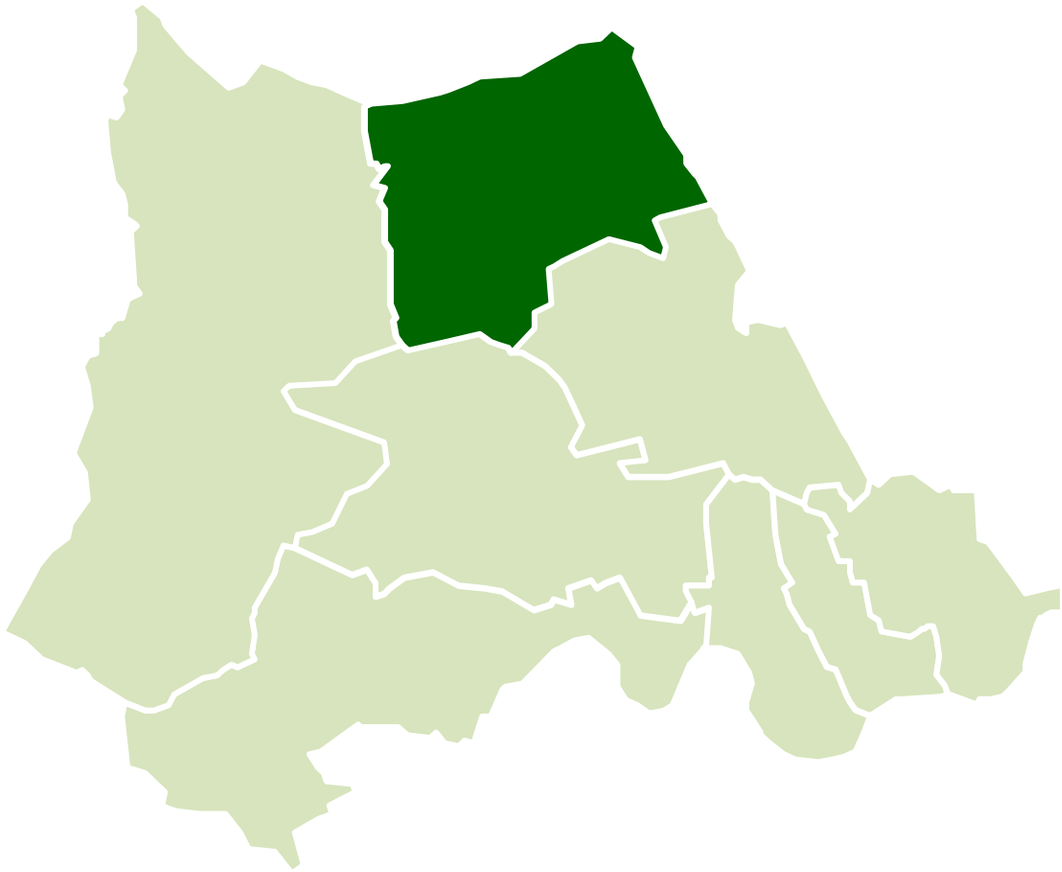
Harrow Sustainability and Transformation Plan (STP) Summary

April 2017



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Glossary of Terms

- **Accountable Care Systems (ACS)**: brings together a number of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget. ACS take many different forms ranging from fully integrated systems to looser alliances and networks of hospitals, medical groups and other providers.
- **App:** is short for application - this can be any type of computer program**.** Applications have been around for as long as computers, but the term 'app' is associated with the software that runs on a smartphone or tablet device.
- **Discharge to Assess (D2A):** is where people no longer require an acute hospital bed but may still require care services, are provided with short-term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
- **Joint Strategic Needs Assessment (JSNA):** is the means by which CCGs and local authorities describe the future health, care and wellbeing needs of the local populations and to identify the strategic direction of service delivery to meet those needs.
- **My Community ePurse:** is a personal budget and support planning tool that enables you to receive a personal budget and purchase services using this allocation all in one place using a PayPal electronic e-purse.
- **Patient Activation Measure (PAM)**: is a tool that enables healthcare professionals to understand a patient's activation level, or their level of knowledge, skills and confidence to manage their Long Term Condition.
- **Primary Care Hub(s):** have the key characteristic of an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care.
- **Risk Stratification:** The process of separating patient populations into high-risk, low-risk, and rising-risk groups.
- **Social Prescribing:** is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.
- **Whole System Care**: recognises the contribution that all partners make to the delivery of high quality care.

The purpose of the Sustainability and Transformation Plan

- NHS England's Five Year Forward View (FYFV) sets out a vision for the future of the NHS.
- Local areas have developed a **Sustainability and Transformation Plan (STP)** to help local organisations plan how to deliver a better health and care service that will address the FYFV 'Triple Aims' of:

  1. **Improving people's health and well being**
  2. **Improving the quality of care that people receive**
  3. **Addressing the financial gap**

- This is a new approach across health and social care to ensure that health and care services are planned over the next five years and **focus on the needs of people living in the STP area, rather than individual organisations.**

- This provides us in NW London with a unique opportunity to:
  - **Radically transform the way we provide health and social care** for our population
  - Maximise opportunities to **keep the healthy majority healthy**
  - **Help people to look after themselves** and **provide excellent quality care in the right place when it is needed**
- The STP process also provides the drivers to **close the £1.4bn funding shortfall** and **develop a balanced, sustainable financial system** which our plan addresses.

- Harrow providers and commissioners (both local government and NHS) contributed to the development of the NWL STP, to deliver a genuine place based plan for the borough, with a strong focus on Primary Care Transformation as a key enabler for sustainable system change.
- Existing Harrow plans have been built on within the STP, including the:
  - Harrow Health & Wellbeing Strategy 2016-20
  - Harrow JSNA 2015-20
  - Harrow 2016/17 Better Care Fund Plan
  - Harrow CCG 2016/17 Operational Plans
  - The Harrow Ambition Plan 16/17 – 18/19
  - Harrow Out of Hospital strategy
- This document is a summary of what the NWL STP means for Harrow, capturing work that is in-progress and work that is aspirational over the coming years.

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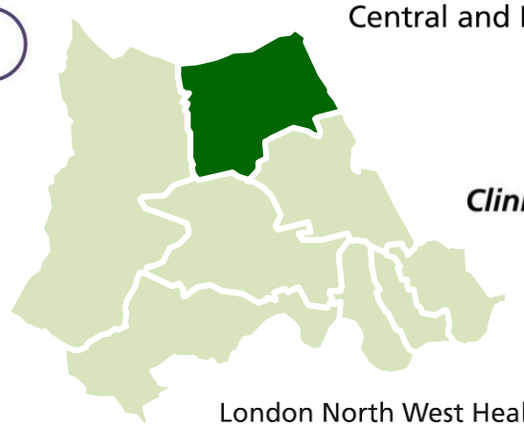


London North West Healthcare NHS NHS Trust

Understanding our population – the health and wellbeing of Harrow

Children

- Nearly 1 in 5 of Harrow children live in poverty, which can lead to poor health outcomes as an adult.
- Children in Harrow have similar levels of obesity as the England average (21% of 10 and 11 year olds), which increases the risk of cardiovascular disease and diabetes in later life.
- About 3,100 children (5.5% of children) were in need of a service from Social Care in 13/14. These children are vulnerable and many have poor mental and physical health.
- In Harrow there are many babies born with low birth weights, who are more vulnerable to infection, developmental problems and even death in infancy.

Serious and long term mental health needs

- One in 7 adults in Harrow have a mental health problem.
- Over 97% of people referred to Talking therapies, are seen within 6 weeks.
- Hospital admissions due to drug-related mental health and behavioural disorder are amongst highest in London, with higher prevalence of schizophrenia, bipolar affective disorder and other psychoses.
- About one fifth of people accessing substance misuse services are having concurrent contact with mental health services.
- Rates of unemployment are higher in those with mental health conditions. Unemployment is directly associated with poor mental and physical health including cardiovascular disease, depression and suicide plus those out of work are more likely to smoke, drink alcohol and be physically inactive.

Mostly healthy

- There are high rates of obesity in Harrow, and many residents don't take enough exercise (31% of adults are physically inactive). A physically inactive person is likely to spend more time in hospital and visit the doctor more often than an active person.
- Those living in the most deprived areas of the borough are less likely to live near green space, and these areas have the lowest rates of physical activity and higher rates of obesity and cardiovascular disease.
- There are low amounts of fruit and vegetables eaten, which impacts on health and obesity levels.

Other

- More deprived areas in Harrow have poorer health outcomes; we need to urgently address this inequality and ensure that everyone in Harrow has an opportunity to start, work, live and age well.
- Harrow is an ethnically diverse borough; over half of our residents are black or an ethnic minority. This means that rates of some conditions such as diabetes and heart disease is greater; there is a 3-fold increased risk of diabetes among people of South Asian origin compared with white people and risk increases at a younger age and lower weight.

Cancer

- Incidence for all cancers is lower in Harrow than the England average.
- Early diagnosis is important for improving survival rates, however rates of bowel and breast cancer screening are lower in Harrow than the national minimum standard.
- Cervical screening rates are also low, and are declining in young women. In addition, vaccination against Human Papilloma Virus (HPV) – which causes almost all cervical cancer – is lower than the England average.
- There is increased risk of certain cancers in Asian and Black ethnic groups, which is particularly relevant in Harrow. Women from these groups have a lower under-65 survival rate for breast cancer and higher risk of cervical cancer in those over 65 years.

Older People

- Harrow has a higher proportion of those aged over 65 compared to other NWL boroughs, and a third of those aged over 65 have at least one long term health problem or disability.
- People in Harrow are living longer with ill health (approx. 20 year gap in healthy life expectancy and life expectancy).
- These is a shortage of appropriately trained health care professionals to meet the care needs of our growing elderly population.
- Older people are at greater risk of falls and associated injury, such as hip fractures, which is associated with a greater need for institutional care.
- There will be increased NHS & social care costs due to the ageing population and increasing dementia prevalence.

One or more long-term conditions

- Cancer, heart disease and stroke are the biggest causes of death in Harrow.
- One in ten people in Harrow have Type 2 Diabetes, which one of the highest rates in England. We also have the highest rate of 'pre-diabetes'.
- Many people (15%) with a long-term condition or disability feel that their day-to-day activities are limited in some way.

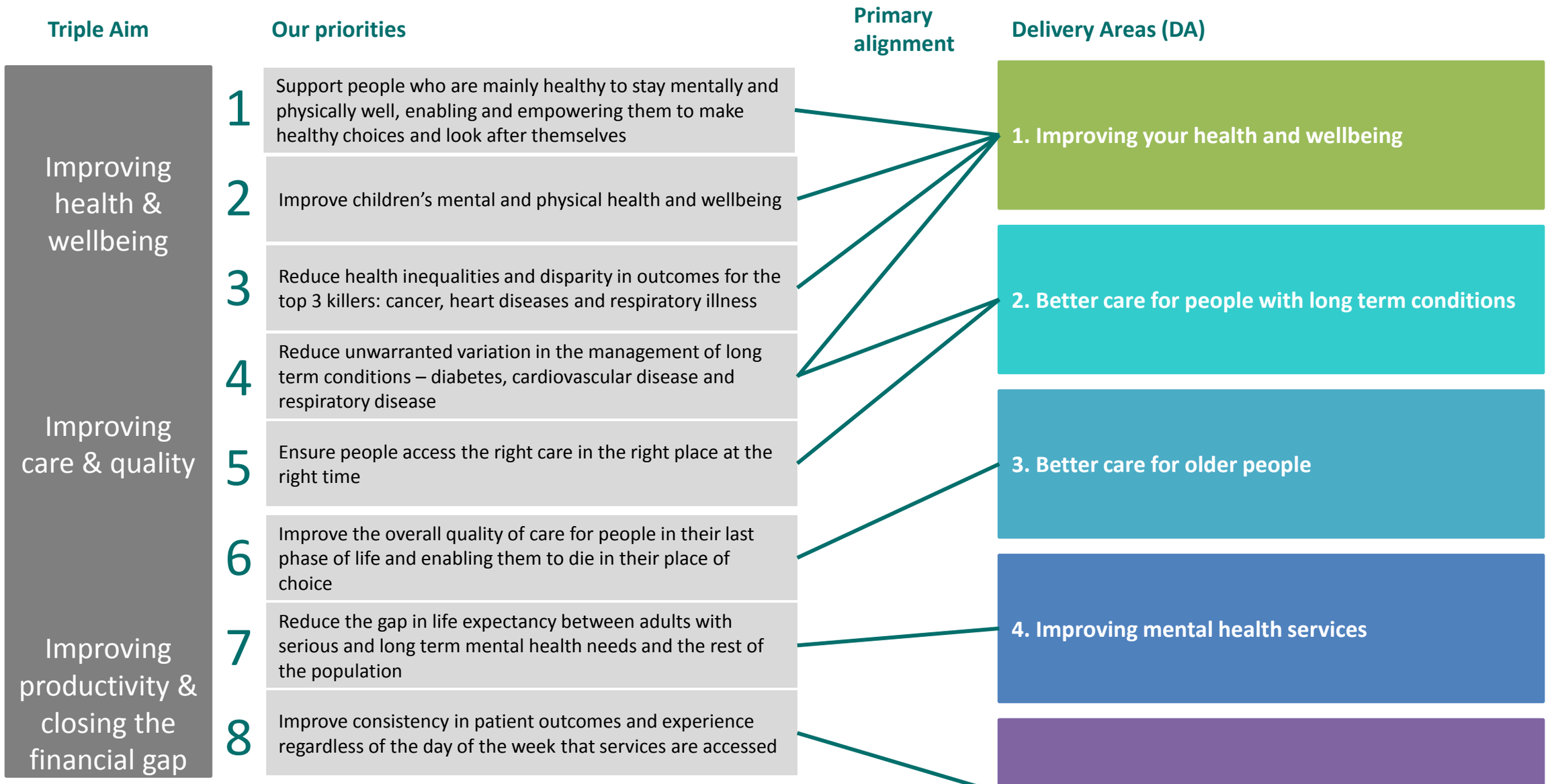
Other

- A quarter of adult social care users do not have as much social contact as they would like, leading to social isolation. Feeling lonely and socially isolated in older age has been suggested to be as harmful to health as smoking 15 cigarettes a day.
- There are high rates of fuel poverty (over 10%), implying that many Harrow residents are living in cold homes, which may be having a knock-on impact on their health (e.g. cardiovascular and respiratory diseases).
- There are high rates of TB (the fifth highest rate in London) and high rates of statutory homeless.

NWL priorities and Delivery Areas (DAs)

Harrow, as part of North West London, has developed **a set of nine priorities** that will enable us to achieve our vision and **fundamentally transform our system.**

We will focus on **five delivery areas** in order to deliver against these priorities at scale and pace.



DA1: Improving your health and wellbeing

We are supporting everybody to play their part in staying healthy

I am equipped to self manage my own health and wellbeing through easy to access information, tools and services, available through my GP, Pharmacy or online. Should I start to need support, I know where and when services and staff are available in my community that will support me to stay well and out of hospital for as long as possible.

What we are going to do	How we are going to do it in Harrow	When are we going to do it 17/18	18/19	2019>
We are **reducing loneliness** by encouraging everyone to be part of our local community	• We are increasing community networking and provide opportunities for residents to help each other through Harrow Communities Click. • We are integrating more with voluntary services and using social prescribing more (e.g. the 'Age of Loneliness' app) to improve community networks.	★ ★	★ ★	★ ★
We are **increasing self-care** We are working to **prevent cancer** We want to **reduce the stigma** of mental health problems	• We are using technology (including apps), expert patient programmes and personal health budgets (My Community ePurse) to increase self-care provision. • We are working in partnership to improve cancer screening uptake, particularly in marginalised and seldom heard groups in Harrow. • We are promoting the Time to Talk campaign to reduce mental health stigma.	★ ★ ★		
We are **encouraging employment** for people with a learning disability or mental health problem	• We are providing an employment mental health service that is linked to existing talking therapies, which aims to support people with mental health conditions into employment. • We have signed the NHS Learning Disabilities Employment Pledge and are developing an action plan to increase employment for people with a Learning Disability.	★ ★		
We are **enabling and supporting healthier living**.	• We are developing new, and promoting existing ways of signposting residents to facilities, information, advice and services which promote health and wellbeing. • We are promoting the NWL People's Health and Wellbeing Charter which aims to manage and reduce demand in health and care services through encouraging behavioural change in residents and staff. • We will begin a pilot at Northwick Park hospital to reduce emergency activity caused by alcohol.	★ ★ ★	★ ★	★ ★
We are **addressing issues that affect health** such as housing, employment, schools and the environment.	• We are developing a healthy workplace programme across health and care staff and encouraging other large employers in Harrow to do the same. We will achieve commitment to the Healthy Workplace Charter before 2018-19. • This year, we will will conduct health impact assessments on redevelopment areas (e.g. Grange Farm, Civic Centre) and make recommendations to promote health and wellbeing.	★ ★		
We are **supporting children to get the best start in life** *[see also DA4: Improving mental health services]*	• We are redesigning early help & the 0-19 public health nursing health visiting services to better meet the needs of our population. • We will ensure that diagnostic, assessment and integrated care pathways are in place for people with a Learning Disability, autism and complex and challenging behaviour. • We will improve the availability of Long Acting Reversible Contraceptives (i.e. implants, injections and intrauterine devices), maternity and abortion services and services for early pregnancy loss. • We will reduce childhood obesity through nutrition education and physical activity. • We will work with our population to increase immunisation rates.	★ ★ ★ ★	★ ★	★ ★

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DA2: Better care for people with long term conditions

Every patient with a long term condition (LTC) has the chance to become an expert in living with their condition

I know that the care I receive will be the best possible wherever I live in NW London. I have the right care and support to help me to live with my long term condition. As the person living with this condition I am given the right support to be the expert in managing it.

What we are going to do	How we are going to do it in Harrow	When are we going to do it: 17/18	18/19	2019>
We are **improving quality and access** in primary care. *[See also DA5: Safe, high quality sustainable services]*	• We are increasing access to primary care (aligned with GP Access Fund) so that residents can see a GP when they need to, rather than going to an urgent care centre or A&E. • We will ensure that referrals to our specialists are necessary and appropriate, through the Referral Optimisation Service. • We will standardise treatment of asthma and diabetes patients in GP practices, to improve care. • We are educating primary and community clinicians in insulin initiation for diabetes patients, providing care closer to home and at lower cost than in a hospital setting. • We are supporting integrated care teams and primary care to proactively monitor patients at risk of hospital admission through the Risk Stratification Dashboard, and intervene as necessary. • We are supporting the development of GP federations, enabling delivery of primary care at scale (to around 50,000 people), which should improve access for patients.	★ ★ ★ ★ ★ ★		
We are **increasing early cancer diagnosis** We are **enabling faster treatment** of cancer	• We will learn from the Healthy London Partnerships Transforming Cancer Programme to improve diagnostic capacity, patient information and inter-Trust referrals for our residents with cancer. • We are improving access to cancer treatment through providing enhanced local acute oncology services, and a new straight to test endoscopy service at Northwick Park, which will reduce the time to treatment and minimise unnecessary outpatient appointments.	★ ★		
We are **improving outcomes and support** for people with common mental health needs. We are **addressing the mental health needs** of people with long-term physical health conditions. *[See also DA4: Improving Mental Health Services]*	• We are improving the mental health of people with diabetes by providing talking therapies to diabetics with depression and / or anxiety. • We are increasing access to, and availability of, early intervention mental health services, such as psychosis services, psychological therapies and community perinatal services.	★ ★		
We are **improving people's health and outcomes** We are developing new ways of **preventing and managing long term conditions**.	• We are implementing an Integrated Diabetes strategy so that diabetic patients can be managed in community clinics with consultant and GP led support. • We are enhancing community respiratory services, so that patients can be treated closer to home. This will be through acute consultant input to community clinics, and a new pulmonary rehabilitation service. • We will develop a community cardiology service to provide care closer to home. • We are improving our falls prevention service that will provide support to nursing homes. This should avoid falls and their subsequent admission to hospital.	★ ★ ★ ★	★	★
We are **promoting self-management** and 'patient activation'	• We are implementing a joined up approach to new technologies, developing local and regional apps to signpost self care tools and information. • We are deploying a Patient Activation Measure pilot with patients engaged in Whole Systems Care, with a view to improving their knowledge, skills and confidence in managing their own health. • We are helping the voluntary sector to support self-care through access to expert patient programmes and personal health budgets. • We are providing self-help training for diabetes patients.	★ ★ ★ ★		

DA3: Better care for older people

Caring for older people with dignity and respect, and never caring for someone in hospital if they can be cared for in their own bed

There is always someone I can reach if I need help or have any concerns. I know that the advice and support I receive helps me to stay independent. There are numerous opportunities for me to get involved easily with my community and feel a part of it. I don't have to keep explaining my condition to the health and social care teams that support me; they are all aware of and understand my situation. I know that, where possible, I will be able to receive care and be supported at home and not have to go into hospital if I don't need to.

What we are going to do	How we are going to do it in Harrow	When are we going to do it: 17/18	18/19	2019>
We are taking a **whole systems** approach to commissioning and delivery of local services	• We will continue to progress local innovative delivery of Whole Systems Integrated Care (WSIC) and Primary Care Transformation • We will take action following a NWL-wide market analysis of older people's care homes to ensure Harrow has enough quality provision to meet the needs of our population.	★ ★		
We are **implementing an Accountable Care System**	• We will develop and procure an Accountable Care System(ACS) business model. This will support our services through working across the care pathway, removing boundaries and supporting an efficient and effective care service.	★		
We are **upgrading rapid response and intermediate care services**	• We will accelerate deployment of the Integrated Urgent Care Pathway in Harrow, aligned with the NWL plans and Better Care Fund (BCF) developments, to provide residents with an alternative to A&E. • We are providing a rapid response in-reach service to our nursing homes so that residents can be treated within their nursing home, rather than being admitted to hospital. • We are extending the virtual wards initiative, where people are provided with intensive nursing and social care within their own homes, rather than in hospital.	★ ★	 ★	 ★ ★
We are creating an integrated and consistent **transfer of care approach** across Harrow	• We are improving alignment, information sharing and joint delivery between services e.g. Improving Access to Psychological Therapies (IAPT) and the local authority re-ablement team. • We are rolling out a Harrow Integrated Health and Social Care single assessment process to support early interventions and accelerate discharge to appropriate non-hospital care settings. • We will protect adult social care activity levels through Better Care Fund funding. • We are exploring new models of care including Discharge to Assess and Hospital at Home to support our resident to get the right care in the right place..	★ ★ ★		★
We are **improving care in the last phase of life**	• We are identifying patients who are potentially in their last phase of life through advanced care plans and risk stratification, which will improve management of those patients in their preferred setting (usually in their own homes). • We are increasing staff training on managing End of Life Care across all Harrow providers, to ensure patients are managed according to their wishes. • We are improving and implement proactive signposting to last phase of life resources for both patients and carers, to increase care in the community and reduce dependence on acute hospitals. • We are streamlining processes to improve access to palliative care funding to enable people to make choices and have a degree of control over their own End of Life care pathways. • We are reviewing how to integrate the Palliative Care nursing team with other End of Life services, so that care provided to patients is seamless. • We are redesigning the End of Life pathway in partnership with Brent CCG and London North West	★ ★ ★ ★ ★ ★		

North West London Whole Systems Integrated Care

The Better Care Fund

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DA4: Improving mental health services

No health without mental health

I will be given the support I need to stay well and thrive. As soon as I am struggling, appropriate and timely advice is available. The care and support that is available is joined-up, sensitive to my needs, personal beliefs, and is delivered at the place that is right for me and the people that matter to me. My wellbeing and mental health is valued equally to my physical health. I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing.

What we are going to do

How we are going to do it in Harrow

When are we going to do it

	17/18	18/19	2019>
We are implementing the new model of care for people with serious and long term mental health needs			
• We will improve specialist community-based support through opening up Early Intervention in Psychosis team access to all age patients - specifically for patients who are over 35 – and embedding a link worker model for delivery of interventions to patients who are over 35.	★		
• We will embed physical health check assessments within inpatients and Early Intervention in Psychosis community teams, ensuring outcomes are factored into care plan management.	★		
• We will improve pathways between the mental health Single Point of Access and Local Teams.	★		
• We will provide different types of accommodation for mental health patients - moving towards independent living with floating support. We will also implement a Supported Housing Strategy, to improve access for people with mental health issues to access good quality, affordable housing with tenure options.			★
• We will implement Community Based Packages to provide mental health care closer to people's homes.	★		
• We will improve the efficiency and responsiveness of community teams through using data analytics to centrally schedule community team visits and minimise the time spent on non-face-to-face activities. We will also install hard/software infrastructure to allow for video conferencing with patients.			★
• We are enhancing our investment in Primary Care Mental Health services, to improve access to mental health services.	★		
• We are providing mental health training to GPs (through an Advanced Diploma in MH Care), peer support, and other treatment types in line with proposed Like-Minded model.	★		
We are focussing interventions for target populations			
• We are providing specialist perinatal mental health community services.	★		
• We are promoting the 'Five ways to wellbeing' amongst older people to improve their mental health	★		
• We are supporting the 'Work and Health Programme', which provides work placements for people with common mental health needs	★		
We are **improving crisis support services** We are delivering the '**Crisis Care Concordat**'			
• We are improving urgent/crisis care in the community so that patients can be treated at, or close to, home. We are doing this through providing a 24/7 single point of access, timely assessment, more crisis management, supporting recovery at home in the community and extending out-of-hours Children and Adolescent Mental Health Service (CAMHS) provision.	★		
• We are also exploring alternatives to inpatient admissions, such as crisis houses/recovery houses.	★		
We are implementing 'Future in Mind' to **improve children's mental health and wellbeing**			
• We are carrying out an options appraisal for 'tier free' CAMHS service transformation across North West London, including a review of workforce training needs	★		
• We are improving access to local care and support for carers and patients through developing an emotional health and wellbeing service offer , ensuring links to Primary Care Transformation	★		
• We are providing a new community eating disorder service for children & young people	★		

[See also DA2: Better care for people with long term conditions]

DA5: Safe, high quality sustainable services

High quality specialist services at the time you need them

I can get high quality specialist care and support when I need it. The hospital will ensure that all my tests are done quickly and there is no delay to me leaving hospital, so that I don't spend any longer than necessary in hospital. There's no difference in the quality of my care between weekdays and weekends. The cancer care I receive in hospital is the best in the country and I know I can access the latest treatments and technological innovations

What we are going to do	How we are going to do it in Harrow	When are we going to do it: 17/18	18/19	2019>
We are **improving quality and access** in primary care. *[See also DA2: Better care for people with long term conditions]*	• We will implement care models for three Primary Care Hubs which will provide integrated delivery for identified pathways. • We will open an East Harrow Hub in 2018/19 which will include a walk-in centre. This will improve access to primary care and reduce pressure on urgent care and A&E, and will support our Integrated Urgent Care model. • We will implement an integrated patient information solution which will provide real time integration between GP Practices and Harrow's Community Services provider.	★		★
We are delivering the **7 day services standards**	• We are supporting enhanced access to primary care through the establishment of GP Network hubs to deliver primary care services, especially at evenings and weekends. • We will support development of a 7-day inpatient emergency service with increased consultant input.	★		★
We are **reconfiguring acute services**	• We will implement the ongoing programme to improve the quality of services through restructuring and consolidating services (Shaping a Healthier Future). • We will introduce a paediatric assessment unit at Northwick Park. and work to achieve London Quality Standards on e.g. consultant cover.	★ ★		
We are using specialised commissioning to **improve pathways from primary care** We are supporting **consolidation of specialised services**	• We will use CQUIN and QIPP levers to improve the efficiency and quality of care for patients, focussing on: innovation (increasing tele-medicine), improved bed utilisation by implementing a Clinical Utilisation Review, initiatives to reduce delays in critical care, cost effective HIV prescribing, and enhanced supported care at the end of life. • We will establish a Renal Clinical Improvement Network to build on existing centre of excellence. • We are implementing the national Hepatitis C programme to reduce the likelihood of liver disease resulting from Hepatitis C infection. • We are contributing to NWL-wide reviews CAMHS, radiology, imaging, HIV, paediatric transport and neuro-rehabilitation services and will implement the recommendations arising from these.	★ ★ ★		

Shaping a healthier future

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NHS Central London Community Healthcare

NHS Harrow Clinical Commissioning Group

Central and North West London NHS NHS Foundation Trust

London North West Healthcare NHS NHS Trust

Enablers to support the 5 Delivery Areas

There are three enablers to support delivery of the 9 priorities and 5 delivery areas. These enablers cut across all areas, and will support the STP plans to make them effective, efficient and delivered on time.

The below figure is taken from the NW London Strategy and Transformation Plan and provides an overview of how the enablers will change the landscape for health and social care in NW London.

Delivery Areas	Estates will…	Digital will…	Workforce will…
1. Improving your health and wellbeing	• Deliver **Local Services Hubs** to enable more services to be delivered in a community setting and support the delivery of primary care at scale. In Harrow this will be through the East Harrow Hub. • Increase the use of advanced technology to **reduce the reliance on physical estate** • Develop **clear estates strategies and Borough-based shared visions** to maximise use of space and proactively work towards 'One Public Estate' • Deliver **improvements to the condition and sustainability of the Primary Care Estate** through an investment fund of up to £100m and Minor Improvement Grants • **Improve and change our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care	• **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, removing the reliance on paper and improving quality • **Build a shared care record** across all care settings to deliver the integration of health and care records required to support new models of care, including the transition away from hospital • **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care • **Provide people with tools for self-management and self-care**, enabling them to take an active role in their own care • **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence	• **Target recruitment** of staff through system wide collaboration • Support the workforce to enable 7 day working through **career development and retention** • **Address workforce shortages** through bespoke project work that is guided by more advanced processes of workforce planning • Develop and train staff to **'Make Every Contact Count'** and move to **multi-disciplinary ways of working** • Deliver **targeted education** programmes to support staff to adapt to changing population needs (e.g. care of the elderly) • Establish **Leadership development forums** to drive transformation through networking and local intelligence sharing
2. Better care for people with long term conditions			
3. Better care for older people			
4. Improving mental health services			
5. Safe, high quality sustainable services			