagnostic facilitates to enable gynaecology services to be treated in community clinics • Promote self-management in gynaecology by improving the provision of information to patients • To improve referral process in gynaecology to enable more timely referral from primary and secondary care into specialist services.	• Treat patients in the most appropriate location • Improved patient experience • Improved and sustained management within the community for cardiology patients with stable cardiac conditions • Waiting times will be less than 6 weeks for non-urgent gynaecology referrals without impediment to urgent referrals •

Localised	• Provide education and support to GPs to enable them to manage more cardiology patients solely within primary care • Within cardiology services provide quick opinions and treatment plans for the referring clinicians. the aim is to diagnose and refer back to the GP with a detailed management plan, and follow up only as appropriate • To provide GPs with structured emails and telephone support so that they can improve the management of gynaecological conditions in the community • To increase the provision of on-going educational and training resource for GPs and other health professionals delivering the gynaecology service • Provide increased amounts of ophthalmology care in primary care and community settings in order to reduce the demand for secondary care ophthalmology services	• Improve quality of life for patients across all service • Primary care clinicians have improved competency in managing cardiac patients • Gynaecology patients will have a reduced duplication of diagnostic activity and assessment visits with unnecessary patient visits to the service minimised. • Reduce the incidence of preventable blindness due to cataracts • Patients have improved access to ophthalmology services within community locations Reduce the total number of patient appointments related to ophthalmology, particularly in secondary care

Integrated	• Provide a high quality cardiology service within community clinics to assess, diagnose and manage patients in need of non-invasive cardiological assessment and treatment • Enhance the management of patients presenting with gynaecological conditions within the community and actively manage the demand for secondary care services • Use a multi-disciplinary team approach within gynaecology to ensure early signposting to other services and enable more appropriate requests for diagnostic tests. Clinical teams will have direct access to specialist consultant support, diagnostic facilities and physiotherapy. • Develop working relationships in ophthalmology services and provide increased support to clinicians working in primary care and community settings (including professional optometrists). This will reduce the demand for secondary care ophthalmology services	• All patients are treated the most appropriate location • Reduced time to diagnosis (allowing earlier intervention as clinically appropriate) • Reduced time to treatment • Increased patient understanding of their conditions, treatment and after-care • Improved relationship and joined up working between Optometrists, GPs and Secondary Care clinicians • Creation of robust foundations for the development of more comprehensive community eye care services
Centralised	• Provide a single point of referral for Gynaecology patients • Enhance the management of gynaecology patients within primary care and actively manage the demand for secondary care services • Provide more detailed cataract information to the Consultant Ophthalmologists to support treatment decisions and help improve the care that is provided in hospital	• GP referrers will be provided with full and detailed discharge letters within five days of discharge from the secondary care service • A simplified ophthalmology pathway with increased patient satisfaction

Service Area 3 (C)	Planned Care: Community Dermatology / Neurology (Including MS and Parkinson's)/ Paediatrics / ENT and Minor Surgery
Service Lead	CL: Dr Amol Kelshiker ML: Sue Whiting
Overview	Harrow CCG is seeking to review a broad range of activities currently delivered either within outpatients settings or HHL community settings. The aim is to deliver services providing a patient- centred model of care within community settings To provide clear improvements to the patient experience, patient safety and clinical outcomes. Amongst other metrics, these benefits will be assessed via patient-reported outcome and experience measures.
Need	Harrow CCG faces a significant financial challenge, which is reflected in the scale of Harrow's QIPP plan and the cost impact of associated commissioning intentions for 15/16, the main principle behind all of Harrow's plans is to ensure that the right care is provided in the right place, at the right time, and by the right person. Based on available data, referral trends, population profile and expected service demands – current service models in place are not sustainable in the future; highlighting the urgent need for service re-design process.

Key Actions for 2016/17

Theme	Action	Outcome

Personalised	• Improve the level of provision of community based services. • Provide a 'one stop' (same day) community service for patients registered with Harrow general practices with quick access to diagnostics and full Consultant led clinician consultation with minimum follow-up • Review of existing community based Diabetes services (at Alexandra Ave Health and Social Care Centre and Pinn Medical Centre) commissioned to expand and develop clinics based on local patient and population requirements. • Developing an education programme for Insulin initiation and GLP training with the aim of delivery via Primary/Community Care.	• Effective patient education and support for self-management, and support for carers. • Enable speedier discharge from secondary care into primary care enabled by more detailed care management and treatment plans • Effective programme of support, ensuring direct access to consultant advice and guidance to Primary Care Clinicians.
Localised	• Provide education and support to GPs to enable them to manage more patients within primary care • Provide more detailed care management and treatment plans to enable speedier discharge from secondary care into primary care • Redesign of the community paediatric service and pathways with a shared model of care for Children and Young people	• Up skilling of primary care clinicians. • Integrated management of patient care between Secondary Care Consultants and Primary Care Clinicians. • Improved patient satisfaction and health outcomes due to improved patient journeys

Integrated	• Integrated service model inclusive of community nursing elements • Improve health outcomes through earlier diagnosis and treatment.	• Treat patients in the most appropriate location; • Improve patient experience; • Provide a cost-effective service
Centralised	• To ensure minimal non-attendances (DNA's) for out-patient appointments by provision of a local service with minimal wait times • Develop referral pathways that ensure that referral to treatment (RTT) targets are met, and maximise the effectiveness of secondary care capacity.	• Patients accessing appropriate service at appropriate time • Clear and clinically led/approved patient journey • Development of direct access criteria for complex patients

Service Area 4	Adult Mental Health
Service Lead	CL: Dr Dilip Patel ML: Lennie Dick
Overview	Commissioning high quality, recovery focused mental health care delivered in the most appropriate and least intensive settings. Achieve national and local priorities for improved access and treatment provision. Ensure a consistent approach to mental health across secondary and primary care. Deliver the requirements of 'Future in Mind' and review the alignment of mental health services
Need	Meeting the transformation and priorities for mental health in secondary and primary care. Implement new and enhanced models to deliver urgent care and assessment through a single point of access. Meet the assessment and access needs in dementia and talking therapies.

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Develop access points for 'self-referral' to IAPT • Service-wide implementation of outcome measures • Continue to develop carer and vulnerable involvement • Continue to develop support and training for carer involvement across Harrow • Continue support for voluntary and community organisation for carers and patient support groups e.g. HPPN, to aid better health	• Increased access to talking therapies • Improved mental health outcomes for BAME and Migrant groups • Improved engagement and self-management for service users • Carers with an enhanced understanding of the care they provide

Personalised	Localised	Integrated	Centralised

Localised	• Re-design of Community Mental Health Services • Develop new pathways for Personality Disorders and Perinatal care • Enhance Urgent Care Pathway • Consult and train clinical teams on applying the single point of access • Strengthen MAS and Dementia care	• Improved access to services for patients • Improved quality of service • Better patient and carer experience • Prevention and emotional support for carers
Integrated	• Implement plans for Early Interventions • Improve psychosis preparedness • Focus on achieving parity of esteem for mental health • Engagement with CNWL to enhance the urgent care pathway and single point of access • Support greater collaboration between primary and secondary care	• Improved outcomes as a result of more equitable spending on mental health compared to physical health • Greater number of patients with mental illness are treated by their GP • Faster access to services for patients in crisis
Centralised	• Review, and redesign of perinatal services to ensure effective delivery of multi-tiered services across NW London • Prioritising safeguarding structures and training across all services • Carry out a joint IAPT procurement between Brent, Harrow and Hillingdon • Collaborate with NW London on Learning Disabilities	• More effective perinatal support for women, who can better access a tier of care most appropriate for their needs • Improved safeguarding processes through a clearer, more consistent and collaborative approach

Service Area 5 (a)	Children and Young People
Service Lead	CL: Dr Genevieve Small ML: Sue Whiting
Overview	The CCG has responsibility for commissioning the majority of health services for children. Our aim is to ensure children and young people have easy access to the right support from the right service at the right time.
Need	Birth rates in Harrow are significantly higher than the national average and over the part 10 years the number of births to families living in Harrow has increased by 39%

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Offer more children's services to children and young people (CYP) at home and in educational settings • Improve transitions between paediatric service and Adult service provision i.e. within OT/PT/SALT • Improve the epilepsy pathway for CYP and families	• Increased numbers of CYP are aware of mental health and emotional wellbeing and how to manage it
Localised	• Redesign of the community paediatric service and pathways with a shared model of care for Children and Young people • Improve access to children's services, through development of a Single Point of Access • Improve 19-25 OT/PT/SALT provision through creating an EHC plan that identifies need for provision	• Increased numbers of CYP are able access timely and appropriate care. • Increased numbers of CYP have their needs met in Harrow

Integrated	• Work more closely Harrow Council to implement and embed a new Special Educational Needs and Disability (SEND) reforms for children and young people aged 0-25 yrs. • Redesign the community paediatric asthma service to reduce acute activity	• Multidisciplinary model of care ensures that the most appropriate clinical discipline is able to manage patients •
Centralised	• Implement the SEND reforms • Continue to work jointly with Harrow Council to develop the 'Local Offer' for CYP • Update media information sites for professionals and Children and Young People and their families	• Streamlined services for CYP • Agencies are working together • Less CYP are attending A&E unnecessarily

Service Area 6 (B)	Children and Adolescent Mental Health Services (CAMHS)
Service Lead	CL: Dr Genevieve Small ML: Jessica Thom and Lennie Dick
Overview	Ensure children and young people have easy access to the right support from the right service at the right time. When clinical support is needed children and young people receive effective mental health support, designed collaboratively with children/ young people with an outcome focussed model and delivery.
Need	Demand for a wider offer of mental health provision in Harrow is increasing yearly, with CYP with Challenging behaviour, self-harm, ADHD, autism and dual diagnosis (MH &LD). If this trend continues these CYP mental health needs will become more entrenched needing more acute services.

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Develop access points for 'self-referral' to IAPT • Service-wide implementation of outcome measures • Continue to develop carer and patient involvement	• Increased access to talking therapies • Improved mental health outcomes for BAME and Migrant groups • Improved engagement and self-management scores for service users
Localised	• Re-design of Community Mental Health Services • Develop new pathways for Personality Disorders and Perinatal care • Enhance Urgent Care Pathway • Consult and train clinical teams on applying the single point of access • Strengthen MAS and Dementia care	• Improved access to services for patients • Improved quality of service • Better patient and carer experience •

Integrated	• Implement plans for Early Interventions • Improve psychosis preparedness • Focus on achieving parity of esteem for mental health • Engagement with CNWL to enhance the urgent care pathway and single point of access • Support greater collaboration between primary and secondary care	• Improved outcomes as a result of more equitable spending on mental health compared to physical health • Greater number of patients with mental illness are treated by their GP • Faster access to services for patients in crisis
Centralised	• Review, and redesign of perinatal services to ensure effective delivery of multi-tiered services across NW London • Carry out a joint IAPT procurement between Brent, Harrow and Hillingdon • Collaborate with NW London on Learning Disabilities • Provide community ophthalmology services at locations across the borough to ensure equity services	• More effective perinatal support for women, who can better access a tier of care most appropriate for their needs • Patient satisfaction with the service(s) will be high. • GP referrers will be provided with full and detailed discharge letters within five days of discharge from the service

Service Area 6	Medicines Management
Service Lead	CL: Dr Kanesh Rajani and Dr Dilip Patel ML: Hugh Caslake
Overview	Our ambition is to optimise medicines use to improve health outcomes by enabling timely, safe and effective medicines related care, tailored to the needs of individual patients throughout the local health economy by utilising the skills of GP practices, Primary care networks and community pharmacists. In line with the CCG's strategic focus on integrated care, Medicines Management will increase its focus on prescribing for vulnerable high risk patients, within whole systems.
Need	Getting the most from medicines for both patients and the NHS is becoming increasingly important as more people are taking more medicines. Although medicines are the most common intervention in healthcare it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended (World Health Organization 2003).

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Maintaining safe and evidence-based, appropriate and cost-effective prescribing • Improved reduction in medicines wastage and improving patient compliance with medications • Greater ownership, demonstration and implementation of prescribing decisions by clinicians by involving the patient to improve medication compliance and concordance with their treatment • Safer prescribing when patients transfer back into primary care	• Patients managed in primary care where clinically appropriate • Patients are empowered and educated to lead a healthy lifestyle and develop confidence in managing their own care. • Patients' prescribing transferred in a safe and timely manner

Localised	• Supporting general practice and networks with clinical pharmacists and medicines management teams to improve medicines optimisation and appropriate, safe prescribing and reduce wastage • GP practice decision support software i.e. Script switch, Map of Medicine • Localised End of life Pathway which includes 'in hours' and 'out of hours' supply of medication, integrating general practice, palliative care and supply of medication by community pharmacy • DDA assessment by community pharmacists for patients requiring medicines compliance aids e.g dossett boxes	• An increasing proportion of MSK patients are managed in the local community
Integrated	• Hospital discharge summary shared with patient's community pharmacy • Pharmacists input into Multidisciplinary team on the 'virtual ward' • Development of share care service	• Multidisciplinary model of care • Collaboration and support for healthcare professionals • Clear management of patients expectancies
Centralised	• NWL Integrated formulary • Implementation of Electronic Prescribing Services (EPS) • Antimicrobial stewardship	• Clear, consistent and collaborative approach to prescribing • Improved antibiotic prescribing and reduced resistance

Service Area 7	End of Life Care
Service Lead	CL: Dr Amol Kelshiker ML: Sue Whiting
Overview	Harrow CCG commissioning intentions are based on the 6 ambitions as articulated in the recently published National Framework for local action 2015-20 – 'Ambitions for Palliative and End of Life Care'. These aim to ensure that patients are treated as individuals with equitable access to co-ordinated care that is supported by all staff and the wider community where they live.
Need	Palliative and end of life care are a priority for Harrow CCG, the access to and quality of care provided must be improved on a recurring and consistent basis. With the emphasis now placed on local delivery and decision making Harrow CCG has made a commitment to deliver the best care possible set against a background of constrained resources and increasing demand.

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• We will develop mechanisms within primary care to ensure that patients are identified as nearing the end of life • Carers of the dying are fully involved • Patients and their family and carers will have opportunities to have honest, informed and timely conversations • Provide patients identified within the last year of life access to advice and support 24/7. • Ensure the end of life pathway includes bereavement	• Each person will have access to high quality End of Life Care irrespective of diagnosis, are, sex, race or beliefs • Ensure that all people approaching the end of life are offered the opportunity to have a personalised care plan • Ensuring that patients are treated as individuals and can make informed choices about their care •

Localised	• Healthcare professionals across Harrow CCG will have access to specialised education, support and training to improve the quality of care provided to all dying patients across Harrow • Every person in Harrow at the end of their life has access to palliative care services and local expertise in order to improve the quality of their life	• 24/7 advice and support for patients and Healthcare professionals including access to a rapid response team who can provide direct care to patients in a crisis • Patients are given access to Hospice at Home to support them in their own homes if this is where they choose to be cared for • Patients are supported with access to social care that meets their needs
Integrated	• Work with all stakeholders to ensure that there are clear pathways across palliative care services with a common goal • Implement shared patient records (Co-ordinate my Care CMC) providing that the patient consents to their records being shared among all healthcare professionals involved in their care	• Ensure that patients get the right help at the right time from the right people 24/7
Centralised	• Access to hospital services when required for appropriate investigations and treatments	• Joined up working across hospitals and community services to deliver patient centred care

Service Area 8	Community Services	
Service Lead	CL: Dr Kaushik Karia ML: Dylan Champion	
Overview	Key to improving health outcomes in Havering and providing more care close to home is providing more services within the community; in particular community nursing, rehabilitation and specialist diabetes, cardiology and podiatry services.	
Need	Better community services are key to the Harrow CCG vision for better care and providing better support for people with long term conditions and at high risk of hospital admission.	
Theme	**Action**	**Outcome**
Personalised	• All patients receiving on-going support within community have agreed care plan and named case manager • All patients receiving ongoing support have at least 2 care plan reviews each year • Increased investment in community nursing services to provide support for 92,700 contacts per year • Increased investment in provision of respiratory services	• Better patient care • Increased continuity of care • Better targeting of resources available
Localised	• Sub network, GP led multi disciplinary community nursing teams established • Network of specialist community clinics embedded across community hubs	• Better patient care • Increased continuity of care • Increased care coordination • Better targeting of resources available

Integrated	• Sub network, GP led multi disciplinary community nursing teams established • Network of specialist community clinics embedded across community hubs • Agreement with new community services provider of three year service improvement programme	• Better patient care • Increased continuity of care • Increased care coordination • Better targeting of resources available
Centralised	• Establishment of single Community Services SPA, fully operational between 8.00 and 20.00 • Expansion of Rapid Response Service to provide 7 day service between 8.00 and 20.00 • Review and re-evaluation of all community services investment outside of existing community services procurement • Invest in additional community based support for people living in residential and nursing care home	• Better patient care • Increased continuity of care • Increased care coordination • Better targeting of resources available

Service Area 9	Primary Care
Service Lead	CL: Dr Amol Kelshiker ML: Fana Hussain
Overview	Harrow CCG is not the primary commissioner of primary care services in Harrow as this is undertaken by NHS England. However through the new co-commissioning process the CCG will work more closely with NHS England and other local partners to develop and reconfigure primary care services in Harrow
Need	As many as 90% of patients first contracts with health services is with their GP. The CCG works in partnership with GPs and other partners to improve access to these services and to ensure that where safe and appropriate patients health care needs are resolved within practices

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Work through Co-commissioning Committee to increase access to primary care services • Work with GP Practices to increase range of services available at GP Surgery or sub network level • Work with GP practices to provide better on-going support for people with long term conditions • Patient empowerment and self-help training for diabetic patients via supported training program for diabetes self-management and signposting to in-depth training courses.	• Better Patient Care, closer to home • Increased access to primary care • Reduction in A&E, UCC and NEL admissions • Patients are empowered and educated to lead a healthy lifestyle and develop confidence in managing their own care.

Localised	• Improved access to primary care services from 8.00am to 8.00 pm 7 days a week, 365 days a year from two location in Harrow • Work with GPs to ensure that they have a lead role in multi-disciplinary working at a sub network level • Development of an integrated Diabetes strategy encompassing acute, community, primary and social services. • Developing awareness of pre-diabetic conditions and preventative measures.	• Better Patient Care, closer to home • Increased access to primary care • Reduction in A&E, UCC and NEL admissions • Supporting a co-ordinated approach to management of diabetic patients, within the local health economy. • Reverse current trend of diabetes prevalence in Harrow.
Integrated	• Work with GPs to ensure that they have a lead role in multi-disciplinary working at a sub network level Integrated IT solutions to support comprehensive patient journey through local health system • Development of data sharing agreements and protocols to facilitate joined up working across primary care. • Development of Primary Care CIC (Community Interest Company) to offer a borough wide level of access to high quality care, which encourages collaborative working in the interest of the patient.	• Better and more timely patient care through better record sharing • Faster and more integrated referral process • Better working amongst GPs at sub network level • Better Value for Money
Centralised	• Support NHS England Review of PMS contract through co-commissioning committee • Embed primary care co-commissioning process across Harrow and implement new model of primary care	• Better and more timely patient care through better record sharing • Faster and more integrated referral process • Better working amongst GPs at sub network level • Better Value for Money

Service Area 10	Continuing Health Care & Complex Care
Service Lead	CL: Dr Dilip Patel ML: Nicky Yiasoumi
Overview	NHS continuing healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a "primary health need". Since October 2014 the CCG has offered and provide for those patients that wish to take up the offer and are in receipt of Continuing HealthCare a Personal Health Budget.
Need	The Continuing HealthCare Service needs to provide an effective and efficient service which will enable to the CCG to deliver person centred care to those patients in receipt of Continuing HealthCare, Funded Nursing Care and Personal Health Budgets.

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• To undertake an expansion of Personal Health Budgets outside of Continuing HealthCare for those individuals with a long term condition or a child or young person with specialist educational needs. • To generate a published local offer for personal health budgets that includes a 3 year plan for implementation	• Personal Health Budget holders and carers have better quality of life as they are empowered to focus on how their care will be delivered. • Reduction in unplanned admissions and overall mainstream service use
Localised	• Improve referral process into Continuing HealthCare from primary care / community services and acute services	• All patients will be provided with a high quality, safe and effective service delivered within the Continuing HealthCare Framework guidelines

Integrated	• Coordinate My Care (CMC) to support patent's at the end of life by community and acute providers – development of an integrated care model that includes the consideration for Continuing HealthCare Fast Tracks	• Multidisciplinary model of care • Treat patients in the most appropriate location • Improve patient experience • Clear management of patients expectancies
Centralised	• Extend the monitoring of the quality of Home Care and Care Home service providers through the use of CQC and scheduled audits conducted by the Quality and Safety Directorate	• Ensure that commissioned care delivered to patients will provide quality, person centred and safe care.

Service Area 11	Safeguarding
Service Lead	CL: Dr Genevieve Small ML: Susan Whiting and Sue Sheldon
Overview	NHS Harrow CCG is fully committed to safeguarding both children and adults and as part of its statutory responsibility the CCG will: • Ensure that, as commissioners of some NHS Health Services, the health contribution to safeguarding and promoting the welfare of children and adults is effectively discharged across the local health economy through its commissioning arrangements; this includes specific responsibilities for Children Looked After and supporting the Child Death Overview Process. • Ensure that all Providers of NHS Health Services have clear and robust policies and arrangements in place to safeguard and promote the welfare of all children and adults, particularly those deemed to be vulnerable or at risk of harm and can assure themselves, regulators and commissioners that these arrangements are effective. • Ensure that the Providers through the CCG's commissioning arrangements and service specifications, be fully engaged to work with partner agencies in order to improve outcomes for children, young people and their families and vulnerable adults
Need	NHS Harrow has a statutory responsible to provide safeguarding services.

Key Actions for 2016/17

Theme	Action	Outcome
Personalised	• Reduce the incidence of Pressure Ulcers (Grade 3 and 4). • Implement a process to ensure all providers can evidence activity to demonstrate they listen to children and young people as regards: Access to services, Service provision, Service quality and improved health outcomes.	• Improved adults and children's safeguarding • Reduce harm to patients. • Incremental reduction in pressure ulcers.

Localised	• Improve support to vulnerable children and adults including those at risk of radicalisation (PREVENT) and/or domestic abuse.	• Improved adults and children's safeguarding
Integrated	• Work with Providers to ensure a smooth transition to the new electronic system and ensure that systems record and report all Domestic Abuse interventions so that appropriate services can be provided to reduce the incidence of Domestic Abuse. • Support the implementation of the Child Protection Information Sharing (CP-IS) is the first national system of its kind. • Develop a comprehensive and easily accessible service provision for children at risk of, or suffering as a result of, Child Sexual Exploitation (CSE) or Female Genital Mutilation (FGM).	• Improved adults and children's safeguarding • Children and young people feel listened to and are able to actively participate in their care in a child and young people friendly NHS.
Centralised	• Improve assurance through contract monitoring that front line service staff are trained to the appropriate level in all safeguarding issues • Implement a process to audit all Providers and ensure that they have Child Sexual Exploitation (CSE)/Female Genital Mutilation (FGM) champions and that all staff members are trained in CSE and FGM procedures. • Improve the investigation process into all incidents of pressure ulcers including undertaking a Root Cause Analysis (RCA) with providers to reduce the incidence.	• Improved adults and children's safeguarding

Information Technology

The CCG's commissioning priorities for 2015/16 are:

IT is a key enabler of the CCGs' clinical strategies for 2016/17 and therefore the CCGs intend to place a heavy emphasis on IT in the CQUINs for the year, as for 2015/16. The objective is to implement three layers of clinical information exchange where at least one of the following is in place in any setting of care:

- Level 1 - There is access to and two way information exchange within a common clinical IT system and a shared record between the GP and the care provider.
- Level 2 - Where the above is not possible due to technical, operational or financial constraints that as a minimum, the respective IT systems in primary care and elsewhere are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards (or other common messaging standards) as defined by the Health and Social Care Information Centre (HSCIC). This includes the sharing of detailed clinical information about episodes of care, for example clinical narrative or progress notes.
- Level 3 - Where neither of the above is relevant or feasible then the Summary Care Record is enabled, available and accessible particularly where patients are receiving care out of area.

The minimum achievement to meet CQUIN targets in 2016/17 between providers and their hosting CCGs will be implementation of Level 2, with a longer term plan to achieve Level 1. Achievement of Level 3 will be sufficient between providers and out-of-area CCGs but will not be sufficient for the hosting CCG. The cost of achieving the required levels of interoperability is the responsibility of the provider and will not be provided by the CCG in addition to existing contract funding.

Commissioning in relation to IT systems 2016/17 should have the following impact:

- Live information flows from and to primary care clinical information systems (as close to "real time" as possible)
- A standardised repository of diverse clinical information on the patient within the primary care record, so that the primary care record is the single comprehensive source of medical history on the patient
- Technology solutions that will allow multidisciplinary teams across different settings of care to function as one integrated team
- Patients to have access to their own medical records and participate in monitoring and reporting on their care
- Utilising Technology (Apps) to improve patients understanding of alternative pathways to A&E and Urgent Care.

Glossary

Acronym	Full Meaning
BCF	Better Care Fund
BHH	Brent, Harrow and Hillingdon CCGs
CAMHS	Child and Adolescent Mental Health Service
CAS	Community Assessment Service
CCG	Clinical Commissioning Group
CL	Clinical Lead
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CYP	Children and young people
CLA	Children Looked After
DTOC	Delayed transfers of care
EOLC	End of Life care
ENT	Ear, Nose and Throat
HENWL	Health Education North West London
HPPN	Harrow Patient Participation Network
HWB	Health and Wellbeing Board
IAPT	Improving access to psychological therapies
ICO	Integrated Care Organisation
ICP	Integrated Care Programme
IM&T	Information Management and Technology
LA	Local Authority
LB	London Borough of-
LNWHT	London North West Hospitals Trust
LTC	Long Term Condition
MDT	Multi-Disciplinary Team
ML	Management Lead
MSK	Musculoskeletal
NHSE	NHS England
NWL	North West London
OT	Occupational Therapy
PoC	Package of Care
QIPP	Quality, Innovation, Productivity and Prevention
SaHF	Shaping a Healthier Future
SALT	Speech and Language Therapy
STARRS	Short term assessment, rehabilitation and re-ablement service
UCC	Urgent Care Centre
WIC	Walk in Centre
WSIC	Whole Systems Integrated Care

Appendix 1: Harrow's Landscape and Health Challenges

This section is extracted from the Harrow Joint Strategic Needs Assessment 2015-20.

Harrow's Geography

Harrow is an Outer London Borough in North West London and approximately ten miles from central London, covering 50 square kilometres (20 square miles). Harrow is the 12th largest borough in Greater London in terms of size. Harrow borders Hertfordshire to the north and four London Boroughs: Barnet to the east, Brent to the south east, Ealing to the south and Hillingdon to the west.

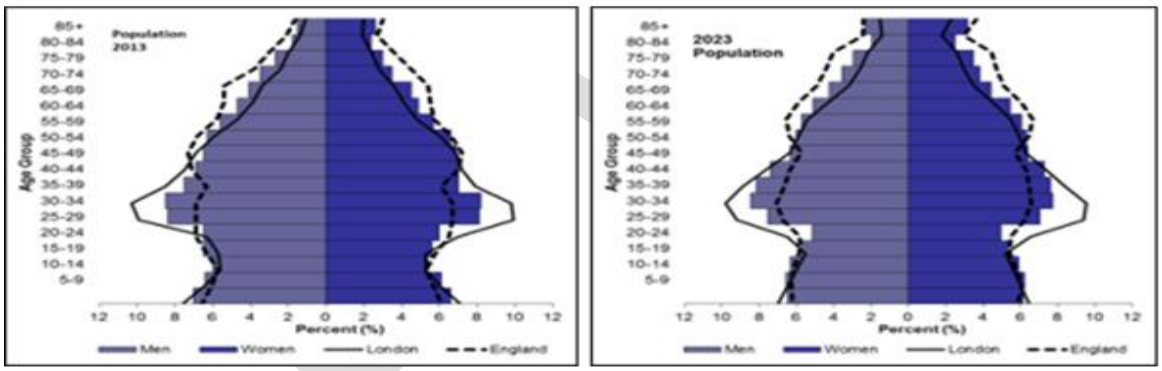
Population

Around 243,500 people live in Harrow. Just over half of them are female. 7% of the population are children under 5 years old and 7% are aged over 75. Compared to London, the population of Harrow has a greater proportion of older people and a lower proportion of people in their 20s and 30s.

Over the next ten years, the population of Harrow is expected to grow over all. The proportion of people who are of working age (16-64) will decrease by 4% and the proportion of those over 65 will increase by 4%.

The age structure of the population varies across the borough with more children living in the south and central corridor and more people aged over 65 living in the north of the borough.

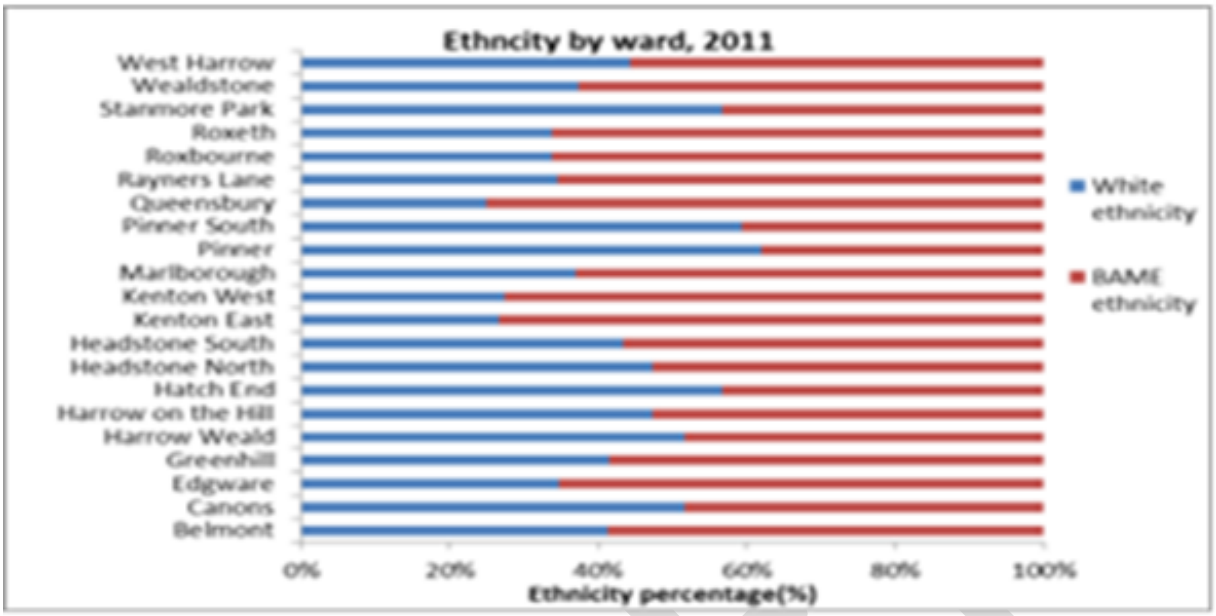
Figure 1 Population structure 2013 and projection for 2023



Ethnicity

Harrow is one of the most ethnically diverse boroughs in the country. In 2011, 42% of the Harrow populations were from a white ethnic background, while 43% were from an Asian/ Asian British background and 8% were from Black/ African/ Caribbean/ Black British ethnic background. Over the next 10 years it is predicted that the local Black, Asian and minority ethnic (BAME) population in Harrow is projected to increase from almost 54% to 68%. Every year Harrow welcomes over 2,000 new British citizens through citizenship ceremonies.

Figure 1 Ethnicity across Harrow



As with the age structure of the population, the ethnic mix also varies across the borough. In Pinner and Pinner South wards BAME groups make up around 40% of the population while in Queensbury, Kenton West and Kenton East, BAME groups make up over 70% of the population. With the increase in BAME population, there may be different patterns of health and illness. For example, higher rates of diabetes and heart disease in BAME groups may require a different and culturally appropriate approach to prevention and treatment service.

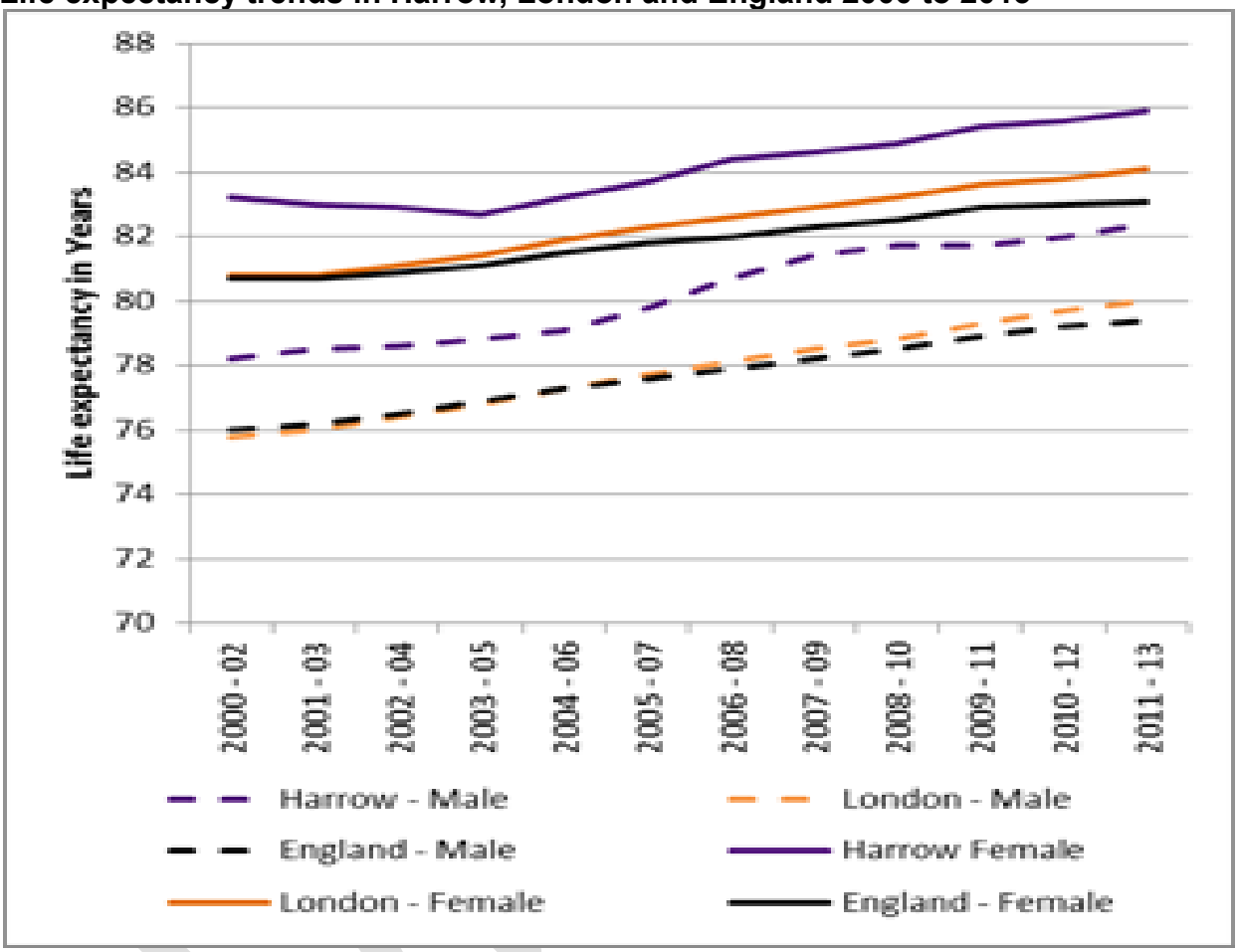
Deprivation

The impact of deprivation on our health and wellbeing is well documented and includes a variety of factors such as housing, employment and income to give a single score. Harrow is ranked 203rd out of 354 Districts in England where 1st is the most deprived. Most deprivation is in the centre of the borough, with pockets of deprivation in the south and east Harrow's least deprived areas are found in the west of the borough. Not all disadvantaged people live in deprived areas and conversely, not everyone living in a deprived area is disadvantaged.

Life Expectancy

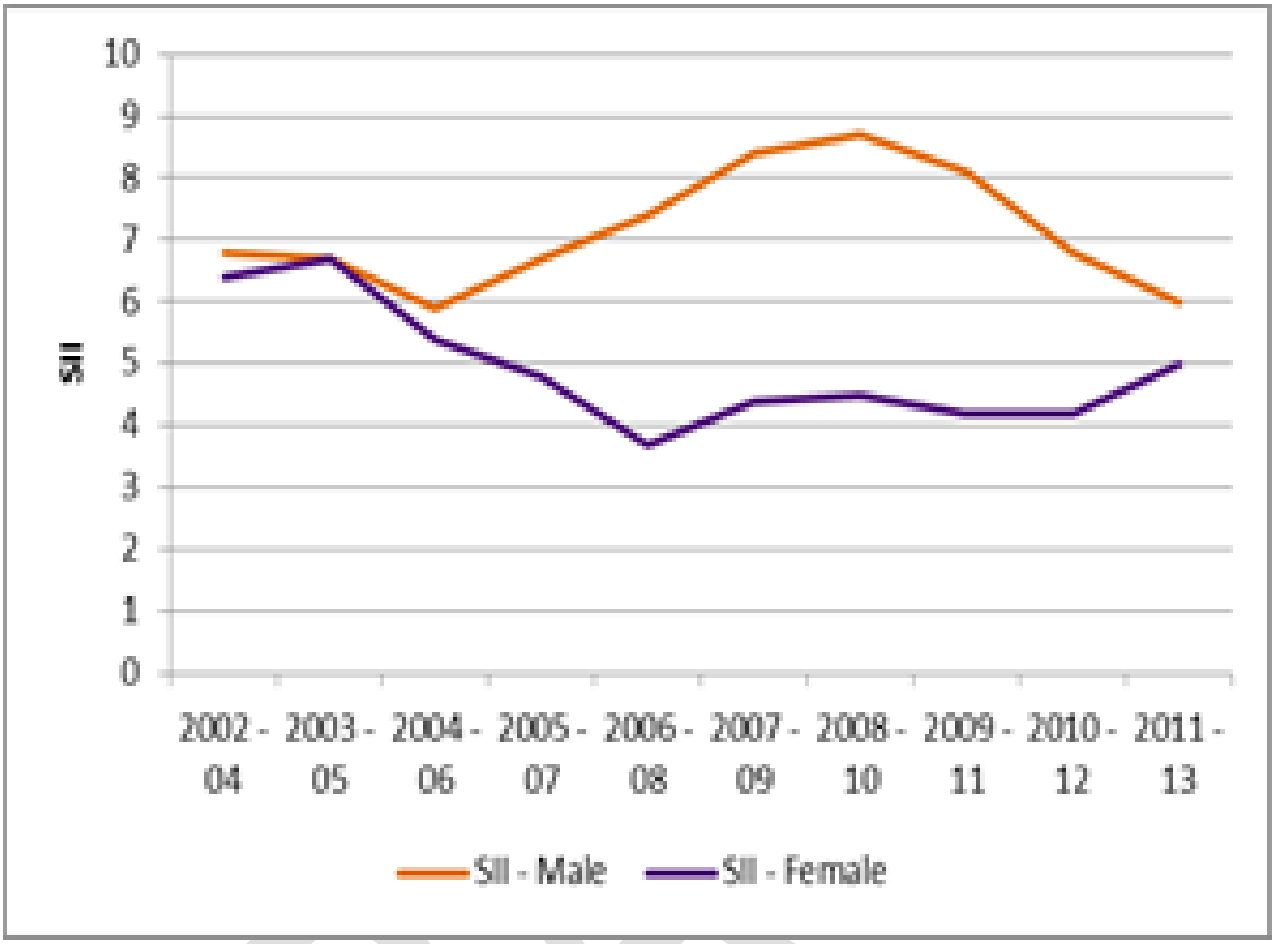
Life expectancy for both men and women is higher the England and London averages. For men in Harrow Life expectancy in 2011-13 was 82.4 years and for women 85.9 years. Over the past 13 years life expectancy has increased year on year and the gap between harrow and London and England has been maintained in women and slightly widened in men.

Life expectancy trends in Harrow, London and England 2000 to 2013



Despite this high life expectancy, there are large differences within the borough. The SII (Slope Index of Inequality) is an indicator of within borough inequalities in life expectancy. The SII trend shows that the gap in life expectancy between the most deprived and most affluent men in Harrow grew from the 2002-4 baseline but has since fallen and is now 6 years, which is below the baseline figure. In women the SII almost halved but has since risen slightly but it is still below the 2002-4 baseline. Both of these show that the gap in life expectancy within Harrow is decreasing.

Trends in SII in Harrow



The length of our lives is not the only overarching indicator of health in the borough; we can also consider how much of that life expectancy we live in health.

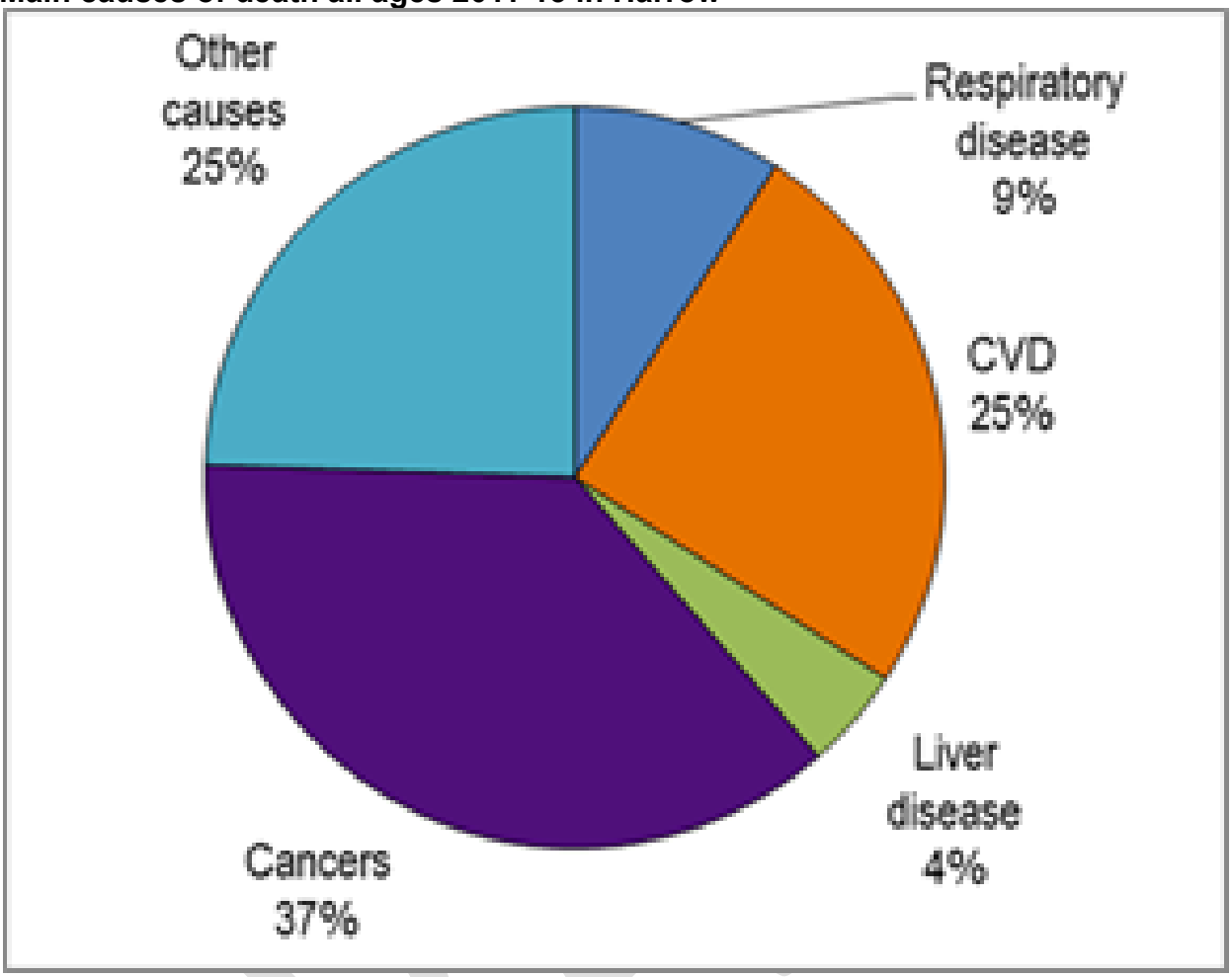
This data has not been available for as long as the life expectancy data but in the three years it has been, it shows an increasing trend towards longer healthier lives. Men can expect to live on average 65.3 of their 82.4 years in health and for women, on average 68.1 of their 85.9 years will be lived in health.

Mortality

Cancers are the biggest cause of deaths in Harrow accounting for almost 2 out of every 5 deaths. A quarter of all deaths are due to heart disease and stroke.

The mortality (death) rates for major causes in all ages and those classed as premature mortality (deaths under age 75) are lower than those for England and London. In many cases, mortality rates from specific causes in Harrow are amongst the lowest in the country. The exception is for deaths from communicable diseases (including influenza and pneumonia) in men, where the rate is higher than that of England.

Main causes of death all ages 2011-13 in Harrow

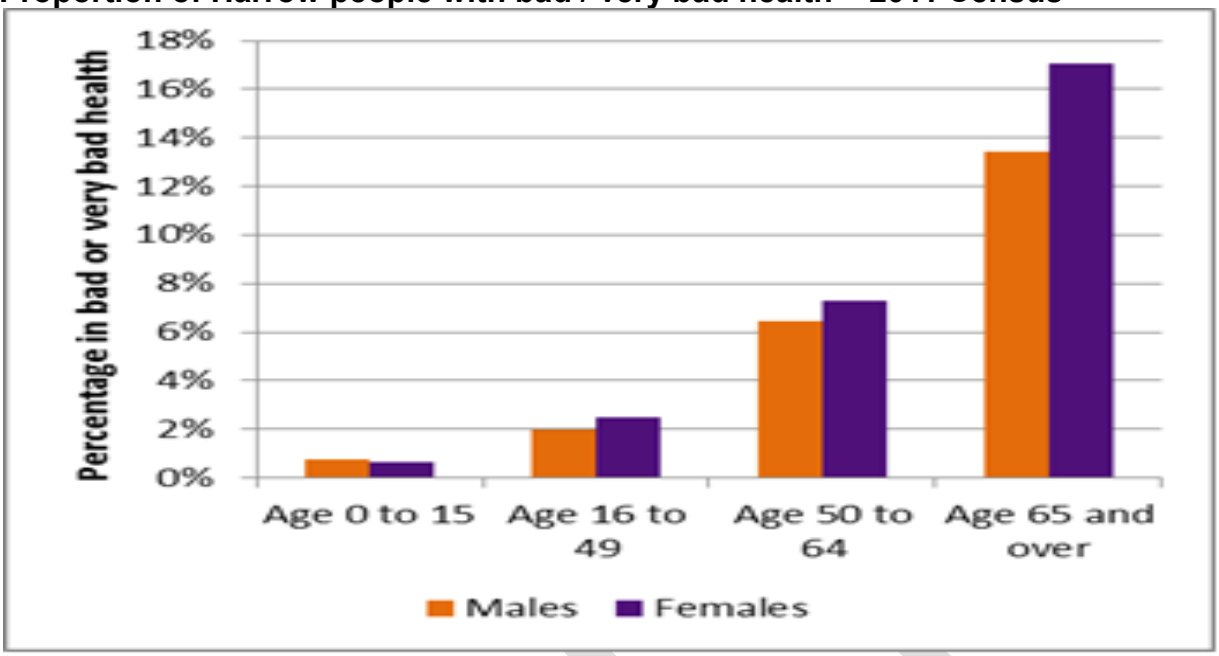


Self Reported Health, long term illness and disability

The census asks about people's general health. Four out of five people in Harrow rate their health as good or very good and only one in twenty rate their health as bad or very bad. However, there are differences in people's health status within the borough.

The proportion of people in bad or very bad health increases dramatically with age and in all age groups except the under 16s, women report higher rates of poor health than men. In the 65 and over age group, one in seven men and one in six women report being in poor health. This pattern is the same across all ethnic groups, although higher rates of poor health are reported in the Asian and "other" ethnic groups.

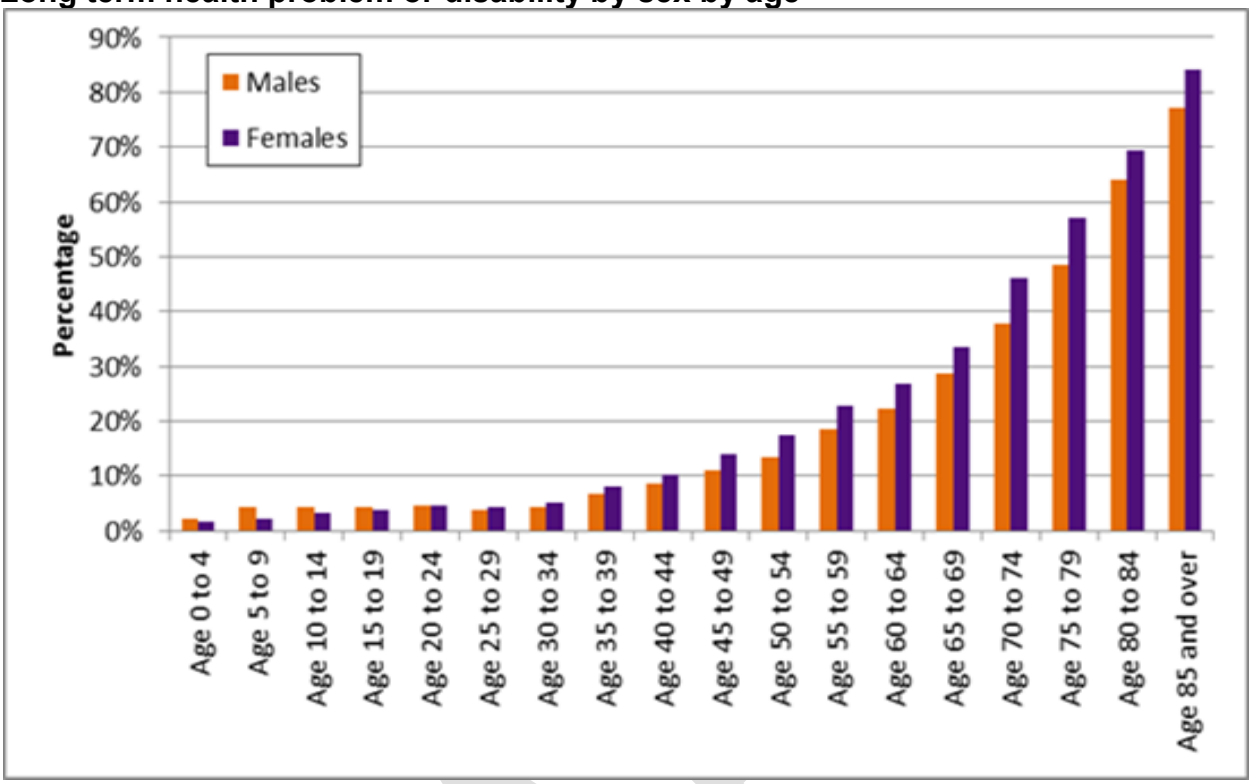
Proportion of Harrow people with bad / very bad health – 2011 Census



Health status is also affected by socio-economic group. Almost 90% of people in groups 1 and 2 (professional and higher management) report that their health is very good or good compared to only 60% in those who have never worked and the long term unemployed.

Nearly 34,000 people in Harrow reported having a long term illness or disability that limited their day to day activities in some way. Under half of these reported that their activities were affected a little and over half a lot. As expected the rates increase with age and in all age groups over 25, a greater proportion of women are affected than men.

Long term health problem or disability by sex by age

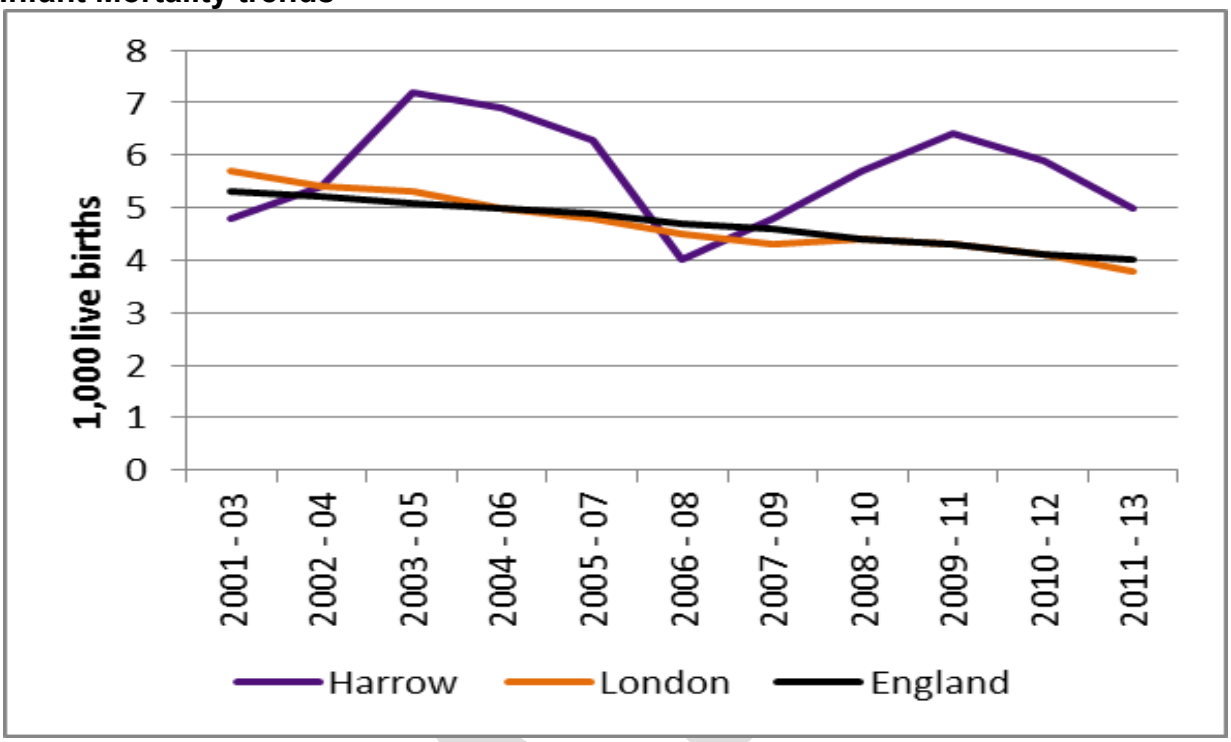


Births

Birth rates in Harrow are significantly higher than the national average and there is a greater proportion of births to mothers over 40 than in England as a whole. Over the past 10 years, the number of births to families living in Harrow has increased by 39% and now stands at around 3,600 per year. The number of births is affected by both the fertility rates and by the size and structure of the female population. Of the 3,559 live births in 2013, over two thirds were to non-UK born mothers: half of these were born in the Middle East & Asia, almost a third were born within the European Union and one in eight in Africa.

Infant mortality in Harrow has reduced in the latest data and is now statistically similar to the England average. However, as this fluctuates we need to maintain a watchful eye on it. All deaths in children under 18 are reviewed by the Child Death Overview Panel and recommendations made and implemented if there are learning points that might avoid future deaths.

Infant Mortality trends



Maternity

Over 40% of pregnant women in Harrow do not receive an antenatal assessment within 12 weeks. This is significantly higher than the England average. The rate of caesarean section in Harrow is significantly higher than the England average. This applies to both elective and emergency caesarean rates. The proportion of babies born with low birth weight in Harrow is significantly higher than the national average and while some of this is thought to be due to the ethnic mix of the population, there may be other factors. Smoking in pregnancy rates are lower than the national average but have increased in the past year at Northwick Park Hospital.