HARROW PRIMARY CARE TRUST

LOCAL DELIVERY PLAN
2003-6

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1. Introduction

The Local Delivery Plan for Harrow PCT is the over-arching strategic document describing the agenda for the next three years for the PCT and its partners. It outlines the priorities for change in health and social care services provided to Harrow residents and identifies the investment required to achieve these much-needed reforms.

The three-year allocation of funds to the PCT recently announced by the Government will be welcomed by all who work in and use the NHS in Harrow. However, both the local and national ambitions for health care are enormous; the key question for the next three years is how we can use both new and existing resources to modernise the NHS into a more responsive and effective service for the residents of Harrow.

This document outlines how Harrow will achieve quality and change, alongside growth. It focuses on the key national and local priority areas:

Improving access to all services through:
- Better emergency care
- Reduced waiting, increased booking and choice
- Ethnic Minority monitoring

Improving Services and outcomes in:
- Cancer
- Coronary Heart Disease
- Mental Health
- Older People
- Vulnerable Children
- Diabetes
- HIV/AIDS
- TB

Cross Cutting Themes:
- Improving the overall patient experience
- Reducing health inequalities

These are the areas on which we must focus; it is not possible - or effective – to attempt to do everything at once. The health economy will therefore dedicate its efforts to these areas, knowing that these are the areas where the greatest health improvement can be made in Harrow.

The plan therefore demonstrates how the health economy will be working together over the next three years to achieve this reform. It will explain not only how money will be spent, but how we hope to change the use of the money we receive year on year, in order to achieve better value for money and a better targeting of resources towards the areas of greatest need.

Based on this context, the key themes that emerge from this LDP are:

Patient-focused services

Increased and improved access to services

Integrated working through partnerships

Integrated pathways of care, designed around the needs and circumstances of the individual patient across the whole community

Improved information and communication technology

Care provided in a variety of primary and community care settings to complement the provisions made by local District General Hospitals

Integration between health and social services in the planning and delivery of services by a multi-disciplinary workforce

Continued improvement in the accessibility and quality of environment in health and social care premises and facilities

These themes underpin the LDP's plans in all service areas and define the framework within which Harrow PCT will develop services over the next three years.

The document is structured as follows

Section 1 – Management Summary
Outlines the strategic objectives of the LDP and the under-pinning three-year financial strategy to support achievement of the national and local priorities

Section 2 – Action Plans
Describes the work-plans of the teams leading the implementation of the various NHS Plan priority targets over the next three years, with milestones along the way. These have been largely drawn up by the multi-disciplinary and multi-agency planning groups which exist within the health economy. The action plans will be used as a performance management tool within the PCT.

Section 3 – Output Schedules
Technical documentation defining in quantitative, graphical form the changes in activity, staffing or capacity which are planned in Harrow in order to support successful achievement of the national and local targets. Each is accompanied by narrative describing the health economy's approach and by a financial profile demonstrating the investment in each service area over the coming three years.

2. Harrow – the population and its health

Harrow is an outer London residential suburb and metropolitan town centre, which performs an important role within the overall housing market and economy of London. There is currently a considerable amount of new house building activity helping to meet a requirement to provide new and affordable homes for the growing population of Harrow. The borough covers an area of 19 square miles, with just over a fifth of the area designated Green Belt. Nearly 78% of households in Harrow either own or are buying their own home, one of the highest levels of owner-occupied housing in Britain· Harrow's apparent attractiveness supported by its leafy image, however, belies the conspicuous pockets of deprivation mainly in the south of the borough and the increasing problems of an ageing infrastructure.

Located 12 miles from Central London, Harrow boasts excellent transport links. The borough is well served by both rail and London Underground lines, which also link Harrow to Heathrow Airport, Watford, Milton Keynes and Birmingham. Five motorways (M1, M3, M4, M25 and M40) are easily reached and provide fast transit to many locations in Britain.

Harrow has a population of about 207,000 has an age structure which is broadly similar to the national average. Although the eigth most affluent borough in London, there is variation in affluence in Harrow with the central corridor, the South East and South Harrow being the most deprived parts of Harrow with the highest health needs.

Index of Multiple Deprivation (IMD)
Harrow PCT

Harrow NHS
Primary Care Trust

Harrow has generally good health indicators, with the second highest life expectancy in London and the second lowest teenage pregnancy rate. The biggest killers are Heart disease and Cancer, both of which are most common in deprived areas. Low birth weight, infant mortality and accidents are also more common in our most deprived areas.

Harrow's key distinguishing feature is its diversity. Harrow is the fifth most diverse Local Authority area in the country, with over 40% of Harrow's residents being from a black or minority ethnic group. Nearly 30% are of Asian origin, with nearly 22% being Indian (the second highest level in England and Wales after Leicester). One third of the population of Harrow were born outside the UK. Nearly a fifth of Harrow's population are Hindu, the highest proportion in England and Wales. 7% of Harrows residents are Muslim, and 6% are Jewish. Although the ethnic minority population is young, the number of elderly people from ethnic minorities will increase over the next decade.

Economic Activity

98,386 people (aged 16-74) in Harrow were employed at the time of the 2001 Census. This is an increase of around 5,000 people since the 1991 Census, although the 1991 Census imposed no upper age limit for recording economic activity[1]. 42.3 per cent worked full-time and 10.2 per cent part-time in 2001 (of those aged 16-74), slight increases since 1991. Only six other London Boroughs recorded higher percentages of part-time workers. 9.9 per cent were self-employed, about 1 per cent higher than in 1991.

Over 14,000 residents aged 16-74 are students, with a third also having some sort of employment too.

3.4 per cent of residents (5,119) aged 16-74 are permanently sick or disabled, thus preventing them from working at all. This level is below both the London (4.6 per cent) and the England & Wales (5.5 per cent) averages.

Levels of unemployment and long-term unemployment[2] were amongst the lowest rates in London, at 3.1 per cent and 0.8 per cent respectively.

The Harrow Local Strategic Partnership

The Harrow Local Strategic Partnership was launched in May 2003 and was formed from its natural predecessor, the Harrow Partnership, which had been in existence for four years. The HSP will build on previous developed relationships and successes of the Harrow Partnership.

Local Strategic Partnerships are intended to improve public services by bringing together those who deliver or commission services together with those for whom the services are being provided. The launch of the Harrow LSPs is part of a wider government agenda to ensure that both national and local government is more accountable. The LSP will be more accountable, effective, open and responsive. It will play an important role in:

- Delivering the Harrow Strategic Partnership Action Plan
- Developing and implementing Harrow's Community Strategy, a 10 year plan which will focus on delivering solutions to local problems and unmet nets (based on a Borough needs analysis). The Harrow community strategy will be launched at the Harrow Strategic Partnership summit in Spring 2004

  The co-ordination and rationalisation of various partnerships and plans

[1] Economically active students have been excluded from both counts

[2] Long-term unemployment includes those who stated that they had not worked since 1999 or earlier

The HSP will bring together representatives from the public, private, voluntary and community in Harrow. Many of its members have been active members of the Harrow Partnership and becoming part of the HSP is a natural progression for them.

Public and Patient Involvement Strategy

An infrastructure of both national and local Public and Patient Involvement (PPI) arrangements was outlined in the NHS plan and continues to evolve. Harrow PCT has developed a local PPI strategy to ensure wider engagement with service users and to bring together the good work already undertaken.

Harrow PCT's public and patient involvement strategy is underpinned by three key elements:
- Enhancing the foundations
- Empowering patients
- Embracing communities

Enhancing the foundations

This refers to developing an understanding of what the PCT currently provides for service users in terms of participation. To comply with section 11 of the Health and Social Care Act, the PCT must ensure that the public are involved and consulted about service developments and changes undertaken by Harrow PCT.

The first step in ensuring the PCT fully understands the nature of existing services is the development of a base lining exercise. From this, the PCT must identify clear areas for action to build engagement, led and supported by a PCT team with Board level representation.

Empowering patients

There is a range of structures within the organisation that enables patients to play a role in the life and work of the PCT (expert patients, Community Health Councils, Patient Advice and Liaison Service) and the objective is to raise the bar - to develop innovative ways of facilitating wider patient involvement. Harrow's Talking Table event set for October 2003 is designed to encourage more groups from a wider set of communities to play a role in the PCT.

Embracing communities

To make public involvement meaningful, the PCT needs to focus on the hard to reach sections of Harrow's communities. As an organisation we need to understand clearly the needs of diverse communities, consistent with race equality scheme and essential for effective local development that we understand what facilities and clinical focus is required in the different parts of the borough. Through involving patients in the work of the PCT from communities typically less involved, we aim to ensure that services are inclusively designed and encompass a range of needs. In so doing, the PPI programme is also expected to develop a range of volunteers from these less heard sections of Harrow's community.

3. Development of the LDP

Harrow Primary Care Trust was established on 1st April 2002, with the following vision statement:

> The Harrow Primary Care Trust (PCT) will be a health-improving organisation working in partnership with other agencies and the public. It will allow for services to be planned and delivered across traditional boundaries, and will help to improve the health of the local population and reduce health inequalities.

The PCT is the lead strategic organisation for health in Harrow and is responsible for managing and developing the Harrow health economy, by working together with all our partners – other statutory organisations, the voluntary sector, service users and their carers. This LDP is the plan describing the work that will be undertaken by the entire health economy, not only by the PCT itself. It is a three-year plan, which will be the guide to the health economy's priorities and work-plan for 2003-6.

Stakeholder Involvement

The LDP has been developed over a period of months, with the active engagement of all key partner organisations, many front line staff and service users and carers. This has been secured through:

Development of the LDP at service-related existing planning forums, e.g. the Mental Health Local Implementation Group, which includes clinical and managerial staff from Central and North West London Mental Health Trust, voluntary sector providers and service users and carers

Consultation on the content of the document with the Local Medical Committee, Local Pharmaceutical Committee, Local Dental Committee and Local Ophthalmic Committee

A borough-wide Stakeholder Involvement Event held in December 2002 for voluntary sector partners, service users and carers, at which participants' views regarding priorities for service improvement and investment were elicited

A Staff Consultation Event held in December 2002, attended by staff from the PCT, North West London Hospitals Trust, Central and North West London Mental Health Trust and Harrow Social Services Department. This event gathered participants' views regarding the priorities for service improvement and investment.

Consultation on the content of the document with the Harrow Carers Forum in November 2002

A Prioritisation Workshop in January 2003, at which the PCT Board and PEC, along with key partner organisations, identified the key priorities for the health economy, informed by the outcomes of all previous events as described above.

The PCT will continue to work closely with all partners and stakeholders in the implementation of the LDP over the coming years.

4. PCT Financial Strategy

Harrow PCT will receive a financial uplift of 30.01% over the next 3 years. This equates to a cash uplift of £49,198 million.

The uplift for each year is:

%	£M
9.11	14,932
9.26	16,561
9.06	17,705

This sustained increase over 3 years enables the PCT to plan to achieve the changes over that period to meet the NHS plan targets, and achieve recurring financial balance. The 3-year allocations are annual allocations and the PCT has to meet the duty of financial balance in each and every year.

The weighted capitation position of the PCT at the end of the 3-year period is that it is 4% over target. Weighted capitation is a way of assessing the needs of the population for healthcare and using variables such as age, sex and deprivation indices to adjust raw population data. Being over target means Harrow PCT receives more funds to invest in healthcare than the needs of the population suggest it should need. The PCT will not lose any of its baseline funds as a result of this position. The NHS uses differential uplifts to baseline funding to move PCTs towards their weighted capitation position. This means that the PCT might receive uplifts lower in the future than areas who under their capitation formula.

The Current Financial Position

The PCT's financial position at the end of March 2002 was a deficit of £0.9M and an underlying financial deficit of £2,9M. This means that investment options for 2003/04 are limited. The PCT does have the opportunity to plan the implementation of changes in the way health is delivered in Harrow in subsequent years.

The year-end position arises from the over-committed position that Harrow PCT inherited. A 2-year recovery plan was put in place with Strategic Health Authority support. This has been less successful than forecast in year 1, with continued over-expenditure on Continuing Care and less saving on Primary Care prescribing than was originally planned. There is good evidence that the PCT has begun to manage the primary care prescribing more robustly and that significant savings (£1.6M) are planned for 2003/04.

The PCT has to achieve savings in 2003/4 of £3M recurrently. In addition in line with all other Providers its own services will need to achieve a cash releasing efficiency savings .The targets for the recurring savings are Primary Care Prescribing £1.6M and a further £1.5M from continuing care and changes in the use of acute facilities.

The Director of Commissioning and Service Modernisation will develop a plan in 2003/04 to enable the PCT to manage within its resources for secondary care. Part of developing this plan will be a realistic assessment of timescale impact and resource needs to implement the project. A similar assessment will be made in relation to continuing care.

All these areas are challenging to make savings from but as they represent 80% of the investment of the PCT they have to be targeted. To assist the process a research project is being undertaken to look at the current investment, needs assessment and weighted capitation position of Harrow compared to 2 other London PCTs. It is hoped that this will lead to a better targeting of areas for reduction

Implications for 2003/04

The PCT Board and PEC have formally agreed that the first calls on the cash uplift of £14,932m are the generic costs of the Trusts from whom we commission services, this equates to £6.2M, the advised uplift on primary care prescribing (£3.3M 13%) and the Directorate of Health and Social Care agreed Recovery Plans for NWLH, St Mary's and Barnet and Chase Farm Trusts (£. 8M). These three commitments, plus other inflation (£1.7M), amount to just over £12m of the almost £15M uplift received in 2003-4.

The PCT has already agreed to a number of areas of investment in 2003/04, all of which contribute to the national and local health priorities. These include:

- Investments in community health facilities through the LIFT project
- Investment in a new gynaecological cancer centre
- Investment of an additional £350k in Harrow's mental health services
- Investment in two projects to develop voluntary sector services for the homeless and for women facing domestic violence, both of which have been identified as priorities within the health inequalities agenda

These agreed "pre-commitments" equate to investments of just over £ 1.0M

The net effect of the above, together with the underlying financial position, and the requirement to fund out-turn on a number of service agreements that over performed in 2002/03 is a requirement for £758k more funding than growth available. That is before funding any specific investment in the key NHS Plan deliverables. The savings plans identified above of £3.1m will enable £0.9m to be released to invest. This is a high risk strategy, and we are working with our providers to ensure those funds are targeted most effectively to meet NHS plan key access targets, that is, no patient waiting more than 9 months for elective, or 17 weeks for a 1st outpatient appointment or more than 4 hours for discharge from A&E. in 2003/04.

Financial Strategy 2004-6

By working to reduce the over commitments and managing the 1st year of the 3 year period as tightly as possible, the PCT will be able to invest more funds in 2004/05 and 2005/06. By eliminating the over-committed position, the PCT will be better able to manage the financial risks that will arise from the new financial flows system.

Outline Investment Strategy 2003-6

The table overleaf demonstrates how the PCT intends to utilise the additional funding which will be received in each of the three years.

Financial Risks / Risk Management

The PCT is committed to achieving financial balance in order to create a stable environment to invest in modernisation.

The PCT has 3 key areas of risk:

1. The resources to invest in 2003/04 are insufficient to meet key access targets based on the PCT's stated investment requirements
2. The continuing care spend is under increased pressure which will be exacerbated by the new continuing care criteria. This makes the required £0.5m saving plan an even higher risks
3. Key service agreements have not been fully funded and the PCT is sharing risk on over performance. No reserves are held against this risk.
4. The continued impact of NICE guidance

The management of these risks will be around prioritisation of targets, continued search for more cost effective service models for delivering continuing care and joint management with Trusts to avoid over performance on service agreements.

Harrow PCT Financial Profile 2003-6

Harrow PCT

	2003-04 (Revenue) £000s	2004-05 (Revenue) £000s	2005-06 (Revenue) £000s
Baseline Pressures			
1 Pay (settlements, drift, etc)	3,448	3,633	3,825
2 Junior doctors contract	1,164	1,170	1,207
3 NICs contributions	34		
4 Capital Charges	792	871	958
5 PFI revenue expenditure - No information			
6 CNST - No information.			
7 Other (specify) GMS Inflation	191	199	207
Non NHS Contract Inflation	1,638	1,720	1,806
PCT Deficit & non-recurrent measures 02/03	2,900		
8 Prices	757	780	803
TOTAL Baseline Pressures	**10,924**	**8,372**	**8,806**
Drugs			
1 FHS drugs	3,188	3,602	4,071
2 HCHS drugs Incl in Prices above - no information			
TOTAL Drugs	**3,188**	**3,602**	**4,071**
Efficiency (cost savings) - PCT Prescribing & Cont Care estimated savings	**(2,453)**	**(750)**	**-700**
Investment in Key Targets			
Access	985	1,360	1,750
Cancer	150	250	250
CHD		200	100
Children	15	190	200
Drugs Misuse			
Older People		830	1,000
Mental Health	452	1,000	0
Patient Experience		100	200
Health Inequalities	100	130	150
Physical Capacity	150	125	880
Workforce	440	200	200
TOTAL Investment in Key Targets	**2,292**	**4,385**	**4,730**
Other Investment (please specify) IM&T	**140**	**100**	**100**
SUB TOTAL	**14,091**	**15,710**	**17,007**
Agreed Recovery Plan contribution	**885**	**851**	**692**
TOTAL Additional Expenditure for PCT	**14,976**	**16,561**	**17,699**

Analysed by Organisation	2003-04 baseline £000s	2003-04 uplift £000s	2004-05 uplift £000s	2005-06 uplift £000s
North West London Sector				
PCT commissioning arm	48,464	5,464	4,771	5,383
PCT provider arm	14116	601	631	663
Other PCTs in sector	1809	90	95	99
St Mary's Hospital	3899	301	316	332
CNWL Mental Health	13787	628	659	692
Chelsea & Westminster Hospital	614	38	40	42
Royal Brompton & Harefield Hospitals	2959	155	163	171
North West London Hospitals	47768	3077	3231	3392
Hillingdon Hospital	1256	75	79	83
Ealing Hospital	205	12	13	13
West London Mental Health	149	8	8	9
West Middlesex University Hospital	33	2	2	2
Hammersmith Hospital	890	67	70	74
North Central London Sector	12851	619	650	682
North East London Sector	219	16	17	18
South East London Sector	939	70	74	77
South West London Sector				
Other Trusts	13390	1047	1099	1154
TOTAL Additional Expenditure for PCT by Organisation	163,348	12,270	11,917	12,887
(NB Excludes NHS Plan investment at this stage)				

<u>Memorandum</u>

	2003-04	2004-05	2005-06
PCT allocation uplift	14,932	16,561	17,705
Under/(over) distribution of available uplift	44	0	6

Further detail regarding the nature and specific aims of the investment shown in this table is given in the main body of the LDP.

5. PRIORITY AREAS

Having evaluated our current services and listened extensively to the views of users, carers and NHS and local authority staff, we have selected the areas of greatest need and where greatest change can be achieved.

The process resulted in the selection of the following areas as priorities:

- Access (to emergency and elective care services, and to primary and secondary care services)
- Mental Health Services
- Older People Services

More detail is given below about the reasons why these were chosen as priority areas and what the health economy will be seeking to achieve during 2003-6 in relation to each area.

5.1 ACCESS

Of all the commitments made in the NHS Plan, the objectives regarding improved access are the most ambitious. While there has already been some considerable success within Harrow, most notably through the Primary Care Access Collaborative, there remain significant challenges in meeting the national targets over the next five years.

In order to deliver the priority areas, it will be necessary in many cases to have additional staff, equipment and facilities. In October 2002, the capacity plan for the health economy was developed in accordance with the national model, focussing primarily on acute services and assuming the maintenance of traditional hospital-based models of care. The plan is not therefore likely to be a feasible route to achieving the ambitious national modernisation targets in terms of workforce, physical capacity or funding.

The aim within the Harrow health economy now is therefore to move from this starting point towards an Integrated Access Strategy which takes account of the inter-relationships between acute and community-based services and which builds in the vision for alternative models of care. This is based on the fact that although the government has laid out its assumptions at a national level about the additional capacity required, local communities have autonomy within the LDP process to work to different assumptions where these can be justified by local circumstances. For example, in order to achieve some of the access targets, Harrow may choose not to support the creation of further posts within the hospital setting, but may instead invest in community-based alternatives, where this represents the right approach for our community. These decisions will be made by the PCT together with its partners over the coming months.

The elements of the Integrated Access Strategy are detailed below:

Emergency Access

Emergency Access is a specific challenge within Harrow. The continuing improvement in access to GPs both within and outside traditional surgery hours will help to alleviate pressure on the A&E Department, and therefore the Primary Care Access Collaborative will remain a priority workstream.

The PCT's other major intitiative to improve emergency access has been NU-Care. This project, which started in 2001, is piloting innovative ways of streaming activity through the A&E Department in order to ensure that the majority of patients with relatively minor complaints can leave the Department within an appropriately short time. The project utilises the skills of GPs,

practice nurses and paramedics to treat minor cases, and integrates Out of Hours GP service with the A&E service. The potential joint appointment of a Nurse Consultant within A&E/NU-Care represents a further advance in this project.

In the longer term, the PCT is committed to developing alternative gateways to emergency access other than the A&E Department. These alternatives will hopefully include at least one Primary Care Diagnostic and Treatment Centre (DTC). The plans for a DTC in Wealdstone are developing through close joint working with Harrow Local Authority, through the LIFT project. The PCT may establish further DTCs in order to provide appropriate alternatives to an A&E visit. This work will be taken forward through the service strategy underpinning the LIFT project for Harrow and will require a whole systems approach, which reflects the complex inter-relationships of the various services, which constitute emergency access services:

Interrelationships of emergency access services

The health economy also needs to focus on the relationship between emergency access points and the bed capacity behind those gateways. In order to ensure that bed numbers and bed occupancy levels are consistent with admitting emergency cases without delay, the Integrated Access Project will include a review of the numbers and usage of existing Medical and Elderly Care beds. The PCT will also work together with providers to ensure that the recommendations of the National Bed Inquiry have been implemented locally.

Planned Access – Inpatient and Outpatient

The national targets for improving access to elective care continue to drive down waiting times for outpatient appointments and for operations over the next five years. Reducing waiting times on this scale will require the total commitment of the PCT in terms of financial investment as well as intensive performance management of our provider Trusts, focused implementation of demand management and innovation in development of primary care-based alternatives.

Thus the PCT will be drawing on the full range of solutions and tools available to us to support this work, including GPs with a Specialist Interest (GpwSI), Specialist Nurses and Therapists, care pathways, use of NHS DTCs and independent sector providers. In 2003-4, we hope that Ravensourt Park Hospital (RPH) will begin to provide a substantial proportion of the elective orthopaedic activity needed by Harrow residents, and moreover that this will be possible at a competitive and appropriate financial rate.

In relation to outpatient activity, the PCT recognises that it too plays a significant role in reducing the ever-increasing rate of referrals into secondary care. The level of additional capacity required results directly from the level of growth of demand within the health economy. As referral rates from Harrow GPs to NWLH continue to grow, the priority for the health economy is to introduce an effective programme of demand management. This will be done using the care pathway approach and the support and tools available from NatPACT, drawing on the experience of other PCTs. The success of this approach is critical in order to ensure that future years' finances do

not continue to be sucked into an ever-increasing growth in secondary care activity. There are several related and ongoing strands of work in this area:

- PCT management of waiting lists project
- Development of Contact Centres to support the Booking Programme
- Development of referral protocols as a part of modernisation programmes within specific specialties

A key challenge in this area will be to ensure that the various streams of work complement each other and co-ordinate their efforts.

One key element of this strategy will be the pilot Expert Patient Programme, which the PCT has already commenced and for which there is great support.

Finally, the PCT is focused on improving access by fundamentally re-designing and implementing new models of care. While the meeting of national targets will inevitably require the continuation of significant financial flows into acute Trusts in 2003-4, by 2004-5 and 2005-6, these funds may be re-deployed into primary and community settings in order to support such new models of care. Underpinned by care pathways, increased GP access to diagnostics and specialist primary care staff, around 10% of what is currently acute secondary care outpatient activity should be managed within primary/community services by 2006. The development of new community facilities through the LIFT project provides a practical framework within which these services can be designed and established so as to provide equitable access across the Borough. This will only occur, however, where community-based services can demonstrate that they can provide services of equal quality and at no greater cost.

Further key issues in relation to the Integrated Access Strategy include:

- Implementation of Choice for patients and the new financial flows regime from 2003-4: the PCT will be seeking to establish the level of risk possible through leakage from the health economy and to make financial provision to fund flows to new providers. We will also be working with GPs to achieve a shared understanding of their enhanced gate-keeping role

- The access gains resulting from the move of General Practice to PMS, and particularly, the access improvements for the vulnerable sections of the community who have most difficulty accessing NHS services through the PCT's Greenfield PMS proposal

- The further development of the Ambulatory Care and Diagnostic Centre at Central Middlesex Hospital

- Understanding the impact of the Bedfordshire and Hertfordshire Acute Services Review, and planning for the changes in patient flows, which will result from these developments. In particular, the PCT will be seeking to ensure that any new service configurations offer both excellence and access to patients. Harrow PCT will be working closely with Hillingdon PCT on this issue over the next three years.

- The establishment of Community Diagnostic and Treatment Centres within Harrow in addition to the LIFT developments

- Planning for the completion of the Paddington Basin Development and anticipating its effects upon access for Harrow residents

  Specific access issues related to Chronic Disease Management, i.e. the extension of Rapid Access Chest Pain clinics, angioplasty access, retinopathy screening for diabetic patients, cancer screening programmes and reducing the waiting times for the diagnosis

of suspected cancers. The PCT and partners through Care Pathways will develop these jointly.

5.2 MENTAL HEALTH

Modernising and developing mental health services is one of the 8 clinical priorities for the NHS. This modernisation agenda, together with the achievement of the six mental health targets arising from the NSF for Adults of Working Age is an integral part of the PCT's LDP.

The NSF sets out very precise standards for the form and quality of services available in each area of the country and implementation of the NSF is led by Local Implementation Teams across the country. The Harrow LIT is made up of service users, carers of service users, voluntary sector representatives, PCT and local authority commissioning and public health staff and the NHS Trusts, which provide mental health services. This body has reviewed the position in Harrow in relation to these targets and prioritised amongst them based on local need and quality of existing services. The priorities of the LIT were as follows:

Complete the establishment of the Assertive Outreach Team in order to take the team to its full size and achieve compliance with the Mental Health Policy Implementation Guide [MHPIG]. This will be achieved through the new funds allocated to adult Mental Health services in 2003-4.

Create a Crisis Resolution Team based on the national service model and learning from the successful service models already established, including one within North West London. The aim of establishing this team would be to create capacity to support around 30 acutely ill people within their homes and prevent hospital admissions. The team would run a day support unit which would be offered as an element of support to service users.

The PCT aims to invest the funds to establish this service during 2004-5. It is working with Central and North West London Mental Health Trust to clarify the impact of the team's establishment on the bed requirements for Harrow patients. The Mental Health LIT has been pressing the Trust and PCT to accept that there is expected to be a significant reduction in admissions once the Crisis Resolution Team is established.

Establish an Early Intervention Team, which will span Harrow and neighbouring boroughs. The LIT has recommended that the scoping and development work for this service be undertaken during 2003-5, with establishment of the team occurring in 2005-6 (year 3 of the LDP). This is based on the LIT's assessment that there is greater local need for the establishment of the Crisis Resolution Team than the Early Intervention Team.

Alongside the above investment in new or enhanced mental health services, the PCT expects to see reform of the mental health system. There is a consistent message from users and carers of mental health services, and from those who participated in the LDP stakeholder events, that mental health services are experienced as fragmented and buck-passing, and that services are not provided in partnership with users and carers. The PCT has supported a whole systems review of Harrow mental health services by CNWL and hopes to see a programme of reform that tackles the attitudinal as well as systemic issues within the service. Potential outcomes of this reform which might constitute evidence of beneficial change include a reduction in the number of inpatient beds needed and used within Harrow, a continued reduction in the number of private sector places used and a new service model and role for CMHTs.

The PCT is working together with Harrow Social Services and CNWL to manage the major risk areas, **which** could slow progress towards meeting the key targets and overall improvements to services. These include:

- additional costs associated with the introduction of new antipsychotic drugs

- continuing dramatic increases in the demand and cost of continuing care placements for mental health service users

Additionally, the PCT will be continuing to devote significant resources and management focus to developing the infrastructure issues which will allow Harrow's mental health services to be delivered smoothly and effectively to service users. These infrastructure issues include:

use of Section 31 Health Act 1999 flexibility powers creating pooled commissioning budgets across the PCT and local authority

going live with the Jade software project to create a single mental health record across NHS and Social Care

supporting the work within Harrow Unified Mental Health Service (HUMHS) to move from secondment of social work staff to TUPE transfer, thus cementing the creation of the fully integrated mental health service. TUPE is an abbreviation for the Transfer of Undertakings (Protection of Employment) Regulations 1981

Mental Health in Primary Care
The NSF introduced a new role of Community Gateway Workers in Primary Care and the PCT aims to establish this new service in 2004-5 (year 2 of the LDP). Early preparation work for the establishment of this service is being undertaken via the Primary Care mapping exercise, which is identifying existing resources committed to counselling within primary care, alongside other services. One of the strong messages from users and carers during the LDP Stakeholder Events was the importance of improving the response of primary care to people with mental illness or related concerns. Gateway workers will be a part of that improved response, but in addition, there is a clear need for a programme of training and for the development of referral protocols across primary and secondary care, in order to ensure that all patients receive the level of care they need in a timely manner.

The NSF also introduced the new roles of Graduate Primary Care and Carers Workers. It is envisaged that this development work will be taken forward during the first year of the LDP with the WDC, in line with national developments on training and further guidance on the Carers workers.

Child and Adolescent Mental Health
Finally, a strong message from all stakeholders in mental health services has been the importance of improving mental health services for children and young people (CAMHS). It is widely acknowledged that there are significant weaknesses in the current CAMHS service, particularly in relation to provision for teenagers. The PCT is engaged in pan-agency work to address these weaknesses and will be prioritising development of CAMHS in both financial and management attention terms over the next three years. Financial investment in 2003/4 will be made in establishing an inter-agency post of CAMHS Development Manager, who will be jointly employed by the PCT and Harrow Social Services. This post will facilitate the rapid implementation of the change strategy.

5.3 OLDER PEOPLE

Harrow has relatively fewer people in older age groups than the England & Wales average, but has a relatively high number of people living past their 85th birthday. Older people make up the majority of users of many NHS services and many are among the most frail and vulnerable patients.

The older people National Service Framework (NSF), was launched in March 2001 and is an action blue print for improving the provision of health and social services for older people over the next 10 years. Harrow PCT supports the 8 standards outlined in the NSF. The standards are:

Standard one: Rooting out age discrimination

NHS services provided regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services

Standard two: Person-centred care

NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services

Standard three: Intermediate care

Older people will have access to a new range of intermediate care services at home or in designated care settings to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care

Standard four: General hospital care

Older people's care in hospital is delivered through appropriate specialist care and by hospital staff that have the right set of skills to meet their needs

Standard five: Stroke

The NHS is to take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stoke service and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation

Standard six: Falls

The NHS, working in partnership with councils, take action to prevent falls and reduce resultant fractures or other injuries in their populations of older people. Older people who have fallen receive effective treatment and rehabilitation and with their carers, receive advice on prevention through a specialised falls service

Standard seven: Mental health in older people

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and for their carers

Standard eight: Promoting an active healthy life in older age

The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils

Medicines Management

It is recognised that medicine management is a fundamental component of each of the NSF standards. Appropriate medicines management systems should be put in place so that the medication needs of older people are regularly reviewed and discussed with older people and their carers. This will ensure older people gain the maximum benefit from their medicines and do not suffer unnecessarily from illness caused by excessive, inappropriate or inadequate consumption of medicines.

In support of the NSF, Harrow PCT aims is to provide a range of services that will keep older people healthy and independent and living in their own homes wherever possible and ensure that when they do need NHS services these are appropriate to their needs and timely. The PCT has benefited from participation in the London Older People's Programme over the past two years and its workstreams will be mainstreamed at end of project in October 2003.

Services for Older People are a priority for the PCT for a number of reasons:

> There is a perceived fragmentation of services for older people across a number of fault lines. These include the barriers between primary and secondary care, between specialist Care of the Elderly services and other general hospital services, between health and social care and between services for physical and mental health.
>
> Older People continue to make up a very large majority of emergency inpatient service users in secondary care, despite a large body of evidence that a significant proportion of these admissions could be avoided.
>
> Significant increases in the number of Continuing Care placements for older people without the evidence that these are the optimal way of providing care or best respond to the desires of older people to retain their independence within the community wherever possible
>
> Ongoing numbers of delayed discharges within Harrow which, while not exceeding the target number for Harrow set by the SSI, still in unnecessary occupancy of hospital beds and keeps older people in inappropriate hospital settings longer than necessary

Thus the aims of the PCT's work in Older People's services 2003-6 are as follows:

1. **To provide consistently high quality, integrated services (a single system of care) to all older people**

The PCT's aim is to create a single system of care, which overcomes the multiple fault lines identified above through effective partnerships, pooling of resources and expertise and agreed pathways of care. The two priorities for 2003-4 and 2004-5 are improving the co-ordination between health and social care services and between the Care of the Elderly Services managed within the PCT and the hospital services at Northwick Park Hospital.

In order to support this aim, the following developments will be required during the coming three years:

Use of the Section 31 Health Act Flexibilities to create pooled budgets and lead commissioning for older people across health and social care. This will include the appointment of Harrow's first Joint Commissioning Manager for Older People's Services.

Consideration of the potential benefits of integration of provision of health and social care for older people and consultation with older people and other stakeholders about this suggestion

Co-location of health and social care services for older people within the new LIFT facilities

Completed implementation of the single assessment process for older people. An IT-based solution will shortly be necessary in order to underpin the new system and this is likely to be modelled on the Jade project to create a single electronic record for mental health users spanning health and social care

Development of an agreed care pathways and agreed quality standards, for example, for stroke services and neuro-rehabilitation with all patients admitted to Northwick Park Hospital.

2. **To increase the provision of Intermediate Care for older people, preventing admissions to hospital and facilitating early discharge into a rehabilitative environment as soon as possible.**

The development of an effective intermediate care service will not only improve the patient's experience of the NHS, but should help the PCT and local authority to improve the entire emergency care system. Thus the PCT will be seeking to demonstrate - through formal evaluation – that the new intermediate care services achieve the following:

Prevention of avoidable emergency admissions to hospital through use of Step-up or Rapid Response services

Reduction in delayed discharges from hospital

Saving in occupied hospital bed days saved as a result of more older people returning home or to a step-down (convalescent) facility with ongoing support and rehabilitation after hospital

Mental Health Services for Older People

As mentioned above, Standard Seven of the NSF for older people requires that older people with mental health problems have access to a full range of primary and community services. Benchmarking of existing Harrow services has highlighted some significant gaps in services and these need to be addressed through a combination of re-engineering existing resources and new investment in order to expand the spectrum of care available.

Major developments over the next three years include:

reform of existing day care services in order to create a day hospital model offering assessment and treatment for people with functional disorders and dementia

development of intermediate care capacity specifically designed to support people in an acute confusional state

dis-investment from excess continuing care provision for this care group into areas of identified need, e.g. enhanced community team provision, culturally-sensitive services for specific communities and support services for carers

Older Adults Mental Health services are also one of the partner organisations involved in implementing the single assessment process for older people.

6. DELIVERING THE NATIONAL TARGETS

This section describes Harrow health plans in relation to each of the national targets in addition to the priority areas of access, mental health and older people discussed above.

6.1 Cancer

The standardised mortality rate for all cancers in Harrow in those aged under 75 are significantly lower than the national rate[3]. However, within Harrow, there is variation in cancer mortality rates between wards related to deprivation factors, reflecting health inequalities. Moreover, the national targets for screening, access to diagnosis and treatment and access to palliative care remain challenging.

Harrow relates to both the West London Cancer Network and the Mount Vernon Cancer Network in terms of service provision. Through participation in these networks, the PCT aims to ensure that national best practice standards are in place and that NICE guidance is followed. The PCT has appointed a Clinical Lead and Commissioning Manager for Cancer.

The PCT has established a Cancer and Palliative Care Steering Group, which will oversee all aspects of cancer services in Harrow, from prevention and screening activities through to palliative care. This group will be drawing up a workplan to span the period 2003-6 outlining the PCT's objectives over this time.

Financially, the PCT is investing significantly in 2003/4 in the establishment of a new Gynaecological Cancers Centre; we are also considering the options in relation to the potential location of the new Urology Cancer Centre for future years. We will also be focussing during 2003/4 on Palliative Care, seeking to improve co-ordination between the various providers of palliative care and develop a shared agenda for development of services through investment of the additional funding available.

The future of Mount Vernon Hospital cancer services is currently being consulted on until 12 September 2003. The North West London Strategic Health Authority (NWLSHA) on behalf Hillingdon, Harrow and Brent PCTs are running the consultation. At the same time Bedfordshire and Hertfordshire Strategic Health Authority are consulting on major strategic developments to hospital services in their area until 1 September 2003. The Bedfordshire and Hertfordshire proposals include options to develop a specialist cancer centre at either Hatfield or Hemel Hampstead, which will have implications for Mount Vernon. The proposals outline the very important role Mount Vernon will continue to play in treating and caring for those with cancer. The outcomes of both consultations will be reported to the NWLSHA during September 2003.

6.2 Coronary Heart Disease

The PCT's mortality rate for CHD is below the national average, but is higher than the national average in wards of economic deprivation. Additionally, the ethnic mix within Harrow means that CHD is an increasingly evident disease and this position will be exacerbated as the proportion of the elderly population from an ethnic minority increases over the next ten years.

The PCT, along with partner organisations such as NWLH, has a well-developed CHD Strategy based on access to prompt, high-quality care along the patient pathway as set out in the NSF. Active participation in the North West London Collaborative Programme has also realised many benefits, which will continue to be reaped over the coming years.

There has already been considerable success in meeting some standards within the NSF, specifically relating to primary care management of CHD, sustainable achievement of the NSF

[3] 24% lower in 2000

thrombolysis standard and the establishment of a Rapid Access Chest Pain clinic with a maximum wait of 2 weeks. Thrombolysis can be defined as a clinical procedure to stop a clot growing.

The future development of CHD services assumes a change in the model of care in order to achieve a radical shift of service into the community for the majority of CHD management, along with ensuring that appropriate capacity exists in secondary and tertiary care for more complex interventions when required. This will entail:

- improvements in prevention and patient education activities, including the developing the Expert Patient Programme for CHD patients

- public and primary care staff education programmes to recognise and act upon the symptoms of chest pain, in order to improve the pain to needle time

- Practice based registers of patients at risk of CHD as well as for patients with known CHD, in order to underpin call/recall systems

- Accessible alternatives to outpatient hospital cardiology services via nurse consultants/GPSI, along with PCT-based diagnostic services

- Increased capacity to provide diagnostics and surgical interventions along the patient pathway

- Increased focus on and provision for patients with heart failure, based on agreed pathways of care and improved co-ordination between primary and secondary care

Details of the investment required in order to deliver this model are currently being finalised, and provision has been made for financial investment in CHD in 2004-5 and 2005-6. Implementation of this model of care is also predicated on a further-extended role for Primary Care and on the provision of appropriate facilities for community services within the new LIFT Primary Care Centres.

6.3 Improving Life Chances for Children

The government will publish the National Service Framework for Children during 2003. This will contain detailed recommendations in six areas – maternity, acute health services, child & adolescent mental health, children with disabilities, children in special circumstances, and healthy children and young people. With the publication of the NSF, children's services will become a more visible focus for the PCT over the next three years. At present, the specific targets within the LDP focus on children looked after by the Local Authority. The NSF will significantly expand the PCT's objectives for children's services development.

The absence of an effective forum for tri-partite planning between the NHS, Education Department and Social Services is recognised by all three key agencies and has recently been remedied through the establishment of a Children's Services Executive. A wider planning forum for children involving the voluntary sector will also be developed. Work is also underway to evaluate the potential benefits of establishing a Children's Trust for Harrow; however, there is agreement amongst all the agencies involved in provision of children's services that improved service co-ordination and delivery are the goal and that structural change should only be undertaken if there is clear evidence that such a change in structure will lead to service improvements.

Priorities for the coming three years within Children's Services include the following:

Ensuring that the recommendations of Laming Report are implemented within the PCT's own services, within General Practices in Harrow and in all the services which are commissioned for use by Harrow children, working closely with other partners of the Area Child Protection Committee. All PCTs will be required to develop local partnerships to ensure a comprehensive approach to child protection.

- Improving targeted provision of health services to children who are looked after by the Local Authority. This is particularly needed in areas of sexual health and mental health services. In addition, it will be necessary to review clinical support to adoption and fostering services in recognition of the increasing numbers of children passing through system.

- Working closely with partners to implement existing programmes including Connexions, Quality Protects and the Children's Fund to improve life chances and address inequalities of opportunity and health status due to social and economic disadvantage; working with partners to secure additional resources to enhance these services, through the creation of a Sure Start or Early Excellence Centre, such as the Early Excellence Centre at Hillview nursery

- Contributing to the ongoing development of the Harrow Youth Offending Team, ensuring that there is sufficient and appropriate input from the NHS to support the Team's objectives in relation to reducing crime and disorder by young people.

Implementing the forthcoming NSF for children through a new planning partnership body including the local authority, parents, voluntary sector groups and children's services providers.

- Participating in the NWLHT review of community and inpatient paediatric services. The PCT will be working together with NWLHT and Brent PCT to ensure that local services meet the new standards within the Children's NSF and can support both rapid access to specialist advice and services of the highest quality.

- Participating in the establishment of a Neonatal Intensive Care Network for North West London, which will include the Northwick Park (NWLHT) unit. While supporting the move to a network approach in order to drive up outcomes, the PCT will be seeking to ensure that mothers and new – born children needing intensive care can receive the care they need as close to home as possible.

Developing new community-based provision for children within the PCT's LIFT developments, aiming to provide outpatient and therapy services closer to the areas of highest need, without damaging the integrity of the integrated children's service managed within NWLH.

6.4 Diabetes

In 2002, a Diabetes audit was carried out which showed that there were approximately 8,500 patients with diagnosed diabetes in Harrow. This means that the age-standardised prevalence is 3.8% of the practice population. It is estimated that the prevalence could be as high as 5.2% if undiagnosed patients are included.

Type 2 Diabetes is unequally distributed in the population. It is highest amongst the elderly, ethnic minorities and the poor. There are inequalities in diabetes in terms of risks, health outcomes, access to health services and mortality. These inequalities are largely determined by deprivation factors. To reduce these inequalities, service planning needs to identify unmet need in high-risk groups. Type 2 Diabetes is related to a range of modifiable risk factors such as diet, exercise, blood pressure and smoking. Effective primary care management will enable

population base prevention as well as improving clinical outcomes for those with existing diabetes to reduce the impact of its complication.

Diabetic complications are serious and they include conditions such as CHD, retinopathy, neuropathy and nephropathy. The audit revealed that 25% of the diabetic population had retinopathy and 7% (non-age standardised) have heart conditions. This is probably an under-estimate due to under-recording in practices.

Implementation of the Diabetes NSF is led by the Harrow Diabetes Partnership Board, which has representation from optometry, chiropody, practice nurses, diabetes specialist nurses, consultants, Community Health Council, service users, pharmacy, GPs and health promotion. It also has specific sub-groups looking at current issues.

The Retinal Screening Sub-Group has carried out an option appraisal looking for the best option for introducing digital imaging for eye screening. Diabetes is the biggest single cause of registered blindness in the UK amongst working age people. It is a complication of diabetes and much of this is preventable with early detection of diabetic retinopathy through screening. Software is currently being examined which also includes a call recall system.

A Diabetes Project Manager has recently taken up post and will be responsible for facilitating the implementation of the Diabetes National Service Framework in Harrow. This is a joint funded post with the pharmaceutical industry and the PCT.

There are six Diabetes Specialist Nurses in Harrow, two based at Northwick Park Hospital and four based out in the community.

The Expert Patient Programme is in progress with 15 patients on the course. The programme aims to empower people to manage their own specific illnesses, some of which are people with diabetes. It is a six-week course and the outcome is that patients should be more confident in managing their condition, gaining understanding, skills and knowledge to improve and enhance their quality of life.

6.5 Patient Experience

The PCT recognises five key clinical and non-clinical factors, which contribute to a positive experience of the NHS for patients:

- Improved access and reduced waiting times
- Better information and more choice
- Closer relationships between patients and staff
- Safe, high-quality, co-ordinated care
- Clean, comfortable, friendly environments

These lie at the heart of the PCT's vision of healthcare provision within Harrow.

The PCT looks forward to the results of the patient surveys to be undertaken by CHAI in order to ascertain how Harrow residents perceive local services performance in relation to these five key areas. Based on these survey results, the PCT will agree, implement and monitor local improvement plans, working together with the Patient Forum. In the meantime, we are scrutinising the information coming through from the newly-established PALS service, as well as working with the many service users and carers who are already integrally involved in the PCT and also through the PCT's involvement in organisations such as Harrow Carers Forum.

The PCT is committed to developing the enhanced accountability arrangements for the NHS, which will come into place in the coming period:

Local Authority Overview and Scrutiny of Health
- Section 11 of Health and Social Care Act 1999
- The new Commission for Patient and the Public Involvement in Health and Independent Complaints Advocacy Service

The PCT published its first Patient Prospectus in October 2002 and will continue to develop the Prospectus as a source of information for Harrow residents.

Through the PCT's commissioning and performance monitoring processes, key targets will be addressed with hospital colleagues concerning access to telephone and television and the introduction of modern matrons and ward housekeepers. The LDP process has established that the target of eliminating Nightingale Wards for older people has already been met within the PCT's major providers.

6.6 Health Inequalities

The Improvements, Expansion, and Reform: the next 3 years Priorities and Planning Framework 2003 – 2006, makes a clear commitment for the NHS to reduce inequalities and health outcomes across different groups. Harrow PCT has both a strategic leadership role in reducing health inequalities and also a service delivery role in reducing inequalities.

Firstly we need to identify inequalities, and it is stated that we should do so using the tool of equity audit.
Secondly, we must ensure that distribution of health benefit from service expansion and developments consistently favours individuals and communities that traditionally are being under-served.
We must also tackle the wider determinants of health.
We should build capacity within the PCT for Public Health improvements.

We are ensuring that information capabilities focus on equity auditing, and that the results of this feed into health service modernisation and health development. Forging closer links with our partners in the local authority and voluntary sector and developing a local strategic partnership will bolster our ability to tackle the broader determinants of health. We are still developing our thoughts on building public health capacity but the modernisation of primary and community care agenda is an important element.

The focus of our activities will be on reducing smoking, tackling coronary heart disease and cancer in our most deprived areas, and working with women and children (and their service providers). In particular we will be looking to strengthen primary care in underserved areas.

6.7 Reducing Drug Misuse

In line with the Governments Ten-Year Strategy published in 1998, the Harrow Drugs Action Team (DAT) is working with other local partner agencies in delivering the national recommendations at a local level. Because of the complexity of the problem, partnership working is essential at every level and the DAT is responsible for ensuring that joint funding and working is facilitated and co-ordinated in Harrow.

There are four main areas of the government's strategy, which tackles drug misuse. One is centred on Young **People.** In Harrow we will continue to address this issue by ensuring that there is appropriate Drugs Education in schools, colleges and youth and community settings. In the coming year emphasis will be given to supporting vulnerable young people i.e. those identified as being most at risk of misusing drugs. This group includes those in care, school excludees, young offenders, homeless, young people involved in sex work and those with drug using parents. It is important that the professionals working with these groups can identify,

support and refer young people with drug problems. Thus we will carry out training with a range of front line professionals and develop a universal assessment and referral tool.

Treatment is another key area and in Harrow there is a Community Drugs and Alcohol Service, which supports those with drug and alcohol problems via a range of treatment and care services. To meet the government target to increase the number of clients in treatment, CDAS has carried out a review of their services and if funding is forthcoming will realign their services to improve the flow of clients into and out of their service. To aid this objective a new liaison nurse post will be developed to ensure the effective transition of clients between the specialist services and local GPs. This new post will also result in more GPs being involved in the health care of their patients presenting with drug misuse issues. The services offered by CDAS will improve over the next year with the implementation of the national standards document; Models of Care which has been developed to promote quality, efficiency and effectiveness in drug misuse treatment services. One outcome will be to improve waiting times for initial assessment. CDAS also supports several schemes, which offer those involved in the criminal justice system who are misusing drugs, opportunities to enter treatment. As we know there is a strong link between drug misuse and crime and partnership working is essential in tackling this extremely complex problem.

The other two areas in the strategy are concerned with reducing **availability** of particularly Class A drugs and strengthening **communities** to address this problem. In Harrow the police have been carrying out Class A drug operations to successfully reduce the availability of Heroin and Cocaine. The success of these operations have a direct causal effect on reducing other crimes related to financing drug habits e.g. burglaries.

With regard to strengthening communities there has been a strong partnership approach to involving the community in identifying and addressing this problem. Over the last year we have developed a range of social diversion schemes aimed at vulnerable young people to engage them in sports, dance, DJ skills etc which diverts them away from potential criminal behaviour. These projects are further being extended to include wider groups of identified at risk young people and will support their potential to develop semi-professional skills. A mobile drugs unit will be launched soon which will be used on estates, shopping areas and at local events to raise awareness of drugs issues and engage young people in an interactive way with the subject. A Communities post will be developed which will work with the diverse community leaders and groups raising awareness of and identifying and supporting drugs issues within each community.

Drugs and drug related crime are of course intrinsically linked to health and health costs. The Home Office Research Study 217 titled The Economic and Social Costs of Crime assigns health costs to various crimes e.g. the health cost for violence against a person is £1,200 per person. Thus any projects or operations that reduce the supply or demand for illegal drugs - and thereby drug related crime - have a beneficial impact on the health economy, freeing up resources for other pressing areas of need as outlined elsewhere in this Delivery Plan.

6.8 London Priorities

6.8.1 TB

Tuberculosis remains a high priority for Harrow PCT. In line with the regional trend, there has been an annual increase in TB notifications in Harrow, with an increase of 77.4% in TB notifications in Harrow residents during the 2-year period from 1999 to 2001. There were 110 notifications in 2001 compared with 62 in 1999.

The PCT is working to meet the targets for TB set by the London DHSC. These are

Adequate nurses to patients ratios in TB clinics – minimum of one nurse per 40 notifications

Ensuring full treatment completion in all patients and 100% recording of this in clinics

Better co-ordination of services for TB across London with effective clinical networks

HIV testing is offered to all patients with TB

Establish links with a Londonwide TB register.

North West London Hospitals Trust provides the services for TB for Harrow residents. They include the screening, diagnosis, management, and follow up of cases as well as the tracing and screening of contacts. The recent increases in the number of cases locally have increased workload of TB nurses

The target ratio of 1 nurse for every 40 notifications has not been met. The current shortfall in TB nurses is at least 1 WTE nurse for Harrow PCT.

The local TB services and the PCT have established network links with the London wide TB register. This will enable the follow up and treatment compliance and completion levels to be more accurately estimated.

There is improved sector working across the sector. Locally, HIV testing is being offered to all TB cases.

6.8.2 HIV

The main public health challenges of HIV/AIDS in the UK are·

- Increasing numbers of diagnosed HIV infected people
- Impact of migration from high prevalence areas
- Numbers of individuals presenting late
- Increasing costs of long-term care

The best PHLS estimate of the total number of adults living with HIV in the UK, diagnosed and undiagnosed, is 41,200 at the end of 2001.

In common with other localities within the North West London sector, Harrow has seen rising numbers of people with HIV and other STIs in recent years. There were 152 newly reported (prevalent) HIV infections in Harrow in 2001. The prevalence rates within Harrow are 4.9% of gay men & 2% of black Africans. However, within the black African community, the total number of people affected by the disease as carers or dependents is 2.6 times higher than the number infected.

The routes of transmission in Harrow are heterosexual transmission, men who have sex with men, injecting drug use and mother to child transmission. The number of new diagnoses in the heterosexual population is rapidly rising, while due to increased antenatal testing, vertical transmission has fallen in Harrow. Vertical transmission is defined as transmission of a pathogen such as HIV from mother to a foetus or baby during pregnancy or birth.

HIV is a chronic disease and achieving better support for people living with HIV is increasingly a major need. Current figures project significant increases in calls upon social service budgets in order to support the HIV-affected population, in particular children of people living with HIV.

6.8.3 Ethnic Monitoring

Harrow has a racially diverse population. Over a third of Harrow's population are from black and minority ethnic groups, of who the majority are from South Asian ethnic groups. Figures from the

Greater London Authority indicate that nearly half of all new births in Harrow are from Black and Minority Ethnic (BME) groups. We have undertaken a mapping exercise to show which wards have the largest proportions of people from BME groups. These wards are predominantly in the South and East of the borough. We know that BME populations have higher risks of coronary heart disease, diabetes and stroke. The majority of our BME populations are relatively young and therefore there are important issues about how we prevent these diseases.

Each NHS organisation is required to produce a Race Equality Scheme as required by the Race Relations (Amendment) Act (RRA) 2000, which must include clear plans on collection and use of information on ethnicity. Ethnic monitoring is central to delivery of the Statutory General and Specific Duties under RR(A) A 2000 especially in the planning and delivery of equitable, culturally competent services.

According to the DH (London Priority Guidance 2003 – 06), the current level of ethnic coding in London is unacceptable. Hence new targets have been set for the NHS organisations to ensure compliance with the RR(A) A 2000, non compliance with which may result into the PCT being challenged by the Commission for Racial Equality, who are empowered to take legal action against public bodies.

Targets for Primary Care Trusts include:

- **By November 2003**: development of Ethnic Monitoring Action Plan [EMAP] including directly provided services and general practice
- **By March 2004**: EMAP to include General Dental, General Optical and Community Pharmacy Services; at least 50% of all GP and directly provided services to reach a minimum of 75% valid ethnic coding.
- **By March 2005**: 100% of all GP and directly provided services to reach a minimum of 75% valid ethnic coding.
- **By March 2006**: 100% of all GP and directly provided services to reach a minimum of 95% valid ethnic coding.

Health Visiting

Health Visiting contributes towards to targets of the LDP in many ways

Improving access - Within Harrow innovations which include Health Visitors running minor illness clinics for children in GP practice, free up GP time allowing those who require immediate attention to be seen quickly. Health Visitors also give telephone and child health clinic advice on a daily basis often acting as a first point of contact and supporting and education parents regarding appropriate use of medical services.
Mental Health: In light of the strong message from carers regarding the importance of improving the response of primary care to people with mental illness. It is important to remember postnatal depression, which on average affects between 15-20% of the child-bearing population and can have devastating affects on the individual and her family. Health Visitors in Harrow are currently leading the development of an integrated care pathway for postnatal depression. As part of this pathway Health Visitors will introduce universal screening and will provide early intervention for post natally depressed women in Harrow.
Child and Adolescent mental health: Health Visitors locally are developing evidence based programmes of parenting support for families experiencing persistent problems with their children's behaviour. This provides more appropriate interventions for families requiring support with parenting and will in turn relieve CAHMS of some of the time consuming and inappropriate referrals they receive allowing them to deal more effectively with clients requiring their specialist input.
Tackling Health Inequalities: Health visiting targets vulnerable hard to reach families and aim to prevent inequalities in health through early intervention. Current mapping of Health Visitors caseloads will ensure that more resources are focused on the vulnerable and deprived groups. Health Visitors work on reducing health risks from pre-conception onwards,

working in partnership with the public and other professionals. Several local innovations that Health Visitors are involved in such as the Young Parents Project and the Children's Fund Domestic Violence project, target vulnerable groups at high risk of social exclusion and the associated health risks. Specialist Health Visitors including the Health Visitor for Homeless and travellers and the Health Visitor for refugees and asylum seekers provide advice, advocacy, intervention and referral again for groups most at risk

7. The Role of Primary Care

The priorities for Harrow are relevant to primary care as well as to hospital or specialist services. This is a common theme across all service areas: the national and local strategies for Mental Health, Diabetes, Older People and CHD, entail changes to the practices and responsibilities of primary care. Many strategies for achievement across the health economy rely on achieving greater emphasis on community-delivered services.

Within Harrow, there is already close working between NHS organisations to achieve the necessary shift in service design and activity patterns. The results of an audit undertaken by North West London Hospitals NHS Trust of their outpatient provision identified those services, which could better be provided in a non-hospital setting. An Outpatient Modernisation Group operates as a joint venture between NWLH and the Harrow and Brent PCTs, leading work to review outpatient provision, oversee co-operation between secondary and primary care and to make appropriate investment where necessary in order to kickstart modernisation efforts. Initial work has focused on Orthopaedics, ENT, Rheumatology, Neurology, Endocrinology, Cardiology and Gastroenterology.

This approach has to date focused on improving service design and capacity in the specialties in which highest referral growth is predicted. However, in many cases the focus has remained largely limited to improving the patient journey ***within*** the hospital setting. The PCT is committed to extending the scope and ambition of this modernisation programme by focusing on the process of transfer from primary to secondary care and back again in order to ensure that there is sustainable capacity to meet future demand. Without achieving change to the service model, the health economy will inevitably sink most, if not all, of the financial allocation for 2003-6 and any further funds, into secondary care.

The PCT has therefore agreed with its key partners, notably NWLH and Brent PCT, to embark on a process of radical service re-design. This strategy has the following aims:

To improve the accessibility, appropriateness and convenience of services to patients

achieved through e-booking, reduction in DNAs, provision of services in community locations, faster access to professionals, more cost-efficient use of professional skills

To better utilise the existing skills of primary care professionals

achieved through extending the roles of practitioners, particularly community pharmacists, optometrists, dentists, GPSIs and practice nurses in contributing to the priority health improvement targets

To reduce the growth in referrals to secondary care year by year

achieved through better feedback to practices on their referral practices, clinical involvement in commissioning processes, development of care pathways and the development of alternative primary and community-based services

- **To create improved access to diagnostics from primary care**

Need to work closely with NWLH to develop protocols for GP access to diagnostics and ensure that this development results in substitution of GP activity for consultant activity and not just increased activity.

This strategy requires a far higher degree of engagement with GPs in relation to their referral practices than the PCT has yet developed and consequently, the PCT is currently considering the best way to take forward this strategy.

The RAISE project

Harrow PCT has been successful in securing funding for the RAISE project. This is a project to improve asthma care in Harrow and we are one of six PCT's being funded by an unrestricted educational grant from 3M pharmaceuticals. Respiratory disease is the most common reason for GP consultation and emergency admission to hospital and we will use the principles of Clinical Governance to improve care for these patients: patient and public involvement in asthma management, clinical audit of current asthma care, education and training of GPs and nurses and ensuring clinical effectiveness by following British Thoracic Society Guidelines for asthma management.

8. Partnership Working with the London Borough of Harrow

The relationship with Harrow's local authority, the London Borough of Harrow is key to the PCT's aim to improve the health of the population of Harrow. Multiple aspects of the council's work are central to this objective, including the provision of Housing, Regeneration, Environmental Health and Education services. The authority is currently undertaking a major change programme under the umbrella of the New Harrow Project, which will re-shape the council into a more effective and focused organisation and the PCT is working closely with the authority to support the programme of change.

The local authority leads the Local Strategic Partnership (LSP) for Harrow, which is taking forwards the progress in multi-agency joint working established by the Harrow Partnership (now the Harrow Strategic Partnership) in past years. The PCT is a key player within the LSP and is fully committed to playing our part in community development and regeneration.

One key development in the past year has been the introduction of the power of local authorities to undertake scrutiny of the NHS. The PCT has worked closely with LBH to develop an agreed approach to NHS Scrutiny in order to ensure that the process is constructive and valuable, and will support council members in drawing up and managing a programme of scrutiny topics each year.

Other important areas of work on the joint working agenda for the PCT and council over the coming three years include:

Development of the LIFT progamme to develop modern, community-based facilities for health and social care services

Further improvement to the emergency planning processes designed to support the response of statutory authorities to major incidents

Establishment of accessible one-stop shop services within a shop-front premises in Wealdstone

Development of Intermediate Care services providing alternatives to hospital admission and supporting rehabilitation and convalescence outside hospital

Further progress within the regeneration programme for the Rayners Lane area

Further development of the Joint Commissioning Team between the PCT and Social Services

Implementation of the Section 31 Health Act Flexibilities, allowing improved commissioning and provision of services across traditional boundaries through lead commissioning and pooled commissioning budgets

Joint working to reduce delayed discharges from hospital, including developing a constructive and shared approach to the reimbursement system

The development of Extended Schools and Healthy Schools progarammes by the Education Department, with the support of the PCT

9. Underpinning Strategies

9.1 Workforce

The PCT is working together with partner NHS Trusts to expand and modernise the workforce, developing workforce strategies that put the needs of patients first and link into the four pillars of practice outlined in the NHS Plan.. The PCT is developing local plans for recruitment and retention that will support the delivery of the primary care strategy. There is a keenness to look at workforce issues in an innovative way and to learn lessons from other PCTs.

However, across the health economy, recruitment and retention rates are highly variable and some areas have a turnover of over 25% p.a. Some services are unable to recruit staff permanently and are dependent on agency and locum staffing to meet service needs. Thus workforce recruitment and retention constitutes a major risk in relation to achieving the many ambitions and targets outlined in this document and therefore will be a priority area for the entire health economy in the coming years.

However, there are opportunities on the horizon, which present opportunities to use the workforce differently in a way, which directly supports the objectives set out within this plan. Specifically, the expert support of the Changing Workforce programme within the Modernisation Agency in developing alternative workforce solutions is available. Moreover, potential of the new GP contract to support workforce shift and the potential impact of any local consultant contract negotiations provide further opportunities to maximise the productivity of the existing workforce. Finally, the PCT is aware that a number of professional groups within Harrow, such as Community Pharmacists, are very keen to increase their own contributions and to enhance their roles such that the NHS gains full benefit from their training and skills. Drawing on all these opportunities will be an essential strategy for achieving the ambitions set out within this plan.

The PCT will be developing a workforce strategy during 2003, which will include the following areas:

Establishing recruitment and retention strategies to support delivery of excellent healthcare

Working towards Improving Working Lives accreditation (the PCT is at pledge status) and ensuring we involve staff in key decisions.

Developing links and working more closely with other local NHS and social care organisations and the Workforce Development Confederation, The Modernisation Agency and NatPaCT to increase the education and development facilities and opportunities available to staff.

Increasing other benefits to staff such as childcare facilities (including exploring working with the Harrow's Early Years Development and Childcare Partnership), corporate discounts, participating in key worker housing schemes and other innovative benefits to working in the economy (Brent has a full time child care co-ordinator)

Commencing work with local independent primary care contractors (GPs) to model best practice in human resource and organisational development.

Being committed to the development of a diverse workforce that reflects our community, including the delivery of equalities training to all staff and supporting recruitment and development of people with any disability. All Trusts are committed to meeting requirements under the Race Equality Scheme and the PCT has been awarded the two ticks (✓✓) disability accreditation.

Working to develop our organisation with the health and social care providers, users and their carers, and the Workforce Development Confederation, The Modernisation Agency and NatPaCT to increase the education and development facilities and opportunities available to staff.

9.2 Physical Facilities

Together with Brent and Hillingdon PCTs, Harrow received approval in August 2002 to form a third wave LIFTCo. LIFT, a government initiative, is a joint venture between the Department of Health, the local health and social care services and the private sector. The result will be increased investment in primary, community and social care facilities. This in turn will lead to the ultimate objective of better, more integrated and more easily available primary, secondary and social care services in the community.

Healthcare providers will need to work closely with local government to deliver 'seamless services' for patients. The direction is towards a one-stop centre approach allowing the patient access to a range of health and social care services from one local centre. Following a standard procurement process, a LIFTco should be established by December 2003. The PCTs and its partners own a number of sites it could develop into primary care centres. The first tranche primary care centre in Harrow will be located at the Alexandra Avenue site, South Harrow and will be built by 2004. This development will be followed by the development Kenmore Clinic in Kenton.

The LIFT project for Brent, Harrow and Hillingdon will focus on the following areas as priorities:

- Growing older people population
- Children and young people, as they are a relatively needy group
- Deprived members of the community who are likely to have the poorest health
- Socially excluded who find it most difficult to access care
- Deficiencies in primary care, community health and social services premises are addressed
- Develop services and facilities with secondary care partners
- Minority ethnic groups, who may have particular needs
- Delivery of the NHS Plan and the local modernisation agenda
- Health promotion activity to help reduce the unnecessary burden on health services in the future.

Physical facilities is an underpinning strategy that should support the service developments required to achieve the Local Health Delivery Plan's targets. The Action plans consistently identify a need for more space, accessible and modern facilities in the community to adequately house staff and equipment to support service developments. The LIFT project will support many of these requirements.

Other physical capacity developments, which will have implications for Harrow PCT, include:

- The need to improve a number of GP premises – Harrow PCT has 13 single practices and 10 double-handed practices in Harrow (total practices: 39). GP practices will have an opportunity to re-locate to modern primary care centres in Harrow.
- Diagnostic and Treatment Centres (DTCs) providing GP access to diagnostics, outpatient services, therapies. We are awaiting approval for a DTC to be established in Wealdstone.
- Edgware Community Hospital – the hospital is being developed
- Bedfordshire and Hertfordshire future hospital reconfiguration - (subject to outcome of public consultation)
- Northwood and Pinner – provides respite, rehabilitation medical and terminal care services to Harrow Residents over the age of 65. Hillingdon Hospital Trust is currently drafting a Strategic Outline Case (SOC) for the redevelopment of the hospital sites at

Hillingdon and Mount Vernon following a review of the whole health economy in Hillingdon. The SOC and LIFT project will complement any future developments at the community hospital, including intermediate care services

BeCaD – Bouygues Consortium have recently been appointed to build a new hospital in Brent. A completion date has been set for December 2005

- Paddington Basin – the Modernising specialist acute hospital services in West London consultation proposed that specialist renal services, including transplants, specialist children services and specialist heart and lung services be concentrated at fewer hospitals to create larger centres to help develop and maintain clinical expertise. A new larger hospital will be built on the Paddington basin site, next to St Mary's hospital. This development will have implications for the Royal Brompton and Harefield Hospitals, St Mary's and Hammersmith hospitals as services transfer to the new site.

Nursing home capacity

The need to increase Intermediate care physical capacity – older people are a priority for Harrow PCT

9.3 IM&T

Over the past 3 years NHS Trusts and the Harrow Partnership (now the Harrow Strategic Partnership) have worked together to put into place a shared infrastructure and have sought to provide skills for staff to support use of IT for modernisation. A set of plans for ICT is now available for the next 3 years for each aspect of development of the PCT and its care providers. The PCT will continue this collaborative work, which has already seen achievements in terms of:

Providing access to PCs and the internet for all front line staff

For GPs, development of collection information on CHD and Diabetes and sharing with hospital colleagues and preparation of electronic booking tools, present use is small scale

LIFT readiness – when the new buildings are put up a single set of IT tools to support Social Service and NHS staff is now available

For Mental Health, an electronic care plan with a life chart of events

- An Information Sharing Agreement between Social Services and the NHS is now in place

Particular issues for the ICT function that will be addressed in 2003/4:

- Patient focus and engagement through development of communication tools relevant to active participation in health maintenance and self-care and access to support, this will build upon the work of the Borough team,

IT skills, confidence and competence for staff through use of training room within a context of service development as documented on a new Primary Care management system

Better provision of ICT support services to GPs and front line staff

Extending and consolidating recording of information in primary care environments and increasing use of clinical communication tools to support care pathways and seamless provision of care to patients and clients

Provision of a Single Assessment Process for Older People services across all of the context for care

For Children services, improved information sharing with a particular focus on the vulnerable

Ethnic monitoring and information governance

Support for Clinical Governance

New national resources will be available and Harrow will be an active participant in the London-wide approach to provision of ICT tools. At the same time there will continue to be priority set within Harrow PCTs developing agenda. Financial constraint and economy, effectiveness and efficiency of solutions will inform investment.

9.4 Clinical Governance

The development and the delivery of any plan rely on having a focussed and supported workforce with supporting systems in place to guarantee a consistently high quality service for all the population of Harrow.

In July 2002, the PCT Board agreed the framework for taking forward the Clinical Governance agenda for the PCT following a major key stakeholders event. This framework will ensure that Harrow PCT has robust systems in place for ensuring:

Continuous improvement of patient services and care
A client – focussed approach that includes treating patients courteously, involving them in decisions about their care and keeping them informed
A commitment to quality, which ensures that health professionals are up to date in their practice and properly supervised, where necessary
The prevention of clinical errors wherever possible and the commitment to learn from mistakes and share that learning with others.

The Professional Executive Committee (PEC) will have an important lead role and will advise on clinical quality issues and the development of provider, contracted and commissioned services across the PCT in order to make significant and focussed improvements. The PEC will be consulted on all relevant areas of the Clinical Governance Development Plan and will also identify areas where further attention to clinical quality is required by the PCT.

The Clinical Governance Development Plan has been developed and encompasses the organisational development required by the PCT to ensure that the public receive the highest quality of care possible. It encompasses the systems required by the organisation for monitoring and improving services which includes:

- Patient and public involvement
- Risk management
- Clinical audit
- Research & development
- Education & training – workforce fit for practice
- Communication
- Information management technology
- Complaints, gratitude's and claims
- Clinical effectiveness – NSF,NICE guidelines.

The Primary Care Trust has agreed *organisational values* for clinical governance and the aim is 'to ensure that high quality care is delivered to patients by a well - trained workforce with enthusiasm.'

Appraisal for all staff is being implemented across Harrow PCT and includes the General Practitioners. Harrow PCT GP's are enthusiastic about the process and 15 have currently successfully undergone training and 5 have been appraised. The process has been supported by the LMC. It is expected that all GP Principals will have been appraised by before the end of the year.

Introduction of NICE Guidance

The PCT is formalising the process for monitoring the implementation of NICE guidance. It has conducted a baseline survey on the current position on implementation for all guidance published to date and assessed resource implications for primary care and host providers.

Delivering and developing the workforce

Harrow PCT aims to be recognised as a leading NHS employer in London and a recognised NHS model employer. We will recognise and reward staff for the work they do and will continually provide development opportunities so that we recruit and retain effectively. In particular, we will:

- Improve our recruitment success, introducing e-recruitment systems, to expand our pool of potential applications, streamline our recruitment processes and design proactive recruitment campaigns to target staff. We will also explore the opportunities that overseas recruitment provide
- Retain our staff by motivating them with interesting and varied work and through involving them in the running of the PCT
- Build our commitment to training and education and work hard to provide effective career and skills development for all staff groups
- Enable staff to achieve their desired work-life balance, working with staff, managers and our trade union colleagues to design policies which support this through the improving working life provision

10. Risk Analysis

This LDP contains many ambitious plans and high aspirations. It emerges however, within a context characterised by significant constraints and risks, which have been identified in the course of the preparation of the LDP as follows:

Constraints in the current environment

- Financial deficits within the PCT, the local acute Trust and the Harrow mental health services
- Limited management capacity and fledgling performance management systems within a PCT which is one year old
- Radical ongoing change within one key partner, the London Borough of Harrow, with the implementation of the New Harrow Project, limiting the capacity for long-term planning
- Information systems which cannot provide the quality of data required in order to plan and monitor services as needed

  Recruitment and retention difficulties in Harrow reflecting the workforce problems across London
- Uncertainty relating to the outcome and impact of major service reconfigurations, specifically the Beds and Herts Acute Services Review and the Paddington Basin Development

  An emerging policy and financial framework regarding the extension of Patient Choice and the use of HRG costings
- Uncertainty regarding the possibilities arising from the new consultant and GP contracts

Risks to Implementation of the LDP plans

Costs of development of primary and community-based service models services exceeds current costs of hospital based services

The time-lag for the primary/community alternatives to come on stream is longer than the health economy can afford, both financially and in terms of the failure to change

The financial and service impact of the revised continuing care criteria could alter service patterns and reduce growth funds available

A failure to make sufficient change to older people's preventative services and to intermediate care could increase demand for continuing care and resources will therefore continue to go into continuing care by default

New NSFs or new must-do national targets may emerge during the three-year period and be tackled within the existing allocation

New teams or services are created through additional investment, but the systems and behaviour don't change

As many health economies will be investing in the priority service areas at the same time, it may be difficult to recruit enough staff to do all the extra work without which the targets cannot be met

The upshot of these conditions is that despite the best possible planning, there are a number of factors which could affect the development of services in Harrow over the next three years. Some of these are exogenous to the PCT and can only be identified and tracked. Others however are internal to the PCT or Harrow health economy and the PCT will be seeking to manage actively these in order to reduce their potential impact. Some of these risk management strategies have already been identified and strategies put in place. For example, there is a risk that the underlying financial deficit of the PCT is not eliminated in 2003/4. Were this to happen, the deficit would continue to eat up growth funds in future years. In order to eliminate this risk, the PCT will be devoting its fullest possible efforts to the Recovery Plan implementation in 2003/4 and performance managing progress against a clear project plan.

Over the coming months, risk analysis will continue and risk management strategies put into place for each identified risk. These will be detailed in later drafts of the LDP. The risk analysis will also attempt to identify which specific targets are subject to the greatest risk.

11. Implementing and Monitoring the LDP

Implementation

Implementation of the LDP must occur across the whole health economy and is dependent upon effective whole systems working. Success will rely in particular on clinical leadership within the PCT and clinical engagement in the commissioning process on both the commissioner and provider sides.

The Harrow context demands that implementation plans demonstrate that the opportunities and impact of LIFT have been considered and feed in to the service strategies for the LIFT project.

Performance Management

The LDP framework requires PCT's to operate effective performance management systems so that progress against the plans and trajectories can be monitored over the three years. At times, amendments will need to be made and action taken in order to ensure that the aspirations outlined within this plan are realised, or plans changed in order to reflect changing context.

The PCT must, through its LDP performance management process, ensure that the following aims are achieved:

Openly report to the public and local community on progress across the health economy

Hold provider organisations to account for the delivery of commissioned services

Demonstrate to the Strategic Health Authority that our plans are achieving the intended outcomes and that the health economy is on track to meet national and local targets

The LDP will be performance managed robustly within the PCT and reporting against LDP plans will be part of the PCT's Performance Management, which will include full consideration of progress at the public meetings of the PCT Board. Particular attention will be given to the PCT's three priority areas of Older People, Access and Mental Health, but will not be confined to these areas.

However, key to performance management will be the effective operation of the various Partnership Boards and Steering Groups that oversee all the areas of work contained within the LDP. The PCT will need to ensure that good practice is consistently used across all service areas in relation to the involvement of frontline staff, service users and carers and the voluntary sector in planning and developing implementation strategies In particular, these forums must be able to demonstrate how funding has been used to add value to services provided or commissioned in a manner which satisfies the stakeholders involved.