NHS
Harrow
Clinical Commissioning Group

Draft

Harrow CCG's Commissioning Intentions 2019/21

NHS
Harrow
Clinical Commissioning Group

Content

Annexes:

North West London Commissioning Notice

North West London Commissioning Intentions Appendix

Executive Summary

In line with the Five Year Forward View, our overarching purpose is to improve the health and wellbeing of the local residents of Harrow by commissioning a sustainable model of high quality health care within the resources we have available. We want patients to receive health care which is right the first time, in hospital when this is appropriate, but closer to their home when possible.

Patients are at the heart of everything we do and we make decisions about health services based on the feedback we get. This is to ensure that the services we purchase and redesign are services that residents need and can access.

In line with aspirations from NHS England and NW London Collaboration of CCGs, Harrow's strategic aim is to deliver population-based care for the whole Harrow population from April 2021. The NHS Five Year Forward View (2014) called for new care models to achieve better integration of care across GP, community health, mental health and hospital services, as well as more joined up working with home care, care homes and the voluntary sector.

These new models are being delivered through the development of Integrated Care – where NHS and care partners work together to develop models of care that meet the needs of their population. This can include tackling wider determinants of health and illness – population growth, housing, environmental factors and education etc. Integrated care operates through working collectively to a shared and single set of outcomes, a single funding stream for the services delivered and a single contract.

"Integrated accountable care should be seen as a different way of thinking about planning and delivering care based on people – not buildings or organisations; based on outcomes – not procedures or activity". *(NWL CCG's)*

Early results from parts of the country that have started doing this – 'vanguard' areas – are seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country. The difference has been particularly noticeable for people over 75, who often face a revolving door of emergency admission, delayed discharge and then hospital re-admission.

Since 2016 Health and Care partners in Harrow have been exploring new ways of organising the care system as identified in the Five Year Forward View with the intention of developing integrated care initially through the work of the Whole Systems Integrated Care Programme.

Integrated care models are an extension of this and allow providers to take collective responsibility for providing for the health and care needs for a given population for a defined period of time (typically 5-10 years). Providers are held accountable for achieving a set of pre-agreed outcomes within a given budget or expenditure target.

Since August 2017, Harrow Clinical Commissioning Group, the Local Authority and key Providers in Harrow have been working in partnership to develop and

deliver integrated care initially for a sub set of Older Adults, namely:

- 65+ with moderate severe Frailty
- 65+ in Care Homes
- 65+ with Dementia
- 18+ Last Phase of Life
- 65+ mostly Healthy Older Adults.

The aim is to enable truly person-centred care that supports adults with significant needs to achieve the best possible quality of life with an increased focus on prevention, proactive care and self-reliance. This is aligned with the strategic theme of prevention and early intervention as set out in the Five Year Forward View. The programme aims to ensure that people have a personalised and co-ordinated approach for the care they need, making it easier and simpler to access support.

It is intended that from 1st April 2019, Harrow CCG will commission a new model of care and services for this group of over 65's from a provider partnership working under the umbrella of an Alliance Contract for a population of circa 28,500 and spend £42m.

From April 2020 this will be extended to include all adults over 18 years of age and will be extended to support those adults with long term conditions, severe and enduring mental illness and learning disability.

Finally the programme will be extended from April 2021 to include families – women and children's services.

The development of Integrated Care to deliver population based health across Harrow starts with General Practice – the building blocks for a population based approach based on registered population.

In October 2018, Harrow CCG agreed plans to make a significant investment to support the development of collaborative working across Practices in Harrow. The agreement of this plan saw the confirmation of three locality structures in Harrow, as shown in the diagram. These localities are made up of local Practices within specific geographical areas, serving a population of between 80,000 and 100,000. Our work programme over 2018/19 has supported these Practices to come together to focus on local population needs, to develop plans to collaborate in order to deliver a wider range of services to meet these needs and look for where working together could create greater efficiencies for them as individual Practices. Delivery of this work at a locality level is being overseen by Harrow Health CIC, Harrow's GP federation.

Our Estates Strategy in Harrow is for the development of "hubs" for the delivery of extended services to be delivered in a primary care setting. These hubs have been identified in Harrow as Alexandra Avenue, The Pinn Medical Centre and Belmont Health Centre. These align to the emerging three localities in Harrow. We are aware that we need to develop these hub services, particularly Belmont Health centre, as well as ensuring that all of our

Practices are operating from premises that are fit for the purpose of delivering modern healthcare services.

There is considerable work underway to address workforce challenges, including a number of projects and programme of work focusing on retention of our existing workforce and recruitment into vacancies in Harrow. Harrow has a thriving young doctors group "the first fives", supporting newly qualified GPs, as well as a "final fives" group, supporting and nurturing the talent in our healthcare system as GPs approach retirement. We are also looking at new clinical roles in General Practice, such as Clinical Pharmacists, to offer a new skill set and take the pressure off of GPs.

Primary Care is the bedrock of the Harrow Commissioning Strategy:

The Vision: Strong and sustainable General Practice, driving the development and delivery of integrated care services to improve the health and wellbeing of all people in Harrow.

Objective 1: Primary Care at Scale
A single federation, coordinating the delivery of care closer to home through General Practice, leading our practice resilience programme and at the table as a system leader for service transformation. Provider networks (localities) delivering integrated multidisciplinary team-based care for a specific population and in partnership with local community providers.

Objective 2: Care redesign and service integration
Dissolving the traditional boundaries between healthcare services to ensure a quality driven approach to care delivery that focuses on prevention, citizen empowerment and support for self-care, to free restricted resources to target those with the most complex needs.

Objective 3: Workforce development and reduction of workload
To deliver these ambitious changes, the General Practice workforce will need to be strengthened and re-modelled, with developments underpinned by the Ten High Impact Actions for General Practice. By the end of 2018/19, we will produce Harrow's Strategic Workforce Plan.

Objective 4: Improving Access to General Practice
In response to this important priority area for patients and clinicians, commissioning additional consultation capacity, increasing the use of digital technology in the delivery of care and ensuring equitable access for all to the local improvement services offered in Harrow.

Objective 5: Robust delivery of Harrow CCG's delegated commissioning role
To ensure strong delivery of our primary care commissioning function and realising the opportunities it has presented to fully align primary care development to wider system transformation.

Objective 6: Improving outcomes and reducing variation

To increasingly focus on an outcome based approach in the commissioning of primary care services to reduce health inequalities and to reduce unwarranted variation in outcomes in the services our local population access.

Section 1: About Harrow CCG (HCCG) and the Purpose of the Commissioning Intentions

The Purpose of Harrow CCG

Harrow Clinical Commissioning Group (CCG) is the public agency responsible for purchasing most of the health services for the people of Harrow*. We operate within a financial budget and aim to ensure that we use the money given to us to purchase health services that are appropriate, effective and of high quality; whilst also offering value for money.

Harrow CCG's role is to ensure that the health services in Harrow are designed in a manner that meets the highest possible standards of quality as well as the needs and reasonable expectations of our population now and prepares the way for changing health needs over the coming years, while meeting our statutory financial requirements. This document aims to set out how we will achieve these requirements in 2019/20 – 20/21 and beyond.

Harrow CCG has a clear organisational vision; it is to **'Constantly improve Patient Care and outcomes from where we are now'.**

The CCG's overarching strategy is described in the Harrow Sustainability and Transformation Plan (STP).

The triple aim of the STP is to:

- **Improve Health and Well Being**
- **Improve Care and Quality**
- **Improve Productivity and close the Financial gap**

The Purpose of the Commissioning Intentions

The aim of these commissioning intentions is to set out clearly how the CCG will utilise its resource allocation in 2019/20 – 20/21 to deliver its vision and to highlight any significant changes it is planning to the services that it commissions during that time.

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

- Notify our providers as to what services the CCG intends to commission for 2019/21.
- Provide an overview of our plans to commission high quality health care to improve health outcomes for Harrow registered patients for 2019/21.
- Set out our vision for the future of primary care in Harrow and set out the objectives that we need to deliver to get there.
- Set out the direction of travel towards Integrated Care – where NHS and care partners work together to develop models of care that meet the needs of their population.
- Engage with our member practices in commissioning a model of high quality health care for the residents of Harrow.
- Engage partners, patients and the wider public in shaping the way in which we respond to the health needs of Harrow residents and the way we commission the appropriate services to meet local needs.

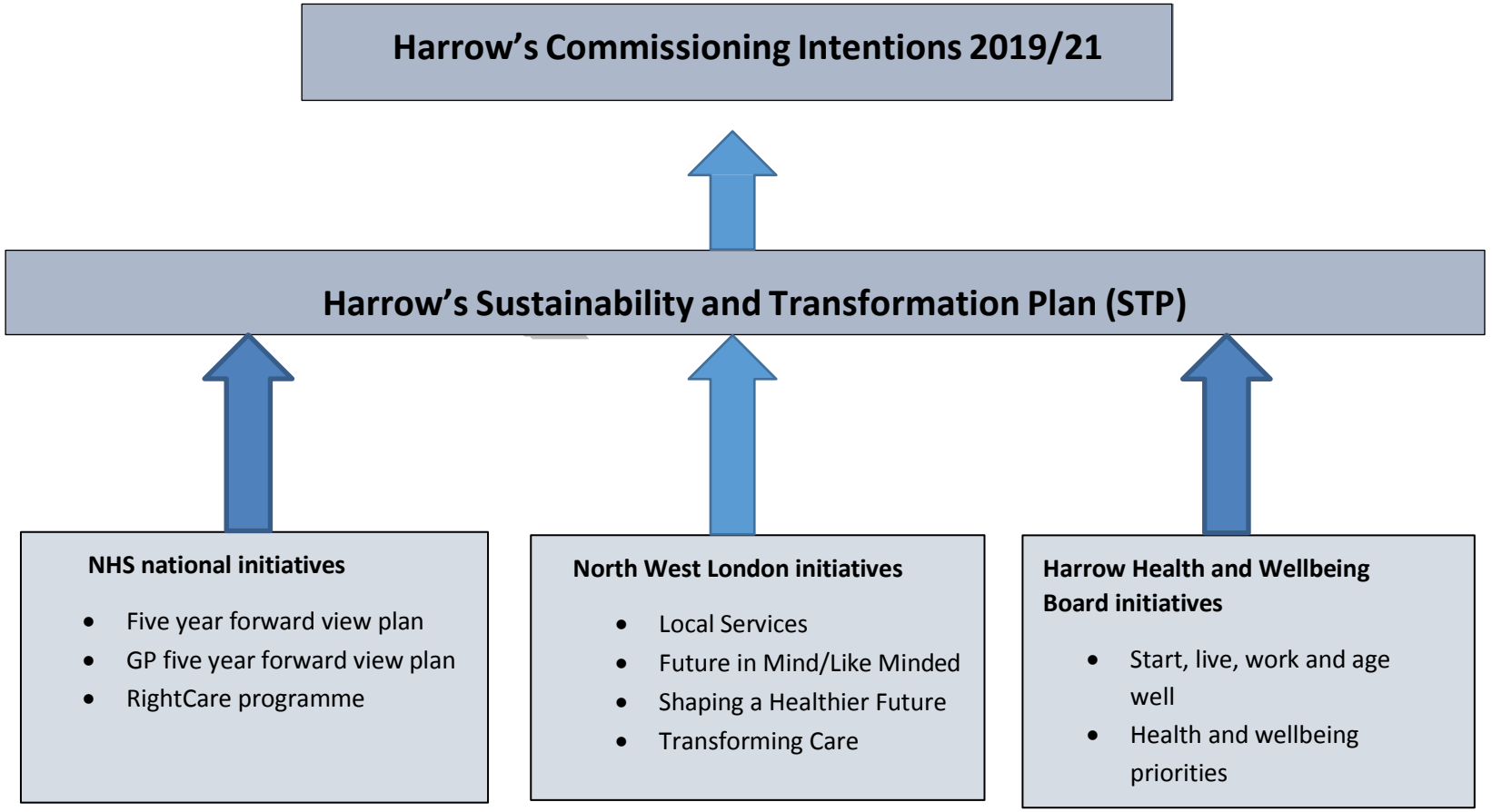
During 18/19 the CCG has involved a wide range of local people including patients, carers and the wider public along with our providers of healthcare services and our members in General Practice in the development of plans for the local health economy. We have also drawn on a wide range of sources of information and feedback.

The Commissioning Intentions for 2019/20 – 20/21 will evolve throughout its 2 year lifespan as a result of ongoing discussions with the public, our health and social care partners and providers of services. This document should be read in conjunction with the Commissioning Intentions for NHS England (NHSE) and for the North West London Collaborative of CCGs. Attached in the annex are the corresponding NWL documents.

The Development of Harrow CCG's Commissioning Intentions

Harrow Commissioning Intentions 2019/21 aim to implement Harrow's Sustainability and Transformation Plan (STP).

Harrow's STP includes a number of initiatives as outlined in the diagram below. These all support the improvement of health outcomes, patient care and NHS efficiency.



Section 2: Understanding Our Population – the Health and Wellbeing of Harrow

In Harrow our Health and Wellbeing Strategy and our Joint Strategic Needs Assessment, developed between the Local Authority and the CCG, are the basis for our understanding of the changing needs and issues facing our population which include:

Understanding our population – the health and wellbeing of Harrow

Children

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

Serious and long term mental health needs

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

Mostly healthy

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

Other

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

Cancer

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

Older People

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

One or more long-term conditions

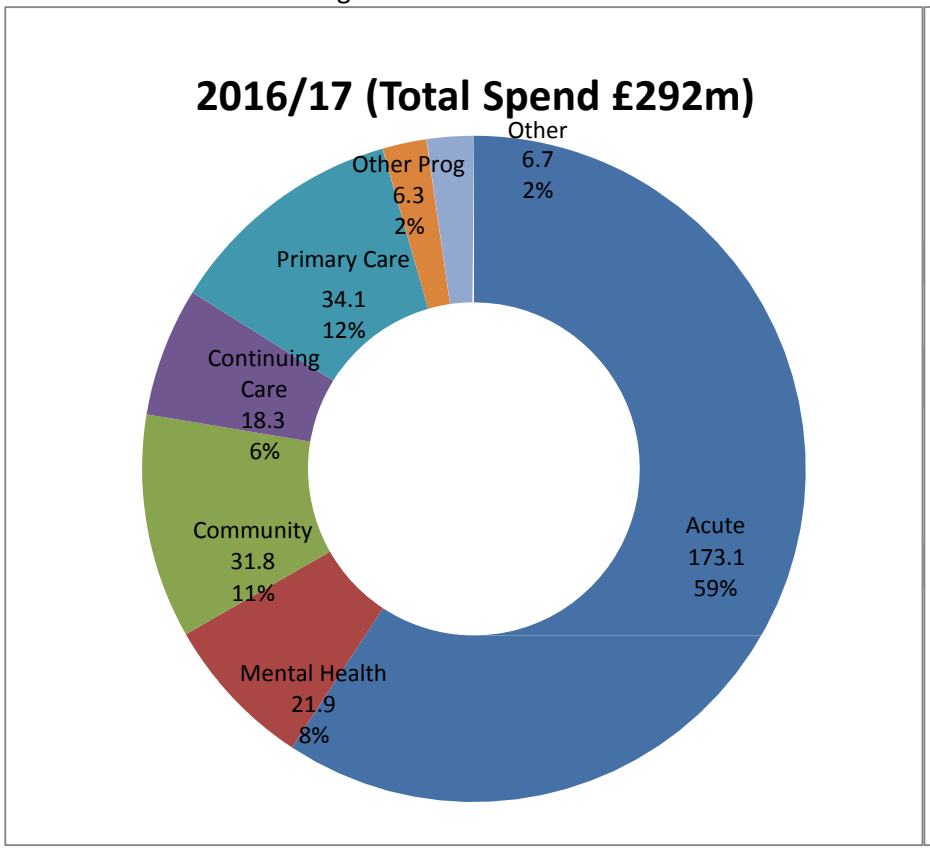
- Cancer, heart disease and stroke are the biggest causes of death in Harrow.
- One in ten people in Harrow have Type 2 Diabetes, which one of the highest rates in England. We also have the highest rate of 'pre-diabetes'.
- Many people (15%) with a long-term condition or disability feel that their day-to-day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

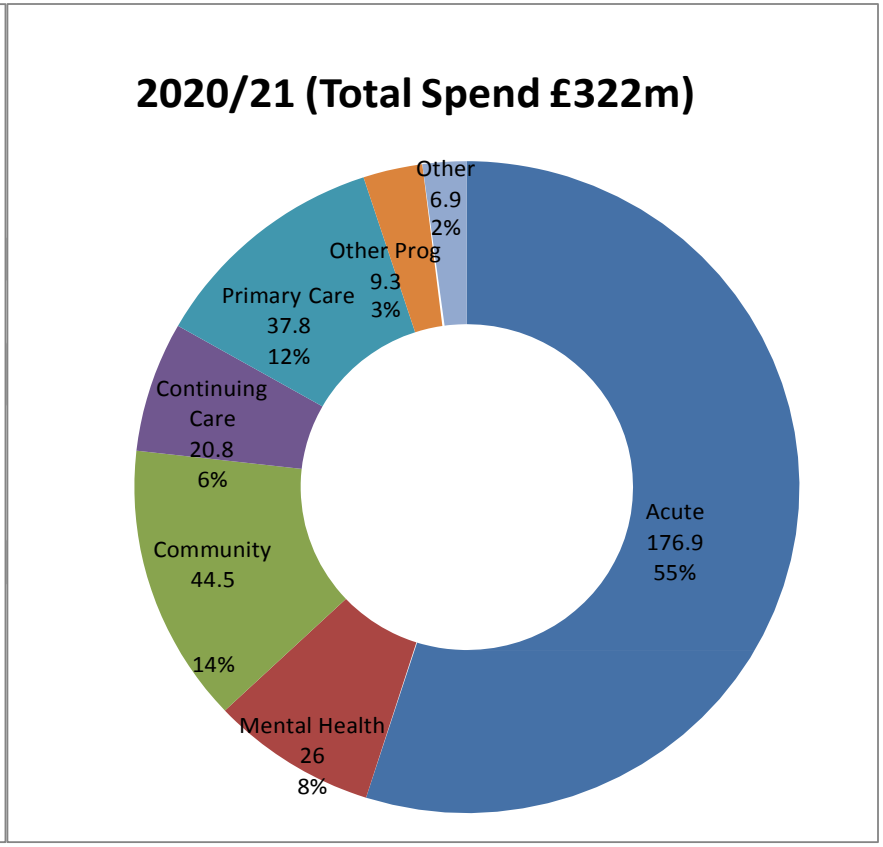
Other

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

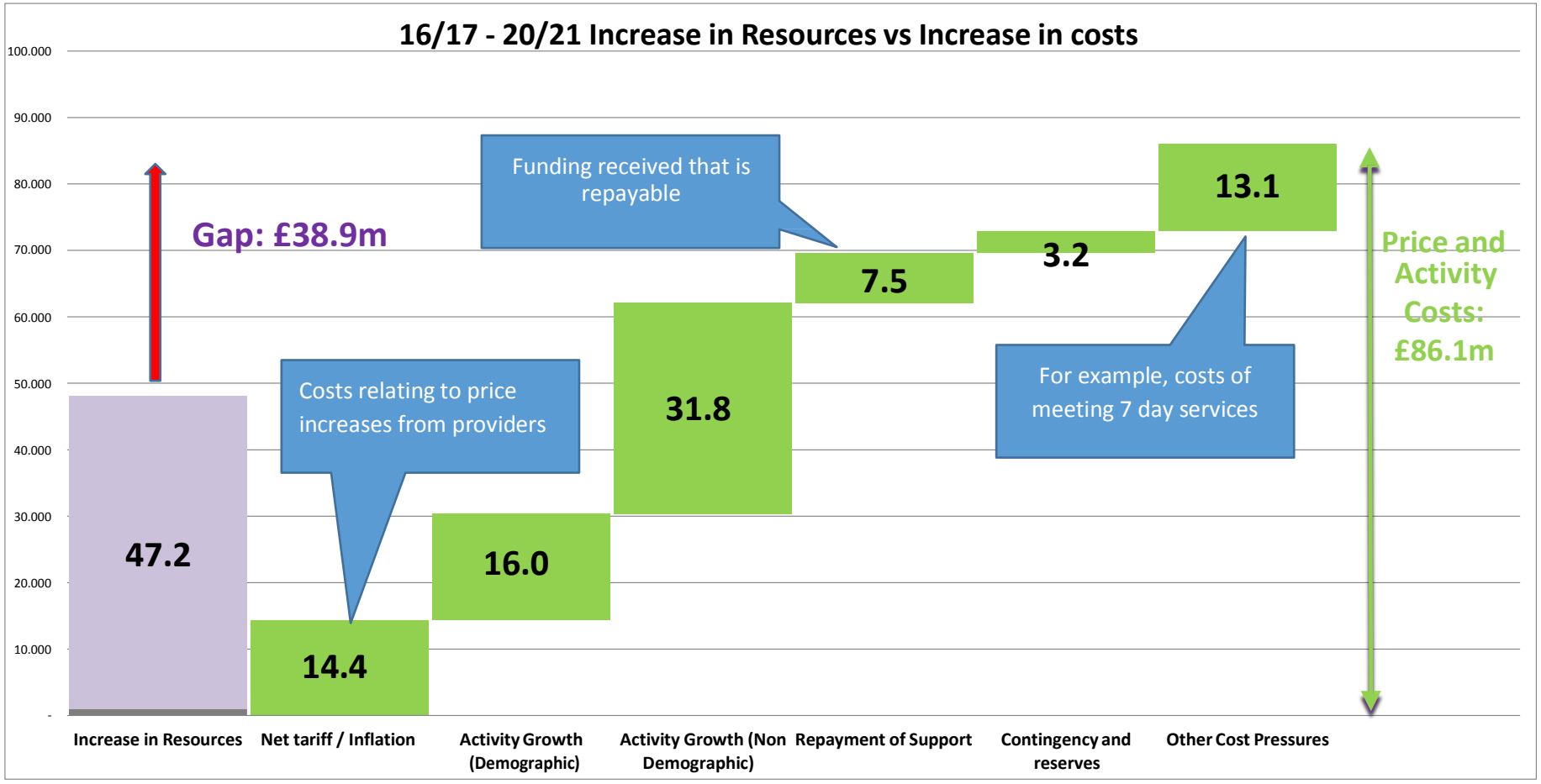
Section 3: The Financial Challenge

The impact of growth in population (demographic growth) and the growth in the prevalence of disease and ill-health through such things as an increase in the rate of diabetes (non-demographic growth) plus a number of other factors will change both the value of spend and proportion of spend within different areas as shown in the diagrams below.





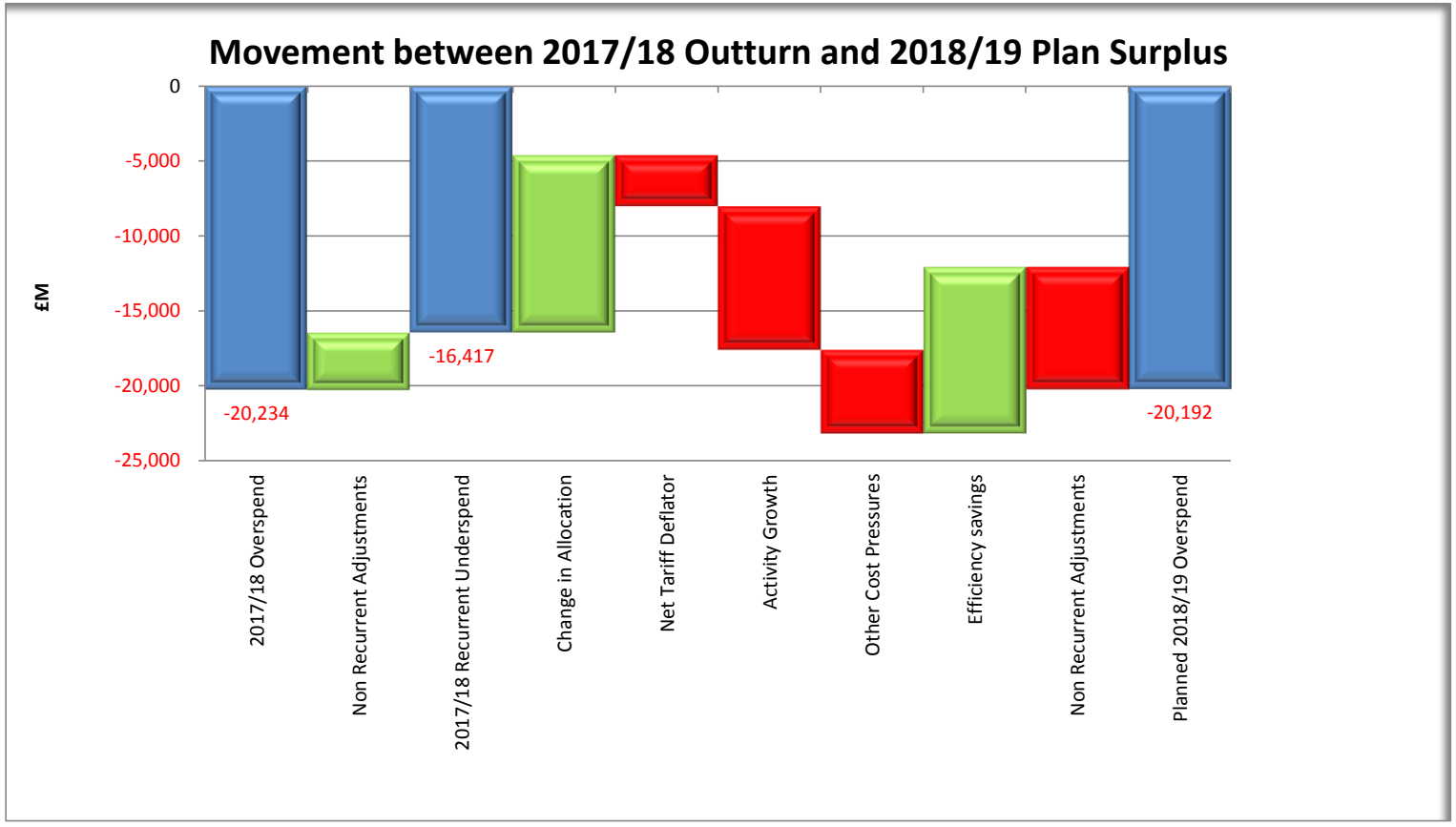
The gap between the expected growth in demand and the expected growth in the financial allocations (the amount of money available to Harrow CCG) requires the CCG to identify approximately £39m of savings between 2016/17 and 2020/21 as shown in the diagram below.



3.1 18/19 Financial Plan and Current Performance

The agreed 2018/19 financial plan was an in year deficit of £20.2m and a reduction in the underlying deficit to £12.2m. The plan included repayment of £11m of support to NWL CCGs.

In order to achieve the plan the CCG would need to deliver a QIPP plan of £20.2m (6% of RRL) of which £5.7m was unidentified at the start of the financial year.

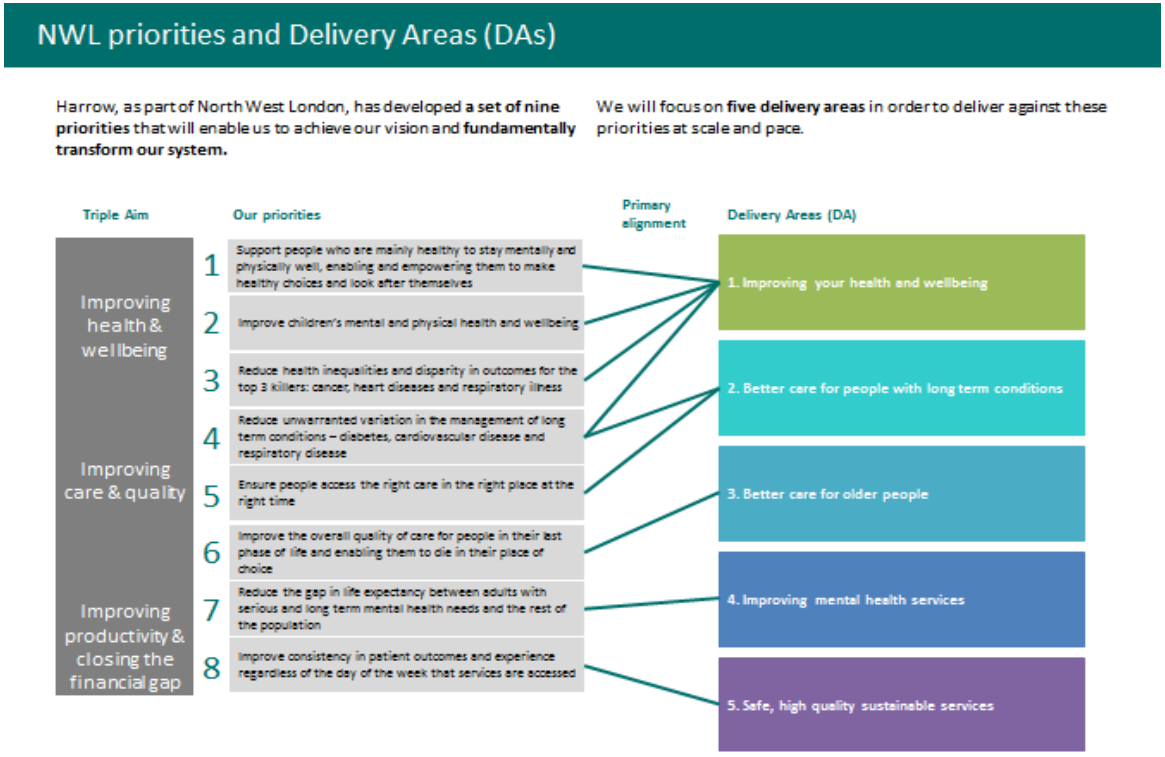


Section 4: The Harrow Sustainability and Transformation Plan

The North West London Sustainability & Transformation Plan (STP)

NHS England has asked for CCGs to work across borders and with the public and providers to develop their response to the Five Year Forward View via Sustainability & Transformation Plans (STPs). For Harrow CCG we are collaborating with the other seven CCGs in North West London (NWL) to produce our STP and are also working locally across our network of partners and providers locally to ensure the STP reflects our local needs as well as NWL priorities.

Harrow, as part of North West London, has developed a set of eight priorities that will enable us to achieve our vision and fundamentally transform our system. We will focus on five delivery areas in order to deliver against these priorities at scale and pace.



Harrow's Sustainability & Transformation Plan (STP) Priorities 2019/20 – 2020/21

The following outline proposals for the development of services (19/20 – 20/21) to deliver the NWL STP priorities were developed for the Harrow chapter of the Sustainability and Transformation Plan. These proposals will continue to be discussed and developed through the STP implementation process.

Delivery Areas	NWL STP Priorities	Harrow Plans 2017/18 – 2020/21
1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves	- We are developing new, and promoting existing ways of signposting residents to facilities, information, advice and services which promote health and wellbeing. - We are promoting the NWL People's Health and Wellbeing Charter which aims to manage and reduce demand in health and care services through encouraging behavioral change in residents and staff. - We will begin a pilot at Northwick Park hospital to reduce emergency activity caused by alcohol.
2	Improve children's mental and physical health and wellbeing	- We are improving urgent/crisis care in the community so that patients can be treated at, or close to, home. We are doing this through providing a 24/7 single point of access, timely assessment, more crisis management, supporting recovery at home in the community and extending out-of-hours Children and Adolescent Mental Health Service (CAMHS) provision. - We are also exploring alternatives to inpatient admissions, such as crisis houses/recovery houses.
3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	- We are working closely with General Practice on a comprehensive disease Prevention Programme, supporting GPs in identifying and monitoring patients at increased risk of developing Cancer, Heart Disease and Respiratory illnesses. The Preventions Initiative, based on sound clinical evidence, is aimed at promoting better health awareness as well as early detection and diagnosis
4	Reduce unwarranted variation in the management of long term conditions – diabetes, cardiovascular disease and respiratory disease	- We continue to work with GPs of Harrow on the safe and consistent management of patients with Long Term Conditions such as Diabetes, Heart disease and respiratory illness. The Care Pathways developed for patients involve both the GP and Community Care providers to facilitate

		joined up healthcare of r each individual patient. Prevention of disease progression and reducing admissions to hospital are the two key aims of the work.
5	Ensure people access the right care in the right place at the right time	- We are supporting the wider use of the NHS 111 service to support patients in getting access to the Right Care in the Right Place at the Right Time. We are opening a GP Access Centre in November, offering bookable appointments for patients 7 days a week. The centre is an extension to General Practice and will support the long term management of patient care
6	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice	- NHS Harrow CCG continues to work closely with our commissioned providers of End of Life care to ensure patients receive the optimum quality of care. Our primary provider, St Lukes Hospice, has an exceptional record for care delivery including supporting patients to die in their place of choice.
7	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population	- We will take an approach that ensures that the physical health of patients with an SMI is routinely screened through a range of measures. In primary care we will develop an enhanced service which screens patients with SMI and ensures a full medication review is undertaken which will flag any contra-indications or long term impacts. When this cohort is receiving inpatient mental health care, they will be given a full physical health screen. As part of our wider service transformation, we are focused on wider population health and prevention; our SMI patients will also benefit from these developments.
8	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed	- We are supporting the wider use of the NHS 111 service to support patients in getting access to the Right Care in the Right Place at the Right Time. We have opening a GP Access Centre in November, offering bookable appointments for patients 7 days a week. The centre is an extension to General Practice and will support the long term management of patient care

NHS
Harrow
Clinical Commissioning Group

Section 5: Delivering the vision for primary care in Harrow

The Vision: Strong and sustainable General Practice, driving the development and delivery of integrated care services to improve the health and wellbeing of all people in Harrow

Patients will be able to book appointments easily, access appointments at convenient times, and contact healthcare professionals in a way which is appropriate for their needs.

Patients will find it simple and straightforward to access the care they need, and health and care professionals will have the tools, systems and skills they need to work together to provide a holistic service

The buildings where patients access health services and where staff work will be easy to get to and fit for purpose.

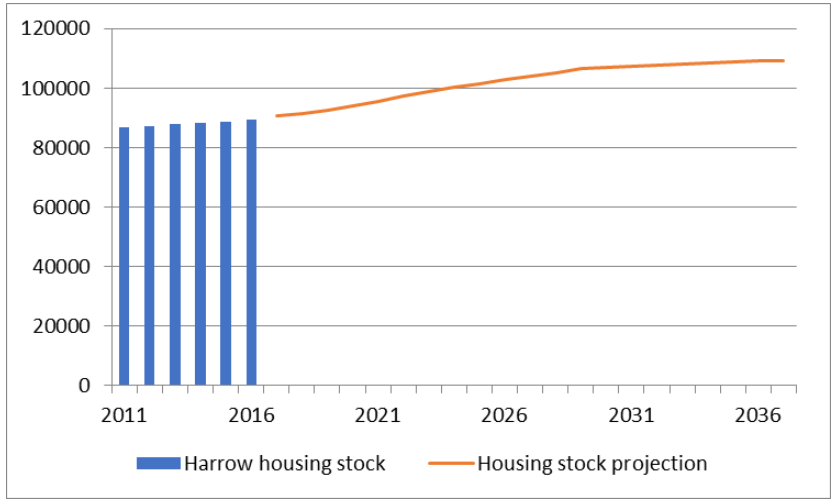
Patients will be educated, empowered and encouraged to care for themselves and manage their conditions, and health and care professionals will have the knowledge and power to direct patients to the right service and prescribe social as well as medical interventions.

Commissioners, health and care professionals and patients will work together to continuously improve services.

Section 5.1: Harrow population projections for Primary Care

The following population projections are from the GLA borough-level projection incorporating the 2016 Strategic Housing Land Availability Assessment (SHLAA) development trajectory. Data are constrained to the central trend projection at the London level. This data file contains the assumed development trajectory from the 2016 SHLAA. The GLA recommends this housing-led variant projection for most uses.
Projections are labelled based on the latest mid-year estimate data which informs the projection. As such this set of projections is a 2016-based projection. Fig 1 shows this increase in the housing stock from under 90k in 2016 to almost 106k in 2026 and over 109k by 2036.

Figure 1 Housing stock projection – GLA 2016

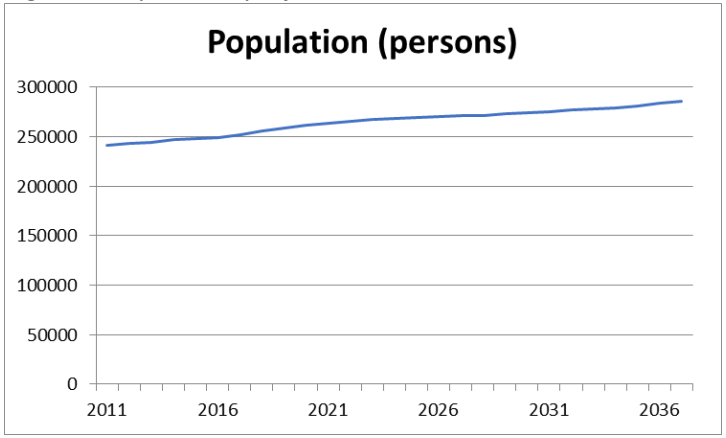


Source: © GLA 2016-based Demographic Projections

There are two contradictory trends in household size: projected decline in average household size arising from an increasing proportion of older people in the population (who typically form smaller households); and observed increases in estimated household size in much of London over the last fifteen years. These increases in household size have occurred through a range of mechanisms, which could be simplistically ascribed to demand for housing

outstripping supply. In Harrow, the population change is largely due to natural change rather than national or international immigration.

Figure 2 Population projections – GLA 2016



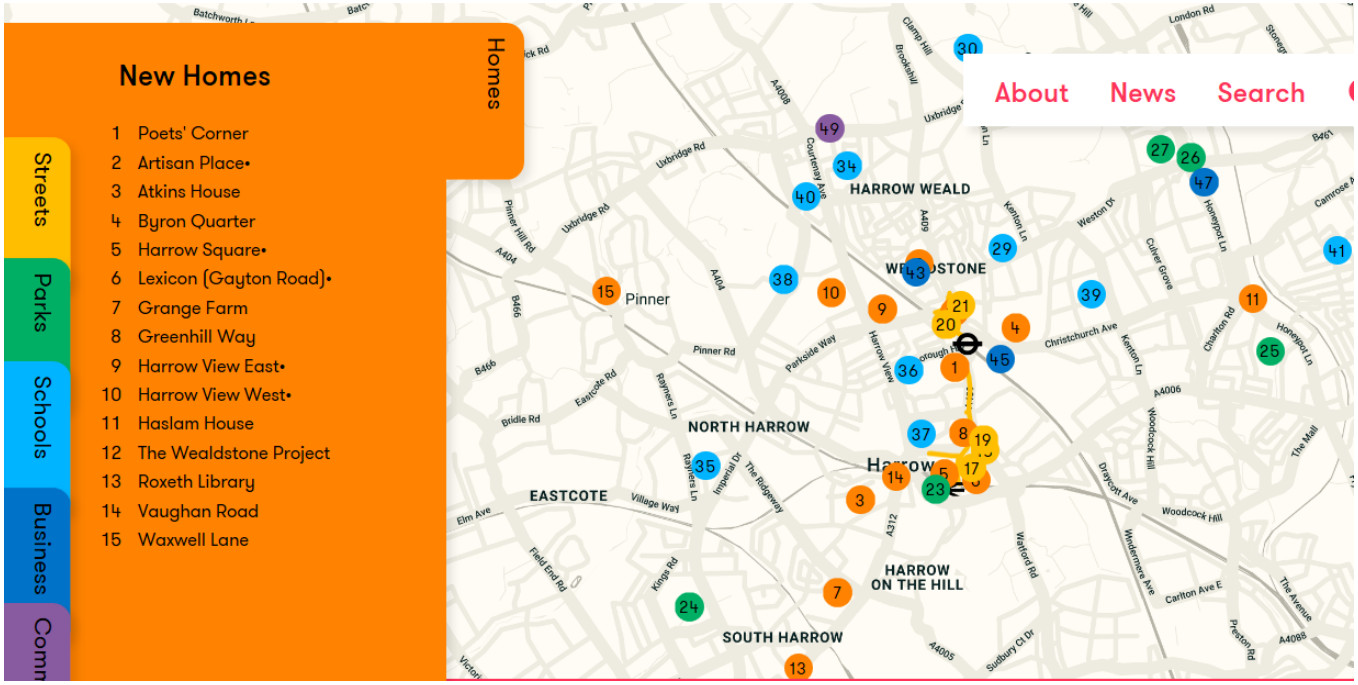
Source: © GLA 2016-based Demographic Projections

Fig 2 shows the population increases from under 250k in 2016 to 270k in 2026 and over 283k by 2036.
The Building a Better Harrow strategy details the changes that will occur in Harrow over the next 10 years. It will deliver:

- 5,500 new and affordable homes in new and existing communities
- 2 new schools and as many as eight rebuilt schools and 30 expansions
- 3,000 new jobs alongside 100 apprenticeships every year
- 500 new Council homes, the first in a generation
- New public squares, better street scene and new green spaces
- Library refurbishments, a new central library and plans for new replacement libraries in Wealdstone and Roxeth
- The creation of an independent arts and culture offer and enhanced leisure facilities
- A smaller council HQ featuring more and better community uses
- Improved transport links and infrastructure in partnership with TfL

The map below shows the location of the 15 main development sites. This does not include conversions of offices into flats as has been seen in parts of the borough.

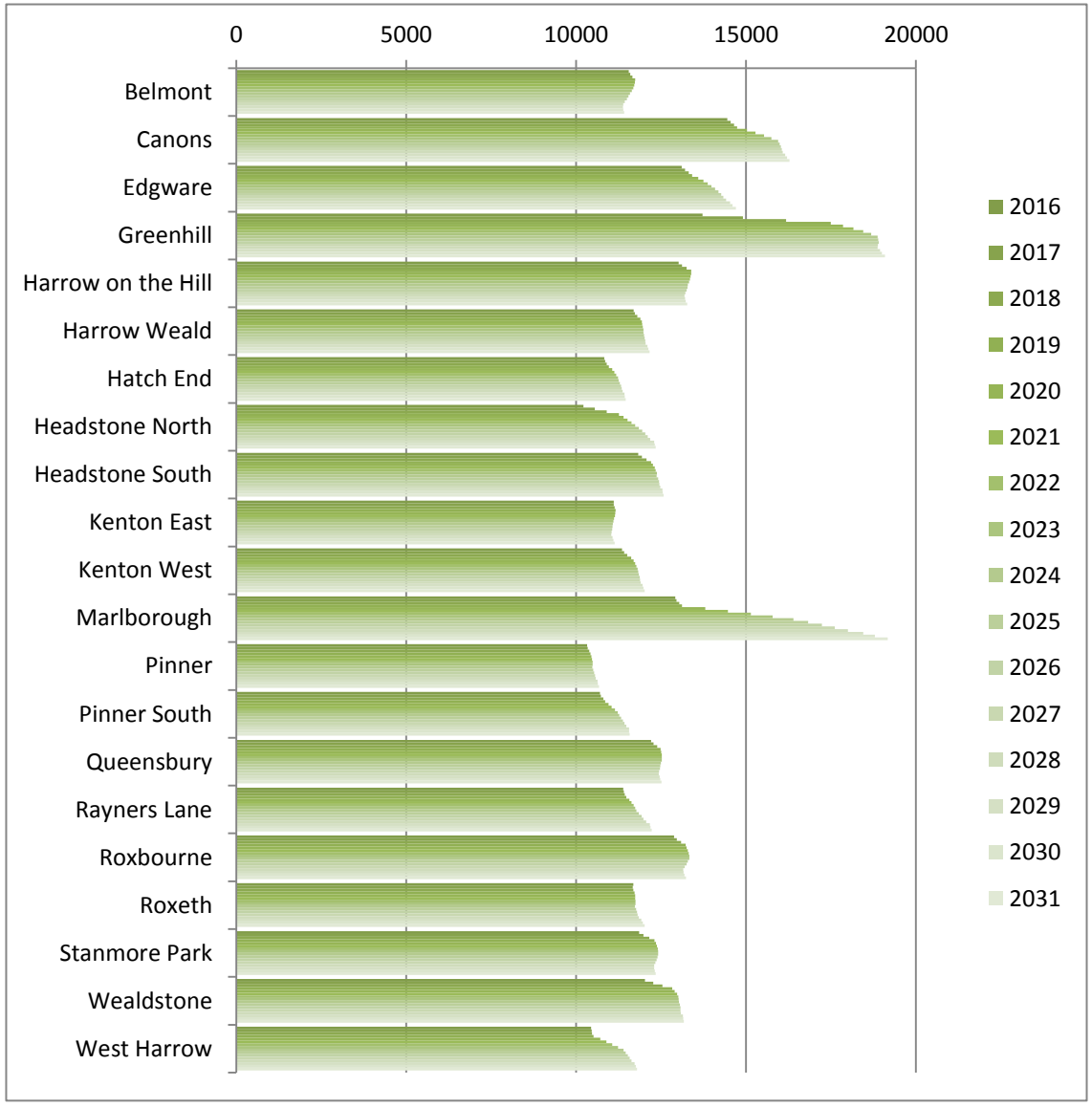
Figure 3 Building a Better Harrow



The areas of regeneration are not equally spread across the borough. Both the highest number of sites and the largest developments are in the Greenhill and Marlborough wards (i.e. Town centre to Wealdstone area). Figure 4 shows the impact of the developments at a sub borough level. Most wards show an increase over the coming 15 years with the most dramatic increases occurring in Greenhill and Marlborough. As a result of changes that have already happened and those that are planned, there will be rezoning of electoral wards.

Figure 4 Projected population change by electoral ward

Source: © GLA 2016-based Demographic Projections



Section 5.2: Improving outcomes and reducing variation

The aim of the Primary Care Strategy is to increasingly focus on an outcome based approach in the commissioning of primary care services to reduce health inequalities and to reduce unwarranted variation in outcomes in the services our local population access. Our outcomes based approach to the commissioning of primary care services will focus around four key areas:

The delivery of preventative services to support people to stay well (immunisations, health promotion services such as stop-smoking services). It is recognised that the CCG could undertake further work to support public health prevention initiatives and improve performance in these areas. As a result, we will build relationships further with member practices, and review potential mechanisms for increasing this support. Additionally, there will be further encouragement for all practices to provide additional services, including immunisations, contraceptive services and child health surveillance	**Proactive identification of long-term conditions** (addressing the prevalence gap). Our prevention Local Incentive Scheme will be the key mechanism for proactive identification of patients and reducing the prevalence gap in Harrow. We know that early identification of patients and supporting early interventions is the most effective intervention that can be made to prevent exacerbation of complications experienced from long-term conditions.
Personalised care planning for people with complex needs (with a focus on preventing non-elective hospital admissions). Following a review in 2018/19 of our Whole Systems Integrated Care approach, we will redefine what is commissioned through General Practice in relation to a care planning approach for our most complex patients, with a focus on preventing non-elective admissions to hospital. In addition, and working with our North West London colleagues, we will have a set of common standards for the management of long-term conditions in primary care.	**Supporting people to self-care where possible**. Harrow CCG will enhance structured patient education programmes that support patients to self-care, as well as ensuing effective sign-posting to services that can offer support through initiatives such as social prescribing. As part of the diabetes transformation programme, the CCG is committed to ensuring that by 2021 40% of newly diagnosed, and 30% of existing, people with diabetes, receive approved diabetes education.

Over the next five years, we will strengthen our commissioning approach to focus increasingly on the outcomes that are delivered through primary care

services, which will be commissioned at a Primary Care Network (locality) level. Through shifting the way we Contract for services from activity based payments, to outcomes based payments, we will show the real potential that General Practice has to further reduce demand for acute based services. Data tools such as a GP dashboard that is being developed to highlight practice-level referral information into secondary care specialties will be rolled out in 2018/19 to support Practices to work collaboratively to deliver healthcare system change.

Section 6: The Harrow Self-care and Prevention Agenda

In addition to the STP priorities the Harrow care system is committed to the following measures to promote self-care and ill-health prevention.

- Mapping and integrating services/facilities which support self-care with use of Patient Activation Measure to segment the population according to ability to self-care, to tailor approaches and evaluate behavior change.
- Action to improve prevention, detection and management of diabetes.
- Building on the action that we are taking on diabetes to create an offer for self-management and patient education for patients with any long-term condition, and deliver these through our locality model.
- Deliver integrated approaches to health and social issues including 'social prescribing' acknowledging the significant impact that debt, housing, employment and income issues have on health and wellbeing.
- Improve the uptake of childhood immunisation in Harrow through targeted support for Practice in developing robust call and recall systems for children registered with their Practice.
- Improve the support that is given to carers in Harrow through General Practice services; through robust processes of identifying carers and signposting them to local services so their health and wellbeing is supported.
- Using RightCare methodology to explore how preventative measures could be enhanced to reduce the impact of these diseases.

NHS Harrow CCG has developed and implemented the Harrow Health Help Now App for use with Smart Phones and Tablets. The app has been designed to provide patients with easy access to health information and local services, empowering them to manage their health and promote self-care. The app offer users the following options:

- Find Local Services
- Check Symptoms
- Get Advice
- Access GP services online

- Access E-referrals service
- Access Mental Health Advice
- Access Information and Advice on Diabetes
- Access information and Advice on Respiratory illnesses
- Access the Care Information Exchange
- Access information on Harrow Council services

The app information is based on the RightCare principles, particularly for Respiratory and Diabetes elements.

Section 7: Listening to the Voice of Local People

The Commissioning Intentions provide a basis for robust engagement between the CCG, partners and providers, and are intended to drive improved outcomes for patients and to transform the design and delivery of care, within the resources available.

In developing (2019/21) Commissioning Intentions, an extensive programme of stakeholder engagement was undertaken following the original publication of the draft document. In particular engagement sessions with representatives from Mind, Harrow Association of Disabled People, Age UK, Harrow Patient Participation Network, Health Watch Harrow, each Harrow GP Peer Group and the Harrow GP Forum took place in Oct - Dec 2018.

Children, Maternity and Children and Adolescent Mental Health Services

Children, Maternity and CAHMS		
No	**"You Said"**	**What Harrow CCG did and will do 2019/21**
1	More opportunity to use schools, libraries, parks and other public places to communicate with young people.	The new integrated emotional health and wellbeing service will make use of Harrow community places.
2	All services should be integrated and they should be inclusive despite disability where possible.	Delivering a new integrated emotional health and wellbeing service, this is open access for Children and Young People (CYP). Redesigning paediatric services for a more integrated model.
3	CCG should have a spokesperson that goes to schools and works with students and parents.	CCG employed a full time engagement and participation lead for CYP.
4	Consideration to be given to providing continuity of	All GP practices registers are open to students requiring temporary registration.

	care for university students. Current arrangements mean difficult to access care during holidays.	

End of Life care

End of Life Care		
No	**"You Said"**	**What Harrow CCG did and will do 2019/21**
1	Community Nursing team should move to a 7 day working schedule to better align with other services and address the delayed transfer of care.	Part of wider work on 7 day working yet to be fully agreed and implemented. End of Life Single Point of Access and Face to Face services operating 7 days a week to better manage patient care.
2	Need to align the acute palliative care team.	Will be part of Integrated Care design for out of hospital services going forward (Integrated Care System). Includes looking at a single point of access and advanced care planning to maximise the quality of life.
3	Planned discharge should not be left until late on Friday.	Performance being monitored closely to try and avoid this happening. Better co-ordination between hospital and community teams has and will continue to lead to improved discharge planning.
4	There should be a timely evaluation of the End of Life single point of access (SPA) incorporating a wide range of stakeholders	Performance being monitored, Single Point of Access (SPA) evaluation demonstrated effectiveness of the service. Options around a wider truly SPA for all services in Harrow being reviewed.
5	Potential for greater education and training between palliative care teams and district nurses.	Training continues to be delivered across Harrow with funding secured.

Equality and Engagement

Equality and Engagement		
No	**"You Said"**	**What Harrow CCG did and will do 2019/21**
1	How will patients have more say?	In Harrow, Patients can have more say through our local Engagement events, through the Equalities and Engagement Committee, via our social media platform (Facebook, twitter and Instagram) and in our get involved section on the Harrow CCG website (https://www.harrowccg.nhs.uk/get-involved)

2	How will the CCG keep patients informed?	In Harrow, we continue to engage with local PPG leads through the HPPN Network and local patient representation groups such as HealthWatch, Harrow Carers and Harrow CVS. Patients are kept updated about the projects we do through Engagement Events, local outreach events and our stakeholder newsletter. Representatives are present at the CCG Governing Body and Primary Care Committee meetings which are held in public and include patient engagement; updates are also available via the CCG website.
3	How will Harrow CCG represent the interest of a diverse group?	When developing and reviewing services in Harrow we undertake Equality Impact Assessments to ensure we consider our diverse population. We recruit patient representatives from our local population in our decision making. We hold Equalities workshops and Harrow keeps the patient at the center of commissioned services.

Health and Wellbeing Priorities

Health and Wellbeing Priorities		
No	**"You Said"**	**What Harrow CCG did and will do 2019/21**
1	Insufficient focus in existing commissioning intentions on cancer	Cancer pathways have been reviewed and been updated with adjustments made according to best practice. This is a continuous process as developments in Cancer optimal pathways get developed.
2	Insufficient focus on healthy eating and prevention, particularly within schools	Work with schools being undertaken by Public Health to achieve Healthy Schools London awards with healthy eating a key theme.
3	Greater focus on support for carers (particularly working carers) required	Harrow CCG and Harrow Council have developed a Carers Strategy as part of the Better Care Fund Programme. This is reviewed annually with the Local Authority.

Mental Health

Mental Health		
No	**"You Said"**	**What Harrow CCG did and will do 2019/21**
1	More effort is required to follow the protocols for Shifting Settings of Care.	Monitoring is currently monthly reviewing activity and performance. Also Harrow CCG has been addressing issues raised by services users and carers with CNWL and Harrow Mind.
2	More training for GPs and staff caring for people with	Mental Health Training is being included in Education Forum's.

	mental health conditions required	
3	Greater promotion and information around translators/interpreters services, Advocacy and PALS required	Harrow CCG has reviewed it Advocacy service and is currently developing a user led model for advocacy. Meetings with Harrow Mind have included a presentation to Harrow CCG, a 'public question' to the Governing Body and the development of a Business Case
4	Stigma and lack of respect remains evident	The CCG along with other statutory and voluntary sector partners have been promoting health and wellbeing. Educating the general public, friends, family and those in the workplace has been the best way to reduce stigma, ignorance and isolation, whilst promoting knowledge, understanding and respect.
5	Limited information in practices concerning mental health	Updates and information on enhancements have been circulated to Practices, with a drive on promoting The Talking Therapies service widely, including to Public Health and the Local Authority. There has also been a major drive for children and young people's mental health.
6	Culturally for Harrow a significant number of people in the community rely only or firstly on their community or spiritual leaders	Harrow CCG commissions the Harrow Association of Somali Voluntary Organisations as one of the ways to extend reach and enhance care and services for communities that may not readily use statutory services. Engagement events have been undertaken with the community. Work is being done to raise awareness in wider communities especially to community and spiritual leaders.
7	Service users and carers require more time with their GP when describing their symptoms	Additional Primary Care Mental Health Nurses were recruited, to a total of 6, thus enabling one nurse per peer group ensuring each of the practices have increased support and a more visible presence. Reasonable adjustments should be in place in all practices to accommodate service users with Learning Disabilities.
8	GP practices and providers are not always aware of the cultural backgrounds and behaviors' of their carers and users	Communication and the skills for working with all cohorts in Mental Health is on-going through awareness training for Doctors and Reception Staff. Mental Health and dementia awareness training is being provided. Reception staff do undertake 'customer care' training. Harrow CCG has organised a 'receptionist development programme' where all receptionist from the practices in Harrow attended. A greater emphasis will put communicated in terms of cultural background.

The following outlines how we have further engaged with our stakeholders to obtain their views on our Commissioning Intentions for 2019/21.

Stakeholder / Audience	Request
Harrow Local Performance and Quality Group Members Include: Voluntary Sector partnerships and networks	• Advocacy support in the community
Harrow Patient Participation Network	• Request to HPPN to support programme for Dementia awareness in Harrow
Harrow Mencap	• Request for additional specialist staff in the Community LD team • Request for Transformation funding to train cares and users in what to do for people with behaviours that challenge.
Mind in Harrow (User Group)	• Advocacy Support in the community
Milmans (Dementia Support)	• Request for Admiral Nurses

Planned Care

Planned Care		
No	**"You Said"**	**What Harrow CCG did and will do 2019/21**
1	Should incorporate within planned care contracts Key Performance Indicators (KPI) to measure 'Did Not Attends' (DNAs).	Reviewed by speciality when implementing outpatient improvements e.g. quality of referrals Both Acute and Community Outpatient services provide monthly data on numbers of patients who "Do Not Attend"
2	Clinical and business case for investment in Obesity Clinic	Still under consideration but currently working with LB Harrow on developing Physical activity and Sports strategy 2016-2020.
3	Clinical and business case for investment in Spinal Pain Service	Pain Management is being reviewed in as part of the MSK procurement.
4	Insufficient capacity within the community for COPD and Respiratory Services	Respiratory service has been launched and continues to be developed to support community based services and avoid unnecessary admissions.
5	Additional capacity required to provide Pulmonary Rehab services	Integrated Cardiology review being undertaken to look at the acute and community pathway.
6	Insufficient speech and language services available in the community	Community Paediatric Service review being finalised, including Speech and Language Therapy for 2018/19 which is being reviewed with Harrow Local Authority.
7	Significant opportunity to improve MSK care pathway	The CCG is commissioning an integrated service for MSK (including pain management).

		This is due to go-live in August 2019.
8	Better data sharing between GPs and other clinical services should be a number one priority for the CCG	EMIS is the mandated system required by all new service providers going forward to enable a safe data sharing / interoperability. A summary of the patient's records will be available for a clinician to access to make an informative decision on patient needs. Patients have the choice to opt out of this from their GPs. We are also working to implement alternative technology options in general Practice, such as Skype.
9	Greater opportunity for integrated services – currently a disconnect between diagnostic tests, GP and acute referrals; not helped by poor record sharing	Work on a fully integrated IT system is on-going work Both Acute and Primary Care Services making use of the ICE Computer system for requesting diagnostic tests and sharing results
10	Currently long waits for secondary care appointments at LNWHT	A demand and capacity plan is close to being agreed. All over 52 week patients will be seen by the end of March 2019. Work continues with LNWHT and Imperial to meet the 18 week treatment target NHS Harrow CCG has increased the number and capacity of its Community Outpatient services to reduce waiting times for patients and improve accessibility whilst the Trust also outsources and insources activity.
11	There is a clear need for more self-help groups and clarity about access and referral arrangements to these services (e.g. Diabetes prevention Programme	The CCG is reviewing alternative options to ensure that there is easily accessible information available to the public regarding, online, via FAQs and signposting.

Primary Care

No	**"You Said"**	**What Harrow CCG did and will do 2019/21**
1	Positive patient experiences with on- line prescriptions and appointment booking	All GP Practice websites are being refreshed and every Practice will have the facility to book online appointments and repeat prescriptions. GP appointments can also be booked via the Harrow Health Help Now app.
2	Positive patient experience with telephone triage arrangements – should incorporate a guaranteed ring back standard	All Reception staff have been trained in 'Active Signposting' enabling them to signpost patients to other clinicians as well as GPs.
3	Significant patient frustration that care records not routinely shared when referred to community or acute service	All Practices in Harrow are using EMIS. As well as this, it is mandatory for all new service providers to use EMIS or compatible systems to ensure that records can be shared.

4	Significant patient frustration about continuity of care and use of locum GPs	Across NW London, Locum banks are being set up in every Borough to encourage locums to stay within the local area. Harrow CCG will be participating in this scheme.
5	Patient perception that average wait for routine GP appointment in Harrow is 2 weeks	Walk-in centres are evolving to GP access centres – they will be able to offer bookable appointments for routine care
6	Patient perception that standard appointment length insufficient to deal effectively with complex or multiple conditions	CCG has commissioned additional capacity at walk in centres for Harrow patients via pre-bookable appointments. Patients are now able to pre-book an appointment via their own surgery to be seen by a GP at our Walk-in Centres on Mon-Fri (6.30-8.00pm) or Sat-Sun (8.00am -8.00pm). The CCG has also commissioned a Primary Care 'Long Term Conditions management and prevention' service to enable GPs to spend more time with patients who suffer with various/multiple long term conditions.
7	Benefits of consultant telephone advice service for GPs to be considered	Telephone consultations are taking place within some Practices, and the new Practice websites will enable all Practices to provide Online Consultations with patients.
8	Positive patient perception of use of text messaging to confirm appointments	31/33 of our Practices are now using text message reminders.
9	Sit and wait service should be available in all GP practices	Walk-in centres are evolving to GP access centres – they will be able to offer bookable appointments for routine care, so that patients do not have to sit and wait for their care
10	Increased promotion required to raise awareness of early and late appointments available	Walk-in centres are evolving to GP access centres – they will be able to offer bookable appointments for routine care
11	Better to have access to own GP for extended hours rather than be referred to a walk in centre in order to provide continuity of care	Patients can access primary care services through their registered Practice via the extended hours scheme, where Practices open until 8pm or later to see their patients. Currently, 28 Practices in Harrow are signed up to this service.
12	Better communication and marketing of community service required	The new GP websites will provide information not only on GP service. But also signpost to other local community services.
13	CCG needs to prioritise re-procurement and reconfiguration of walk in centre services	Walk-in centres are evolving to GP access centres – they will be able to offer bookable appointments for routine care CCG will review contracts and service spec for all GP hubs/Estates with a view to redesign all the services provided by hubs afresh
14	Walk in centre or Walk in tariff to be established at Northwick Park Hospital	Urgent care centre provision at Northwick Park is complemented by community based GP services
15	Greater coordination is required between GPs and community nurses	Integrated care developments will ensure closer working across these services

16	Considerable frustration at lack of walk in service in East Harrow	Now available in East Harrow
17	Better training for reception staff required and receptions to be made more welcoming	Reception staffs from Practices have all completed the 'Receptionist Development Programme' which covers all competencies including customer care.
18	Consider collaborative model incorporating GP Peer Groups for future delivery of walk in services rather than a single provider	Primary care is evolving to network based models. We will be working with them to consider access models for their local populations to enhance the local model.

Unscheduled Care

Unscheduled Care		
No	**"You Said"**	**What Harrow CCG did and will do 2019/21**
1	Better signposting required to set out difference between urgent care centres and walk in centres	Both services are GP led. The UCC have access to more equipment to deal with a slightly higher acuity of patients. The drive to direct patients away from UCC is so that they can care for urgent needs quickly out of the hospital setting. An app and website is being developed to support this redirection and provide self-care and shall be available by November 2016 Significant work undertaken to integrate the Urgent Care Centre and Walk In Centres, giving patients a wider choice of service options, with improved accessibility.
2	Access to specialist care through local GPs difficult	To be addressed through community services re-procurement and the implementation of the locality hub model where specialist services can be accessed at the hubs (Belmont, Alex and The Pinn). In addition to this NHS Harrow CCG has increased the number and capacity of its Community Outpatient services to reduce waiting times for patients and improve accessibility.
3	Physical pathway to A&E is difficult, traffic and access to other parts of hospital	Referred to London North West Hospital Trust.
4	Greater opportunity to work with and educate frequent attenders at A&E	A lot of the frequent attenders are flagged at GP level and are managed through the care navigator service which puts together a care package to manage all the patients' needs preventing them to go to urgent care services. The model for locality based services will review the required services to support these patients.
5	Patients should have their health data available	EMIS is the mandated system required by all new service providers going forward to

	wherever they go – but should not be provided to external agencies	enable a safe data sharing / interoperability. A summary of the patients' records will be available for a clinician to access to make an informative decision on patient needs. Patients have the choice to opt out of this from their GPs and have the right to access their records.

Whole System Redesign

No	**"You Said"**	**What Harrow CCG did and will do 2018/19/20**
1	Need to focus much more heavily on prevention and self-care	PAM model established. Self-care programmes in development, with the model being established first for patients with diabetes. A prevention enhanced care service in place in General Practice
2	Quality of existing falls service needs to be improved	An extension to the community falls services on a consultant led service and integration with an extended acute frailty model.
3	Much greater promotion of existing whole system programme required	Whole system process established and fully utilised across General Practice services
4	Care planning process should be simplified and made more accessible	Care planning approach agreed and made consistent through an enhanced services in primary care
5	Widespread patient expectation that patient records should be shared to support effective integrated care	Sharing of records, where patient permission is given, is in place
6	Considerable GP frustration with limited progress with patient record sharing	Sharing of records, where patient permission is given, is in place
7	Greater opportunities for system-wide approach to support 5000 most vulnerable Harrow Patients	Whole systems integrated care making progress toward this, which will be enhanced through our Integrated Care Partnership
8	Greater opportunity for aligning incentives amongst providers and commissioners to improve the hospital discharge pathway	Business case for Harrow Integrated Care Partnership in development

Engagement in 2018/19

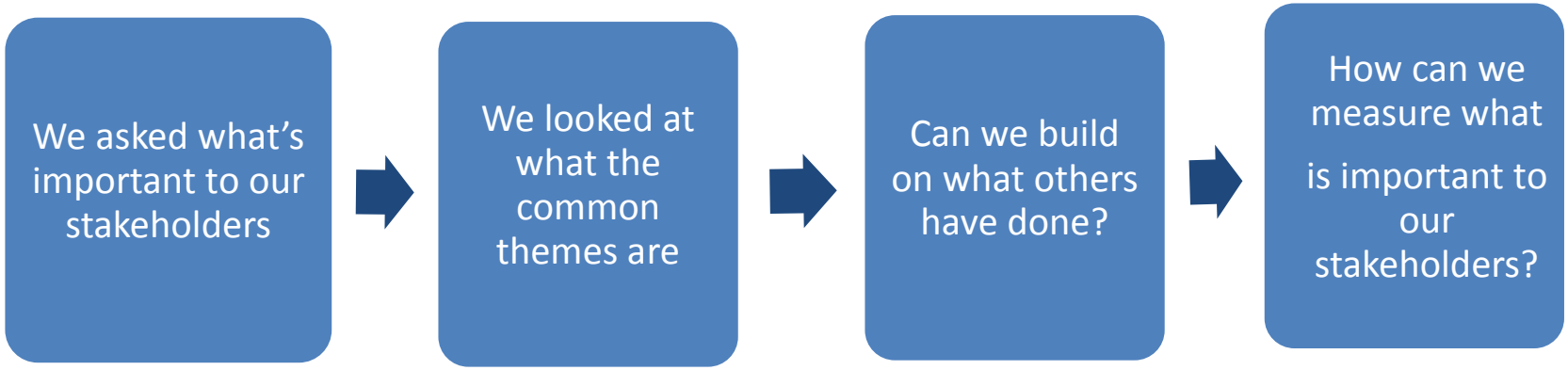
We carried out further engagement for 19/21 Commissioning Intentions:

- We organised a public event on 20th September 2018 to update the Commissioning Intentions to key stakeholders and members of the public, this was then brought together and tested back with stakeholders on 6th December 2018.
- Regularly posted information about the priorities on the CCG's Twitter account
- We added it as a news item for Harrow CCGs "Putting Patients First Newsletter"
- We produced an Easy Read version of Commissioning Intentions 19/21
- Information to be shared on local community websites including Healthwatch Harrow etc.
- We published the Commissioning Intentions document on the Harrow CCG website
- Email summary version to stakeholders (including the Governing Body, GPs and the Health and Wellbeing Board)

We intend to work with key stakeholders to set up a Patient Engagement Working Group to improve the way and how we inform, promote and educate the population of Harrow going forwards.

Section 8: Harrow Integrated Care 65+ Outcomes Framework

Section 8.1: Harrow 65+ Outcomes Framework – The Process



We got almost > 400 responses to our events and surveys.

Clinical Survey: December 2017

Public Survey: January 2018

Clinical Summit: 31st Jan 2018

Public Engagement Event: 7th February 2018

Joint Engagement event: 25th April 2018

We grouped the emerging themes into the 5 NWL Whole System Domains (so consistent with other frameworks being developed in NWL).

Coordinating with colleagues in NW London to not re-invent the wheel

May 2018 - Virtual Workshop held with NWL Virtual partners and shared working drafts with virtual team NWL

Looking for the right measurements to finalise the outcomes framework

2 Meetings of the Outcomes Sub group -22nd May and 6th June 2018 to finalise draft outcomes

Consulted with Harrow Commissioners for feedback / input

Collate baseline data – June / July 2018

Review post QI workshops – Sept 2018

NHS
Harrow
Clinical Commissioning Group

Section 8.2: Harrow Outcomes Framework 65+

4 Domains linked to Quadruple Aims of NHS – Quality of Care, Experience staff and patients and financially sustainable

Outcome Domain	Outcome/I-statement	No	Indicator
1) People have an overall quality of life	I am supported to live a healthy independent life, and know when to seek medical assistance when appropriate	2	Number of days in hospital (emergency), HSCIC definition: Number of emergency overnight bed days per 1000 ≥65 patients (hospital Episodes Statistics)
	My overall experience of care helps me to improve my quality of life	3	Health related quality of life for older people
		4	Patient satisfaction with care
	I have control over my health. I am aware of the choices and options I have to manage my health and social well-being	5	Proportion of people who have control over their daily life.
		6	Proportion of people who can confidentally manage their own health
		7	The proportion of patients that feel like they have sufficient choice.
	I feel all my needs are being treated together and not in isolation. I feel like my care not only encompasses my immediate needs, but also plans for my future well-being	8	Physical checks for people with severe mental illness. The proportion of people with a severe mental illness who have received a the required physical checks.
		9	Number of days spent at home.
		10	Social care-related quality of life / Enhancing quality of life for people with care and support needs (Unmet needs in domains of control, dignity, personal care: food & nutrition, safety, occupation, social participation, accommodation)
	Taken together, my needs are respected and addressed with the care and support that gives me the opportunity to contribute and help me live the life I want to the best of my ability.	15	The proportion of adults in contact with secondary mental health services who live independently, with or without support
		16	The proportion of adults with a primary support reason of learning disability support who live in their own home or with their family
2) Care is safe, effective and people have a good	I receive care at the right time and in the right place and am able to access care when I need it	17	Reduction in number of emergency admissions due to Falls, for 65 years and over, per 100,000 population against expected trend (develop as a lead indicator for flagging frailty factors affecting uptake of health and social care).

experience		18	Proportion of people admitted in hospital for any Ambulatory care sensitive condition (ACSC) (HES / WSIC dashboard)
		19	Experience of NHS service when patients wanted to see a GP but the GP surgery was closed
		20	Delayed transfers of care (DTOCs) (all causes) per 100,000 population
	I am aware of the choices and options I have to manage my health and social wellbeing	22	Improved Patient activation score (PAM)
		23	Proportion of people who use services who find it easy to find informaiton out about services ASCOF 3D1
	I see a health professional that I trust and feel comfortable with	27	More convenient access to GPs
		28	Trust in staff
	I am supported to live a healthy independent life, and know when to seek medical assistance when appropriate	29	Number of days in hospital (emergency), HSCIC definition: Number of emergency overnight bed days per 1000 ≥65 patients (hospital Episodes Statistics)

Outcome Domain	Outcome/I-statement	No	Indicator
3) Staff experience an effective integrated environment	I am working in an integrated way which enables me to support patients and carers	31	Staff who agree they are working in an integrated way to support services users and carers
		32	Staff are able to deliver the patient care they aspire to
		33	I receive timely, accurate and appropriate information about the referral, admission to hospital or discharge from hospital of the patients I am responsible for.
		34	Within my team we communicate closely with each other to achieve the team's objectives.

	I feel I am respected as a staff member can practice autonomously, feel valued and listed to as a member of the team which lets me contribute positively.	35	Improvement in the proportion of staff responding positively to feeling valued
	I feel well-equipped to learn and develop new skills, with the opportunity to use them.	36	Improvement in proportion of staff feeling that training enables them to offer a better service.
	I would recommend my team as a place to work.	37	Professionals who would recommend their integrated care partnership as a place to work.
	I am supported as a carer to be part of a team that works well together and enjoy their work	38	Carers that feel included and consulted in discussions for people the care for.
		39	Carers feel encouraged and supported in their situation.
4) Care is financially sustainable	Providers: I'm confident that the service I am delivering is financially sustainable. My service includes an element of early intervention and the promotion of self-care to optimise patient health and reduce the flow of patients requiring acute care. I am supported to prevent people from getting unwell in the first instance.	40	Shift in spend/activity from acute to out of hospital (Finance reporting - WSIC dashboard)
		41	Reduction in emergency NEL for persons ≥65 years per 100,000 population
		42	Reduction in emergency NEL for persons +65 years with an integrated care record (care plan) and over per 100,000 population
		43	Reduction in spend per head / activity mostly healthy population 65+ (WSIC dashboard NWL)
		44	Percentage of population accessing out of hours primary care or % A & E attendances without admission or access to UCC / 111 Calls
		45	Spend / activity accessing primary care

Section 9: Harrow CCG's Commissioning Intentions for 2019/21

Responding to Local Challenges

Taking into account the North West London (NWL) Sustainability & Transformation Plan (STP) and what we wish to do locally Harrow CCG has built the 19/21 Commissioning Intentions around 12 Transformation Themes and 5 Enabling Themes. The full list of the Transformation and Enabling Themes are detailed below and are expanded upon in Section 6 and 7:

These Themes (Transformation & Enabling) are aligned to the 22 Improvement Areas stated within the NWL STP as shown in the table below:

Transformation Themes	
1. New Model of Planned Care and Urgent Care	**7. Transforming Support for people with Mental Health Needs and those with Learning Disabilities**
2. Transforming Primary Care Service	**8. Integrated Care for Children & Young People**
3. Intermediate and Community Care	**9. Transforming services for people with diabetes**
4. End of their Life	**10. Medicines Optimization**
5. Integrated Support for People with Long Term Condition (Whole Systems Integrated Care)	**11. Continuing Care**
6. Transforming Care for People with Cancer	**12. Integration across the Urgent & Emergency Care System**
Enabler Themes	
13. Developing the Digital Environment	**16. Delivering Our Statutory Targets Reliably**
14. Creating the Workforce for the Future	**17. Redefining the Provider Market**
15. Delivering Our Strategic Estates Priorities	

1. New Models of Planned Care and Unscheduled Care					
Lead:	Tom Elrick	SRO:	Tom Elrick	CRO:	Dr Muhammad Shahzad
2020/21 Outcomes		Commissioning Intentions 19/21		Indicative Commissioning intentions beyond 19/21	
By 2020/21 we will be delivering the following outcomes		We will		Further development of:	
• Coordinated Care for Planned & Unplanned Care Needs across Care Settings • Improved Health Outcomes and reducing Unplanned Care needs through focusing on LTCs • Set up clinical hubs exclusively for patients with long-term conditions • Integrated Health & Social Care support for those patients who need it • Empowering people to plan for their own care • A diverse market of quality care providers maximising choice for local people who have complex needs • Reduced rate of growth in hospital attendances and admissions for people with planned care needs • Increasing scope and amount of activity delivered Out of Hospital and closer to home for patients • Reduction in Length of Stay following a planned admission • Increased use of alternative services to		• Review, and redesign gastroenterology community service Undertake Procurement of the service with launch date for new service in Q2 2019 • Review and redesign of community dermatology and Ophthalmology service. Undertake Procurement of the service with launch date for new service will be Q1 2019 • Review and redesign RightCare Pathways for respiratory (including COPD, Asthma and Pneumonia) and MSK services. • Review pathways and current services in place for managing long-term conditions like cardiology, respiratory, diabetes, AF & hypertension. • Merge pathways for various long-term conditions, if possible • MSK Services Procurement in progress with new service launch planned for Q3 2019 • Spinal Services and Pain Services to be incorporated into new MSK pathway being procured with launch of new service in Q3 2019 • Set up a common community pain management		• Community General Surgery Outpatient Service • Community Urology Outpatient Service • NWL-wide Community Cardiology Outpatient Service • Development of the Urgent Treatment Centre model • Development of the GP Access Centres for Harrow patients

deliver planned care support • Reduce the number of falls and ensure effective treatment & rehabilitation in the community	service, with a focus on managing physical pain alongside taking care of psychological/Mental Health needs – all around service for musculo-skeletal pain, non-muscular (other) pain and psychological needs • Review all therapies in relation of pain management with a view to bring them under one umbrella • Evaluate community cardiology service pilot and procure a full service. • Active discharge planning will be done – discharge summary/care plans will be provided by hospitals to both the patient and the GP • Implementation of newly procured Community Outpatient service for gynecology will be completed during Q1 2019 • Use the results of the 2018 Ambulatory Care Services Audit to develop new enhanced community pathways to support out of hospital care for a range of ambulatory care sensitive conditions. Service launch expected in Q2 2019 • Community Direct Access Physiotherapy will be one element of the new Integrated MSK service being procured with launch in Q3 2019 • Embed the Chronic Kidney disease (CKD) pathway across Harrow • Review, and redesign the Community Ophthalmology service. Undertake Procurement of the service with launch date for new service in Q2 2019	

	• Review, and redesign the current Harrow Electronic referral Optimisation Service (HEROS) pilot. Undertake Procurement of the service with launch date for new service in Q1 2019	
Measuring Success	Supporting the Integration Agenda	Supporting Strategies & Assurance
Delivery of this Transformation Theme will realise: • Reduction in Non-Elective Admissions • Reduction in short stay Admissions • Reduction in overall costs • Reduction in growth rate for attendances and admissions • Increase in care provided in non-hospital based settings • Ensure the Ambulance Handover targets are delivered consistently	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • Review and procurement of community pathways. • Integration of care pathways across LTCs and cancer. • Implementation of RightCare and the STP through cross- organisation/ sector working.	**The work for this Transformation Theme is underpinned by the following strategies:** • Shaping a Healthier Future: Out of Hospital Strategy • 5 year forward plan • Commissioning for Value • RightCare initiative

2. Transforming primary care services			
CCG Team	Lead	SRO	CRO
	Rahul Bhagvat & Lisa Henschen	Lisa Henschen	Dr Genevieve Small

2020/21 Outcomes	Commissioning intentions 19/21	Indicative Commissioning intentions beyond 19/21
By 2020/21 we will be delivering the following outcomes: Excellent patient experience, equitable access and high quality outcomes for everyone using primary care services in Harrow. A happy and motivated primary care workforce equipped with the skills they need to deliver high quality primary care services. A financially balanced health care system, where increased investment made in primary care results in a demonstrable reduction in hospital activity and spend**.**	**We will:** Have established primary care networks ready to deliver at scale services to support patients to be cared for in the community Have evolved our primary care network models to primary care homes, serving populations of 30,000 – 50,000, who will in the future provide a fully integrated, population based, health and social care service Have moved away from commissioning preventative and enhanced care services at an individual practice level and be commissioning these at scale through our federation and networks. Examples include: - Anti-coagulation services - Minor surgery - Phlebotomy services - Preventative case finding - DMARDs - Prescribing - extended access - complex care planning for frail patients over 65 years Work in partnership with our primary care networks to complete detailed workforce mapping and	Further development of population health based models and population budgets for health care.

	support them to have robust plans in place for addressing any workforce challenges Work with our federation to have a robust system in place for support practice resilience, securing the ongoing sustainability of General Practice services Commission out of hospital contracts through our at scale structures in Harrow, ensuring access to these services closer to home for patients and securing better value for the healthcare economy Completed the review of PMS contracts with a redistribution of PMS funding across all Practices in Harrow, delivering an enhanced service offer in primary care Continue to support access to General Practice services in the broadest sense, through GP access hubs providing bookable routine and urgent appointments for patients, supporting extended hours arrangements at an individual practice level and using technology to support patients to access GP services in new ways, including on-line consulting and telephone appointments Extensive Self-Management Plans and personalized records to be used for patients with long-term conditions Utilize social prescribing and various other local non-clinical services in the borough to better manage patients with long-term conditions	

Measuring success	Supporting the Integration agenda	Supporting strategies and assurance
Delivery of this Transformation Theme will realise: • Increase in activity managed outside of a hospital setting. • Reduction in costs across the system per capita to meet the financial gap • Co-ordinated care for people with long-term • conditions including primary prevention for sections of the population developing risk profiles; and secondary prevention for people with multi- morbidities to reduce hospital admissions • Develop prevention care measures for patients with Long term conditions • Enhanced care management and co-ordination in Primary Care supporting integrated support for people with long term conditions (WSIC/Virtual wards) • Sustainability planning	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • The development of at scale working and the evolution of this to a primary care home model is a key element in the delivery of integrated services across Community and Acute Services and is key to the delivery of Out of Hospital (Local Services programme) • The CCG has implemented a programme of work to review, re-design and improve services delivered within the community setting. This work will focus on preventing patients needing to attend hospital when their clinical need can be met in a non-hospital environment. Key areas are rapid response assessments for timely intervention, realigning all rehabilitation services so that seamless pathways deliver coordinated care and an improvement of cardiac and respiratory services that actively respond to early supported discharge from hospital and, where possible avoiding the need to attend or be admitted to hospital in the first place.	**The work for this Transformation Theme is underpinned by the following strategies:** • Our Strategy for Primary Care in Harrow • GP Five Year Forward View • Strategic Commissioning Framework (SCF) • Out of Hospital Strategy • Strategic Commissioning Framework for Primary Care in London

3. **Intermediate and Community Care**			
CCG Team	Lead	SRO	CRO
	Tom Elrick	Tom Elrick	Dr Radhika Balu and Dr Alihusein Dhankot

2020/21 Outcomes	Commissioning intentions 19/21	Indicative Commissioning intentions beyond 19/21
By 2020/21 we will be delivering the following outcomes: • Increasing scope and amount of activity delivered Out of Hospital and closer to home for patients • Reduction in Length of Stay following a planned admission • Increased use of alternative services to deliver patient care. • Delivering increased capacity within community services as an alternative to hospital based care. • Ensure the delivery of an Acute Frailty Service	**We will:** • Implement prioritised outcomes of Local Services Intermediate Care Pathway reviews. • Work collaboratively and continue to develop and implement the new models of care across primary and community services. • Support the new community service provider to embed its operating model and to identify opportunities for innovation and redesign. • Integrate the provision of Intermediate care step bed provision to reduce avoidable hospital admission and optimise patient recover • Improve rehabilitation pathways that follow patients care from a bedded intermediate care environment back to the patients place of residence, improving confidence and consistency in getting patients home quicker and with the most effective support • Increase in care provided in non-acute based settings • Increased access to and capacity within community services • Implement an integrated Cardiology service from secondary care through to Community and Primary Care • Implement a redesigned Respiratory Service to prevent the incidents of long term treatment • Implement an efficient transportation service to accommodate Primary Care and Community Care requirements in the most cost effective way	**We will:** • Commission Intermediate care services to meet the current and future needs of the population and that are integrated fully with other provider organisations. • Align the community service contract to support delivery of the Harrow STP and the Integrated Care Organisation delivery model.

Measuring success	Supporting the Integration agenda	Supporting strategies and assurance
Delivery of this Transformation Theme will realise: • Reduction in Non-Elective Admissions • Reduction in Zero-Length of Stay Admissions • Reduction in overall costs associated with planned care • Reduction in growth rate for A & E attendances and admissions organisation/ sector working. • Align community healthcare services to the Harrow INTEGRATED CARE PARTNERSHIP model	**The work for this Transformation Theme is underpinned by the following strategies:** • Shaping a Healthier Future: Out of Hospital Strategy • 5 year forward plan • Commissioning for Value • RightCare initiative • STP / Local Services Intermediate Care & Rapid Response Programme • Harrow WSIC model.	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • Review and procurement of Intermediate Care pathways. • Integration of Intermediate care pathways with Primary Care and Virtual Wards. . • Implementation of RightCare and the STP through cross-Organisation / Sector Working

4. **End of Life Care**			
CCG Team	Lead	SRO	CRO
	Tom Elrick	Tom Elrick	Dr Radhika Balu and Dr Alihusein Dhankot

2020/21 Outcomes	Commissioning intentions 19/21	Indicative Commissioning intentions beyond 19/21
By 2020/21 we will be delivering the following outcomes: Increasing number of people able to die in their preferred place of death ○ Reducing number of admissions for people in the last year of their life ○ Improve access by clinicians and professionals supporting people at End of Life to care plans ○ Coordination of support to people at End of Life and their families/carers on a 24/7 basis and across all care settings	**We will:** • Roll-out Harrow's specialist palliative care community team • Continue to further develop the successful End of Life Single Point of Access Service. • Implement Harrow end of life strategy and pathway based on national guidance.	**We will:** • Continue to deliver requirements of 'Ambitions for End of Life Palliative Care'
Measuring success	**Supporting the Integration agenda**	**Supporting strategies and assurance**
Delivery of this Transformation Theme will realise: • Increase in people dying in their preferred place of death • Increase in people with anticipatory care plans • Reduction in the costs associated with managing people at End of Life	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • Ensure end of life care is integrated into other pathways e.g. respiratory • Increase use of CMC / common care planning to ensure co- ordination of multi-disciplinary support to people at the end of life.	**The work for this Transformation Theme is underpinned by the following strategies:** 'Ambitions for End of Life Palliative

5. Integrated Support for people with Long Term Conditions (Whole Systems Integrated Care)			
CCG Team	Lead	SRO	CRO
	Lisa Henschen	Lisa Henschen	Dr Genevieve Small

2020/21 Outcomes	Commissioning intentions 19/21	Indicative Commissioning intentions beyond 19/21
By 2020/21 we will be delivering the following outcomes: • A population based approach to deliver integrated care • Improved outcomes and support for people with multiple LTCs and complex needs • Reducing unplanned care needs arising associated with LTCs • Set up clinical hubs exclusively for patients with long-term conditions • Reduced variation in care received by people with LTCs with a particular focus on variation in Primary Care • Increasing focus on improved outcomes through preventative • measures (primary, secondary and tertiary prevention) • Empowered individuals with the confidence and information to look after themselves when they can, and visit the GP when they need to provide greater control of their own health and encourage healthy behaviors that help prevent ill health in the long-term • Reducing inappropriate hospital admissions by developing out of hospital capacity	**We will:** • Oversee the development of the Primary Care Home model through our networks in Harrow, which will be the delivery model of integrated, community based care, with General Practice at the heart. • Have reviewed our model for Whole Systems Integrated Care and put in place a new commissioning approach for delivery of this service, which is: - Centred around local populations - Delivered through true, integrated partnerships of providers - Grounded in an evidence based and data driven approach to ensure that we are providing the right services to the right group of patients in the community • Review pathways and current services in place for managing long-term conditions like cardiology, respiratory, diabetes, AF & hypertension. • Merge pathways for various long-term conditions, if possible	• Further development of population health based models and population budgets for health care.

Measuring success	Supporting the Integration agenda	Supporting strategies and assurance
Delivery of this Transformation Theme will realise: • Increase in activity managed outside of a hospital setting. • Reduction in costs across the system per capita to meet the financial gap • Co-ordinated care for people with long-term	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • This theme will be central and an early adopted of a new integrated approach for delivering care • Patient Activation Measure: an evidenced based tool to measure individual skills, confidence and	**The work for this Transformation Theme is underpinned by the following strategies:** • Whole Systems Integrated Care • ICP Models of Care • Local services

• conditions including primary prevention for sections of the population developing risk profiles; and secondary prevention for people with multi- morbidities to reduce hospital admissions • Develop prevention care measures for patients with Long term conditions • Sustainability planning	knowledge to manage their own health • Reduction in variation in general practice for long term condition management	• Our strategy for primary care in Harrow • Strategic commissioning framework • NHS 5 Year Forward View

6. Transforming Care for People with Cancer

Lead	SRO	CRO
	Tom Elrick	Dr Radhika Balu and Dr Alihusein Dhankot

2020/21 Outcomes 6	Commissioning Intentions 19/21	Indicative Commissioning Intentions Beyond 19/21
By 2020/21 we will be delivering the following outcomes: • Increasing rates of cancer prevented and increasing survival rates • Reduction in the rates of reoccurrence • Reduction in variation rates in the quality of care • Patients and their families better informed, empowered and involved in decisions around their care • Improved health, wellbeing and quality of life for patients after treatment and at the end of life • Reducing number of patients identified as having Cancer following a non-elective presentation	We will: • Ensure that all services for cancer are commissioned in line with NICE guidance through the agreed best practice pathway for London with follow up in line with the NCSI. • Reduce variation in care from primary and acute services so as to meet national quality and performance standards with focus on the 62 day wait and improve patient outcomes. • IAPT services will be reviewed to enhance pathways for the management of psychological support for cancer patients. • Broaden the scope of services to manage the side effects of anti-cancer treatment and stratify follow up pathways. • Establish a CCG Cancer Transformation forum in collaboration with local clinicians, GPs and Third Sector providers. • Work to widen the range of direct access tests for primary care services to improve early detection and screening for patients. • To Work with Harrow Local Authority to exploit opportunities to incorporate healthy living messages within existing communications and project i.e. smoking cessation.	We will: • Complete roll out of Transformational projects across prioritised cancers. • Continue the rolling primary care education programme in partnership with Cancer Research UK and other third sector organisations. • Develop enhanced supportive care for people living with and beyond cancer. • Significantly improve the performance of providers in relation to national cancer care standards. • Develop productive, collaborative relationships with all providers, Third Sector and Patient groups to deliver optimum outcomes and experience for cancer patients

Measuring Success	Supporting the Integration Agenda	Supporting Strategies & Assurance
Delivery of this Transformation Theme will realise: • Reduction in the prevalence gap around Patients identified with Cancer in Primary Care • Reduction in the number of patients identified with Cancer following a non-elective presentation • Increase in life expectancy at 5 years following successful treatment of patients	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • The CCG will continue to jointly work with GPs and acute service clinicians to improve, systems, processes and clinical skills in support of early detection and screening for patients. Most Harrow CCG patients receive all cancer treatment from Northwest London based providers. The CCG will work with the London Transforming Cancer Services team to develop and implement improved and sustainable cancer pathways of care.	**The work for this Transformation Theme is underpinned by the following strategies:** • NHS 5 YR Cancer Commissioning Strategy for London: 2014/15 – 2019/2020 • Achieving World-Class Cancer Outcomes: Taking the strategy forward. • Achieving World-Class Cancer Outcomes: Taking the strategy forward: Equality and Health Inequalities Analysis • Improving outcomes; a strategy for cancer; third annual report • Pan London Cancer Strategy • National Cancer Survivorship Initiative (NCSI 2015) • NCSI Living with and beyond cancer; taking action to improve outcomes; March 2013 • Harrow Joint Strategic Needs Assessment 2015-20 Improving Outcomes: A Strategy for Cancer; Department of Health

7 Transforming Support for people with Mental Health Needs and those with Learning Disabilities			
CCG Team	Lead	SRO	CRO
	Lennie Dick	Angela Neblett	Dr Himagauri Kelshiker and Dr Hannah Bundock

2020/21 Outcomes	Commissioning intentions 19/21	Indicative Commissioning intentions beyond 19/21
By 2020/21 we will be delivering the following outcomes: • Implement and evaluate the reviewed structure for quicker autism diagnostics • Maintain the lowest level of admission for LD whilst developing community support for this group • Evaluate the Transforming Care Partnership • Implement the next phase of the S&LTMHN Business Case • Develop a shared plan with CNWL and the voluntary sector to increase IAPT access (NHSE recommendations) • Evaluate the progress with CNWL (pathway and KUF training) in meeting the needs of people with borderline personality disorder • Evaluate the Urgent Care Pathway and its integration with 111 • Implement 18/19 (Phase) plans for meeting the Five Year Forward plan for Mental Health • Further develop the planned Carers initiatives for MH and LD both in the commissioning structure and operating plan • Implement the 2017/18 training programme for Primary Care including MH, LD, CAMHS and Autism • Build on the transformational plan to develop more service provision within the community through voluntary and community sector partners	**We will:** • Develop the case for at least one Admiral nurse to provide post diagnostic support for carers and support • Develop the case to fund Community Advocacy aimed at addressing the growing need in Harrow • Develop the case to increase the Community Learning Disabilities Team to provide Behavioural Therapy and Occupational Therapy • Work in partnership with Harrow Mencap and CNWL to develop training and support for users and carers to manage challenging behavior • Implement the Joint Health and Social Care Dementia Strategy for Harrow whilst incorporating the Integrated Care Programme for Dementia aimed at meeting the needs for over 65's • Continue the transformation developments with the voluntary and Community Sector (Harrow Community Action) to provide counseling through the IAPT model • Implement 2019/20 (Phase) plans for meeting the Five Year Forward for Mental Health moving from 19% to 22% having access to IAPT • Decommission open rehabilitation beds on Roxbourne and implement a locked rehabilitation service to meet • the more complex and higher dependency needs of patients	**We will:** • Increase IAPT Access to 25% of the prevalence in Harrow • Fully integrate IAPT support for LTC as part of each of their pathway from referral • Full integrate Dementia care for over 65's in Harrow • Operate an Health and Social care integrated system for Community Learning Disabilities in harrow • Operate within a NWL system for Health based Place of Safety • Operate with a reduction in inequalities associated with the care of people with one or more LD • Lead the strategy alongside partners; Public Health, Local Authority, Voluntary and Community Sector Organisations in the b reduction and prevention of suicide • Reduction in risk of harm to vulnerable people • Improved support for people with an urgent mental health need • Significant progress in closing the mortality gap between people with an LD and the wider population • Evaluation of the implementing the Five Year Forward for Mental Health in Harrow

	• Review the opportunity of integrating the Community Learning Disabilities Team with the Local Authority Learning Disabilities Team • Agree and support once signed-off the NW London plan to implement 'Health Based Place of Safety'	
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • People with SMI (Severe Mental Illness) to receive complete list of physical health check to achieve reduction in the mortality gap • Access to community mental health services and IAPT from BME groups, crude rates per 100,000 population • Unplanned readmissions of mental health patient within 30days of inpatient admission. • Percentage of service users in adult mental health services in employment. • Reduction in Psychiatric admissions via A+E • Voluntary Sector transformation and engagement	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • Develop and improve the coordination for mental health within the whole systems Integrated Care plan to close the gap between physical and mental health services • Action response to the service enhancements of 2018/19; NHS England Assurance, Five Year Forward View, Improvement Assessment framework • Further develop the role of the voluntary sector in meeting the needs of BME groups access to psychological therapies • Primary Care Mental Health service development • CNWL service and Pricing review	**The work for this Transformation Theme is underpinned by the following strategies:** • Dementia RightCare • • LD Transforming Care Partnership • Like Minded Business case for S&LTMHN • Mental Health Transformation Plan • Monitoring through the Harrow Local Performance and Quality Group (HLPQG, multi-agency group including HCCG, CNWL, LA, MIND and Harrow Carers) • Assurance through the Harrow CCG Governing Body, BHH SMST, NWL Health and Wellbeing Board and Likeminded STP • NHS England Assurance meetings

8. Integrated Care for Children & Young People (CYP)			
CCG Team	*Lead*	*SRO*	*CRO*
	Steve Buckerfield	Tom Elrick	Dr Hannah Bundock

2020/21 Outcomes	*Commissioning intentions 19/21*	*Indicative Commissioning intentions beyond 19/21*
By 2020/21 we will be delivering the following outcomes: • Coordination of support for children and young people across all health and social care services • Improved outcomes for children and young people with one or more LTCs • Reduction in the risk of harm to children and young people • Improved Emotional Health & Wellbeing of CYP, , including children with Special Educational Needs & Disabilities (SEND)	***We will:*** *Implement the priorities for quality and cost improvement identified through the RightCare Pathway reviews as they apply to children & young people (i.e. Diabetes).* ***Children& Young People's Mental Health:*** • Continue to deliver the Harrow Future in Mind Transformation Plan, embed the CYP Eating Disorder Service and plan for the implementation of the Mental Health Support in Schools Green Paper • Deliver the CAMHS Out-of-Hours and Crisis service in line with the NWL Transformation plan, patient & stakeholder feedback • In collaboration with adult CCG commissioners, develop and embed an integrated ASD & ADHD pathway (with pediatric and CAMHS input) • Deliver the CYP elements of the Transforming Care Plan (TCP) • Integrate CAMHS LD, social care and pediatric provision (e.g. Hillingdon model) ***Children with Special Educational Needs & Disabilities (SEND):*** • Deliver the CCG's responsibilities under the Children & Families Act 2014 (and statutory Code of Practice) in relation to Harrow children with SEND needs • Ensure health services specified in Education Health and Care Plans (EHCPs) are commissioned.	***We will:*** • Embed integration across Health, Education and Social Care

	• Ensure an efficient Continuing Health Care process and Dynamic Risk Register is in place to provide support, assess risk and avoid unnecessary admission. • Learn lessons from the anticipated Local Area (2019) Inspection from OFSTED and CQC. ***Children's Community Health Care***: • Deliver the transformation community pediatrics service (including SEND 18- 25 years) • Implement new pathways to improve access to services for CYP with LTC • Work jointly with the local authority, Education (SEN and local schools) and Harrow Public Health to improve health and social care and education outcomes for CYP & their families, including for young people with Education, Health and Care Plans (EHCPs). • Align service developments with Harrow Council's 'Early Support' and 'Together with Families' Plans ***Looked After Children:*** • Renew the joint funded LAC Nurses Contract which expires in June 2019. ***Primary & Acute Care:*** • Develop and deliver a series of discreet programmes aimed at redirecting acute activity to community alternatives, reducing GP referrals to secondary care and reducing unplanned care activities.	
Measuring success	*Supporting the Integration agenda*	*Supporting strategies and assurance*
Delivery of this Transformation Theme will realise: • Cost effective integrated care solutions for young people with complex needs • Meet the rising demand for health service from young	***The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:*** • Jointly commissioned services and working across Health & Social Care, Education and the Third	***The work for this Transformation Theme is underpinned by the following strategies:*** • Future in Mind NWL CAMHS Transformation Plan

people with SEND needs within existing resources (e.g. SALT) • Reduction in the need for secondary care activity associated with CYP: • Reduction in GP referrals to secondary care • Reduction in unplanned care needs for CYP • Reduction in the costs associated in managing CYP per capita	Sector. • Continue to work closely with NHS England around support to CAMHS patients • Continue to work across NWL to provide efficient and integrated CAMHS services and where feasible, TCP services	• Future in Mind Local Transformation Plan • The JSNA 2015-2020 • The Children & Family Act 2014 • Harrow STP • Harrow Health & Well Being Board plans

9. Transforming services for people with diabetes			
CCG Team	Lead	SRO	CRO
	Jason Parker	Tom Elrick	Dr Hannah Bundock

2020/21 Outcomes	Commissioning intentions 19/20	Indicative Commissioning intentions beyond 19/20
By 2020/21 we will be delivering the following outcomes: Reduced rate of growth in prevalence to improve long term outcomes and slow the growth in demand for health related services Utilise the full allocation of referrals to the NHS Diabetes Prevention Programme 30% of diabetes prevalent population to receive structured education 40% of newly diagnosed patients to receive structured education Reduced variation in management of conditions to reduce the number of exacerbations that occur for people and ultimately improve their long term outcomes Increase the percentage of diabetes patients that have achieved the three NICE-recommended treatment targets (HbA1c, BP, Cholesterol) to 52% Reduce the Foot Amputation Rate Reduce the length of stay for in-patients with diabetes	There have been multiple discussions, both formally and informally over the past year regarding addressing diabetes as part of the NWL STP work on unwarranted variation. The consensus was that a robust single outcome-based service specification was the way forward, and this has now been developed. Our aim is one patient-focused diabetes team across many providers, contracted separately as per CCG need, but all focused on the same outcomes. Our commissioning intentions are: • To create one diabetes service specification with common value-based outcomes to better align with NICE recommendations and best practice. The model focuses on payment for these outcomes. • Primary care, community diabetes services and secondary care specialist diabetes services will be incentivised to work together to achieve common outcomes seeing people as often as required to meet the patients' individual targets and outcomes / improve in-patient care and improving discharge to prevent re-admission. • We are developing value-based payment methodology, including wrap-around quality bonuses, bundled disbursements and capitation payments. These sustained pro-active interventions in diabetes care will be a departure from the current volume-driven, reactive approach that is currently dictated by piecemeal reimbursement.	We will: Continue to reduce rate of growth in prevalence to improve long term outcomes and slow the growth in demand for health related services Continue to reduce variation in management of conditions to reduce the number of exacerbations that occur for people and ultimately improve their long term outcomes

Measuring success	Supporting the Integration agenda	Supporting strategies and assurance
What does this mean for people with diabetes (PWD)?	The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:	The work for this Transformation Theme is underpinned by the following strategies:

a) There will be significant investment in supporting clinical services to deliver an integrated approach to diabetes care, increased collaboration in primary care and a blurring of boundaries between primary, community and secondary care – this should deliver a seamless system for PWD. b) There will be a large emphasis on professional development and workforce redesign to ensure competency, capability and capacity. This will ensure PWD are seen by someone trained in their condition, and who has time to deal with them in a different more holistic way looking at the nine care processes ensuring outcomes have been achieved. c) Risk stratification and care management approach for PWD will be embedded focusing care on those who need it most. d) We will implement the guidance in the London Type 1 Commissioning Pack. http://www.londonscn.nhs.uk/publication/diabetes-commissioning-pack	Currently, the diabetes care pathway is fragmented, leading to lack of visibility of services for both professionals and those affected by diabetes. Services need to be joined up, providing a seamless pathway. One option for this could be the creation of local hubs providing multiple, interlinked services, which is particularly important for people living with diabetes. An ICP will be commissioned to provide a single, joined up service for diabetes; using an outcomes-based service specification.	The Diabetes Strategy for Harrow The North West London STP Diabetes Transformation Programme

10 Medicines Optimisation

CCG Team	Lead	SRO	CRO
	Paul Larkin	Javina Sehgal	Dr Himagauri Kelshiker and Dr Radhika Balu

2020/21 Outcomes	Commissioning Intentions 19/21	Indicative Commissioning Intentions Beyond 19/21
By 2020/21 we will be delivering the following outcomes: • Evidence-based, outcomes-focused medicines expenditure aligned to the STP aims • Reduction in overall medicines expenditure per capita including reduced wastage taking into account growth in costs • Provider-led medicines optimisation • Improved patients' and carers' understanding of their medicines, leading to an improvement in health outcomes and reduction in avoidable harm • Re-designed pathways for LTCs to achieve improved outcomes with medicines • Reduction in unnecessary cost and workload due to discharge from acute trusts due to medicines use • Increased patient use of self-care and prevention, creating capacity in GP practices while reducing spend on OTC medicines **We will:** • Support the development of a new model for medicines optimisation across the entire health economy. The objective will be to more closely align and integrate the medicines budget into the day to day business of providers e.g. GPs, Acute trusts and community providers. This will have the dual benefit of creating greater accountability at the point of prescribing as well as enabling service re-design to support medicines optimisation. The model will be aligned with the principles of ACOs (now ICSs) in line with the Five Year Forward View • Explore the full or part devolvement of the Prescribing Budget, and resource to support, to a Provider • Work in partnership with partners across the health economy to re-design pathways where there is an opportunity to achieve improved health outcomes and system efficiencies via medicines optimisation	e.g. LTCs such as AF, COPD. We will • Further incentivise GP practices to ensure high quality, cost effective prescribing is being carried out without compromising patient care • Increase prescribing quality in Care Homes, diabetes, mental health, and respiratory – building primary care capability and capacity • Further incentivise providers to ensure spend on medicines is of a high quality, and cost effective prescribing is being carried out without compromising patient care. This will include GP practices, acute and community service providers. • Optimise the medicines expenditure and outcomes through provision of practice level medicines optimisation support • Review and streamline repeat prescription processes in practices to increase efficiency in general practice and reduce unnecessary medicines waste • Reduce inappropriate usage of antibiotics through the implementation of NICE NG15, Antimicrobial Stewardship by all providers • Reduce the volume of hospital-related medicines activity by increasing capacity and capability in primary care to increase shared care prescribing arrangements. • Leverage the savings opportunities offered by biosimilar arrangements • Explore the devolvement of the dressings budget, allowing the Provider to explore other models for supply, carry risks and share gains • Explore opportunities to work with the pharmaceutical industry to reduce spend and improve outcomes on medicines • Through the Right Care programme we will undertake a 'roots and branch' review of how Harrow CCG integrates medicines into service provision within an ICS framework. We will do this by: - Diagnosis of current gaps and opportunities - Work with partners to Design services - Commission and contract appropriately to ensure changes are integrated • Support providers to demonstrate the outcomes which will be commissioned for within the redesigned pathway.	We will: • Seek opportunities to leverage the Prescribing Budget to further support new models of Primary Care • Deliver further reductions of medicines waste through improved engagement, communication and commissioning with community pharmacy providers • Further improve patient experience through improving access to medicines • Seek opportunities to work more effectively and efficiently across NWL and London-wide • Implement medicines commissioning opportunities to shift care out of hospital and into the community • Explore other non-medicines related spend e.g. appliances with a view to improving care and quality while reducing spend • Investigate effective use of staffing / resources to best deliver objecti

Measuring Success	Supporting the Integration Agenda	Supporting Strategies & Assurance
Delivery of this Enabling Theme will realise: • Reducing spend per capita on medication • Quality and safety of medicines use is improved • Reducing incidents of harm • Improving outcome for people arising from the effective use of medication • Patient experience is improved with their medicines • Medication waste is reduced • Cost savings achieved • National and local guidance is implemented • Reduction in polypharmacy • Partnership working with relevant stakeholders to improve patient care • Increased and dedicated workforce in primary care to enable true medicines optimisation e.g. GP practice pharmacists in line with the GP forward view • Improved efficiency in care pathways involving medicines	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Harrow:** • Medicines Management cuts across all areas of healthcare provision, and in Harrow we work in partnership with all commissioners and providers to deliver the best outcomes for patients within the resources available to the health economy. • New financial arrangements, incentives and gain share schemes will enable greater integration of the medicines agenda across all providers. These will enable us to ensure that we drive clinical and financial improvements that benefit the health economy of Harrow and it's patients	**The work for this Enabling Theme is underpinned by the following strategies:** • Harrow Medicines Optimisation Plan 18/19 The delivery of this Enabling Theme will be managed and monitored via the **Harrow Medicines Management Committee** which in turn reports to the **Harrow CCG Governing Body**.

11 Continuing Care

CCG Team	Lead	SRO	CRO
	Susan Grose	**Ali Kalmis**	**Dr Genevieve Small**

2020/21 Outcomes	Commissioning Intentions 19/21	Indicative Commissioning Intentions Beyond 19/21

By 2020/21 we will be delivering the following outcomes:
 	
• To continue to provide a Continuing Healthcare Service that enables patients to remain in their preferred place of care and reduces unnecessary admission to hospital.
• To have a pathway for patients to have access to a Personal Health Budget or Integrated Budget
	We will:
	
	• To continue to provide a Continuing Healthcare Service that enables patients to remain in their preferred place of care and reduces unnecessary admission to hospital.
	• Personal Health Budgets planning the roll out for patients with as follows
	  • People with long term conditions- Mental Health, Learning Disability, COPD and Diabetes etc.
	  • Maternity
	  • End-of-life care
	  • Children who have special educational needs with a single assessment in the form of an Educational, Health and Care Plan which includes the option of a personal budget
	  • Wheelchair Service Users
	  • Continued right to have for those patients eligible for Continuing Healthcare
	• To continue to support patients at end of life with choice through the pathway of Fast Track- Continuing Healthcare
	• Continuing Healthcare to expand the procurement of Nursing Homes and Home Care providers with the support from the NHS London Purchased Healthcare Team (AQP NHSE Contracts)
		We will:
		
		• We will continue to explore and evaluate the implementation of Personal Health Budgets via the NHSE London Personal Health Budget network. Also local experiences gained by the Continuing Healthcare Service and the Local Authority Affinity project
		• We will continue to monitor and evaluate the delivery of the Continuing Healthcare Service via the NHSE Continuing Healthcare network and internally within the CCG.

Measuring Success	Supporting the Integration Agenda	Supporting Strategies & Assurance
Delivery of this Transformation Theme will realise: • Increase in people with a Personal Health Budget and an Integrated Budget who are empowered to self-manage elements of their care • Continuing Healthcare to continue to work with the Local Authority in decision making about patients eligibility for Continuing Healthcare, Shared Care and Funded Nursing Care	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • For the Continuing Healthcare Service to co-ordinate with partners to ensure effective commissioning of end of life services • For the Continuing Healthcare Service and CCG Commissioners to work in conjunction with Harrow Local Authority to deliver Personal Health Budgets and Integrated Budgets to the residents of Harrow	**The work for this Enabling Theme is underpinned by the following strategies:** • Continuing Healthcare Framework (2012) • National Framework for Children and Young People's Continuing Care(2016) • Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 • Children and Families Act 2014

12 Integration Across the Urgent & Emergency Care System

CCG Team	Lead	SRO	CRO
		Tom Elrick	Dr Muhammad Shahzad

2020/21 Outcomes	Commissioning Intentions 19/21	Indicative Commissioning Intentions Beyond 19/21
By 2020/21 we will be delivering the following outcomes: • Coordinated support across all Urgent & Emergency Care services • Increased number of patients who have their unplanned care needs met outside of a hospital setting • Increased awareness in the community about how to access appropriate services • Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay • Increase the support available for patients to self-care	**We will:** • Develop and procure a new NHS 111 Service and Clinical Hub • Embed the re-designed and re-procured the model of care at the Urgent Care Centre, enabling positive re-direction for non-urgent patients out of hospital care settings • Support a new Out of Hours model with GP federations • Develop a Patient Education Programme for unscheduled care services • Further develop the patient app to support patients to self-care and access urgent and emergency services appropriately • Integrate the provision of Intermediate care step bed provision to reduce avoidable hospital admission and optimise patient recovery • Facilitate discharge by integrating and further developing home based virtual wards • Expand and update the DoS in line with national standards to support the patient, clinical hub and other providers • Commission a fully Integrated Urgent and Emergency Care system • Reduce demand at the door of A&E and the UCC through improved access in Primary Care, Education and to people with LTCs through Whole Systems Integrated Care model for the management of LTCs • Integrate IT system across the UEC system to ensure professionals have access to essential medical records for people • Maximise the use of community services e.g. through the direction Cat C LAS calls to WICs • Develop and maximise the use of the Ambulatory Emergency Care Unit • Improving support to high intensity users of 999 and A&E services to reduce usage • Review pathway for DVT with a potential to include it under Ambulatory Care Service	**We will** : • Align the Integrated Urgent Care model with provider services i.e. Out of Hours, Urgent Care Centre, Clinical Hub (CATS), NHS 111 and Walk In Centres • Align the Integrated Urgent Care services with the Integrated Care Partnership Strategy • Develop a IT infrastructure compatible with all urgent care systems • Develop productive, collaborative relationships between all providers
Delivery of this Transformation Theme will realise: • Reduction in rate of growth for unplanned attendances at hospital • Increase in people accessing non-hospital based support for their unplanned care needs • Reduction in the costs per capita managing unplanned care needs • Reduction in Zero-Length of Stay and Unplanned Admissions and	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Harrow:** • The Multidisciplinary Integrated Discharge Team and A&E Delivery Board are examples of Integration across health and social care associated with Unplanned Care	**The work for this Transformation Theme is underpinned by the following strategies:** • Unplanned Care Strategy • Commissioning Standards for Integrated Urgent Care • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **A&E Delivery Board** which in turn reports to the **Harrow CCG Governing Body**

Services • a Reduction in Length of Stay following an unplanned admission		

Enabling Themes

14. Developing The Digital Environment		
CCG Team	**Lead:** **CRO:**	
2020/21 Outcomes	**Commissioning Intentions 19/20 – 20/21**	**Indicative Commissioning Intentions Beyond 18/19**
By 2020/21 we will be delivering the following outcomes: • Effective and efficient integrated care services enabled by shared health and care records • Relevant information safely and appropriately available when needed to coordinate care for people • Clear information available to aid planning of services	We will: • Improve access to and use of the Shared Care Records • Develop plans for digitally enabled self-care and the use of real time data in decision making for both clinicians and patients • Eradicate use of fax in care services	• Encourage secondary care to move towards paperless operation at the point of care 2018 – By October 2018 the acute sector / secondary care services will be operating on paperless referrals using the Electronic Referral system (ERS) • Complete development of a shared care record across all care settings including social care, facilitating integrated out of hospital care – 2018. The Urgent Care services based at the acute hospital sites now have access to the patient record on the EMIS platform. As the Integrated Care model moved forward in 2018 and 2019, social care services will gain access to a single care record for each patient. • Extend patient records (from all settings) to patients and carers, and provide them with digital self-care and management tools such as apps, to help them become more involved in understanding and managing their own care – 2018 NHS Harrow CCG will continue to expand the information available on the Health Help App to promote self-care and management for patients. • Use dynamic analytics to inform care decisions and support integrated health and social care across the system through whole system intelligence – The Harrow Whole Systems programme is developing at pace with initial service go-live planned for early 2019
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • High utilisation of Shared Care Record across settings by the right people • Services planned using accurate and timely data • Improved outcomes for patients through shared record keeping	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Harrow.** • The Shared Care Record will facilitate integrated working across settings and across providers.	**The work for this Enabling Theme is underpinned by the following strategies:** • Local Digital Roadmap The delivery of this Enabling Theme will be managed and monitored via the IT Sub-Committee, which in turn reports to the CCG Executive.

14. Creating the Workforce for the Future

CCG Team

2020/21 Outcomes	Commissioning Intentions 19/20 – 20/21	Indicative Commissioning Intentions Beyond 19/20
By 2020/21 we will be delivering the following outcomes: • A primary care workforce that is sufficient to sustain general practice. • An expanded primary care workforce that is competent and confident to work in new models of care delivery and new provider structures. • A supported workforce environment that promotes Harrow as an attractive place to work. •	We are currently • Continue to Improve recruitment and retention to address workforce shortages and delivery of new models of care: - Develop career pathways esp. HCA to Practice Nurse, Practice Burse to Advanced Nurse Practitioner. - Develop newly qualified GP career pathways to partnership or with portfolios - Invest and develop new roles in primary care e.g. Physician Associates, Practice based pharmacists, Mental Health therapists - Develop Practice Manager workforce to meet new business and network manager roles • Greater emphasis on training for clinicians in long term conditions, patent education and prevention. • Ensure supported, and sometimes targeted, recruitment of new staff into general practice including through apprenticeship programmes • Continue to provide staff forums, training and education opportunities • Develop cross-organisational working within the GP Federation and the INTEGRATED CARE PARTNERSHIP • Develop new workforce roles and competency frameworks with HENWL and HEIs • Continue to develop the Harrow CCG Education Forum which aims to support General Practice workforce development. The forum is currently assessing current capacity and capability of the local GP workforce and supporting staff development in priority areas such as COPD, Cytology and Diabetes. The Education Forum will also develop a local GP workforce strategy. Harrow Education Forum is supported by funding from HENWL and is a member of the Brent Harrow and Hillingdon Education Forum, which works to support multi-borough workforce needs • Develop a plan for IT Skills within the workforce along with the requisite tools and enthusiasm for utilising them to improve care • Develop an OD/Health & Wellbeing strategy to develop and support the CCG workforce and promote a positive and pro-active approach to health & wellbeing at work.	We will: • Establish multi-disciplinary, multi-organisational and multi-HEI packages of properly tariffed student placements • Create targeted, multi-organisational pipeline of new staff recruitment • Develop a CEPN (Community Education Provider Network) function sitting with the INTEGRATED CARE PARTNERSHIP provider for multi-disciplinary forums, training and education • Develop more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care • Continue to properly evaluate and develop new workforce roles and competency frameworks with HENWL and HEIs

Measuring Success	Supporting the Integration Agenda	Supporting Strategies & Assurance
Delivery of this Enabling Theme will realise: • The workforce required to sustain general practice and help deliver new models of care or provider structures from INTEGRATED CARE PARTNERSHIP development • The skills and consistency required to care manage multi-morbidity and increasingly complex patients.	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Harrow.**	**The work for this Enabling Theme is underpinned by the following strategies:** • GP Five Year Forward View • BHH and Harrow Workforce Plans 2015-7 • HENWL Training Plan 2016-7 The delivery of this Enabling Theme will be managed and monitored via the

• A supported environment in which staff want to stay and work.		BHH Strategic Education Forum and local Harrow CCG Education Forum.

15. Delivering Our Strategic Estates Priorities		
2020/21 Outcomes	***Commissioning Intentions 17/18 – 18/19***	***Indicative Commissioning Intentions Beyond 18/19***
By 2020/21 we will be delivering the following outcomes: • an estate portfolio that meets the needs of our 2021 vision for care and support in Harrow	• Continue to deliver our Local Estate Strategy for Harrow to support the delivery of the Five Year Forward View and 'One Public Estate' vision • Work collaboratively with Harrow Council to ensure that future health estate requirements feature within its key development areas ie Heart of Harrow, new Civic Centre • Deliver a local services hub business case for the East of the Borough • Maximise utilisation of existing estate • Deliver a temporary solution for Belmont Health Centre, to address current capacity issues, whilst continuing to find a long term solution for the site • Support primary care in accessing Improvement Grant funding to ensure premises are fit for purpose and have the capacity needed to meet the local population growth • Address the needs of the new populations in the housing zones by supporting new primary care provision within these development areas	• Deliver a local service Hub in East of Harrow by 2021/22 • Deliver a primary care solution for Heart of Harrow and other key development areas • Maintain and further develop a clear estates strategy and Borough-based shared vision to maximise use of space and proactively work towards 'One Public Estate' and deliver improvements to the condition and sustainability of the Primary Care Estate through Minor Improvement Grants
Measuring Success		***Supporting Strategies & Assurance***
D***elivery of this Enabling Theme will realise:*** • A service with the capacity and capability to meet the needs of our population	• Prevention: local services hubs will provide the physical location to support prevention and local service care. Investment in the primary care estate will provide locations where providers can deliver targeted programme to improve health outcomes • Reducing variation: Local services hubs will support the implementation of a new model of services across the borough and across NWL which will standardise service users' experience and quality of care • Outcomes for older people: primary care estate improvements will enable the delivery of coordinated primary care and multidisciplinary working enabling care to be focused around the individual patient • Supporting Mental Health needs: local services hubs will allow non-clinical provision to be located as close to patients as possible • Providing High quality sustainable acute services: addressing the oldest, poorest quality estate will increase clinical efficiencies and drive improved productivity. Increasing capacity of major acute sites will enable consolidation of services and drive improved outcomes	The work for this Enabling Theme is underpinned by the following strategies: • Local Estates Strategy • ImBC/Soc 2 • STP • Primary Care Strategy

16. Delivering Our Statutory Targets Reliably		
CCG Lead	***Ali Kalmis***	
2020/21 Outcomes	***Commissioning Intentions 17/18 – 18/19***	***Indicative Commissioning Intentions Beyond 18/19***
Achievement of NHS Targets for Referral to Treatment (RTT), A&E and Cancer Waits and Diagnostics as well as our other statutory targets associated with Mental Health	*We will:* • *Continue to achieve the 92% RTT target for Incomplete Pathways for Harrow CCG Registered population* • *Undertake a full capacity and demand modelling exercise with LNWHT to understand the resilience of our RTT system* • *Return performance of LNWHT to the expected standard of 95% for 4 hr waits in A&E* • *Explore in detail the impact of Cancer Breach Sharing Standards and continue to achieve Cancer Wait Targets whilst undertaking an end to end review to ensure continued resilience based on projected prevalence growth in Cancer.* • *Achieve the statutory targets for IAPT and dementia.*	*The plans beyond 18/19 will be dependent upon national statutory targets and any changes that are made centrally.*
Measuring Success		***Supporting Strategies & Assurance***
D***elivery of this Enabling Theme will realise:*** *Achievement of our Statutory Targets*	*As delivery of our statutory targets normally requires integrated working across multiple providers such as Cancer which will involve Primary Care and a mix of secondary care providers.*	***The work for this Enabling Theme is underpinned by the following strategies:*** Harrow CCG Operating Plan The delivery of this Enabling Theme will be managed and monitored via the Local A&E Delivery Board and Local Planned Care Delivery Board.

17. Redefining the Provider Market		
CCG Lead	***Javina Sehgal***	
2020/21 Outcomes	***Commissioning Intentions 18/19 – 19/20***	***Indicative Commissioning Intentions Beyond 18/19***

• *A market capable of meeting the health needs of the local population within the financial constraints*
• *Payment and risk share arrangements that incentivise innovation, quality and sustainability.*
	We will:
	• *Develop a shadow outcome based commissioning model for older people via an ACO (locally referred to as an Integrated Care Partnership or INTEGRATED CARE PARTNERSHIP) and seek to identify further cohorts to work with*
	  • *Mostly Healthy Adults over 65*
	  • *65+ with Dementia*
	  • *65 + Moderate or Severe Frailty*
	  • *65 + in Care Homes*
	  • *18 + Palliative Care*
		• *Enhance and drive forward the 3 year BCF plan with LBH to deliver longer term alignment and integration across Health and social care*
		• *Deliver a transformation in Primary Care support through our Primary Care Model of Care*
		• *Commission outcomes based services*
		  • *Further develop the concept, scope and impact of our Integrated Care Partnership*
		
		  • *Looking at alternative approaches to commissioning and contracting at a macros level aligned to the new national tariff approaches.*

Measuring Success		***Supporting Strategies & Assurance***

D***elivery of this Enabling Theme will realise:*** *Significant proportion of care delivered through integrated pathways* *A high functioning, cost effective Integrated Care Partnership* *Established GP networks and federation capable of delivering services in out of hospital settings*	***The following areas of this Enabling Theme will contribute to the Integration Agenda in Harrow:*** *The CCG will develop an outcome based commissioning model / Integrated Care Organisation (ACO) / Multi Care Provider (MCP*	***The work for this Enabling Theme is underpinned by the following strategies:*** Harrow CCG Operating Plan

Section 10: Our Local Quality Priorities

7a. Our Quality Priorities

We believe that the people of Harrow are entitled to a high quality and safe experience in any of the healthcare services commissioned by Harrow CCG.

At Harrow CCG, we will listen to our patients and carers, and work with all our service providers to achieve continuous improvement and reduce variation in the quality of their services.

We will work closely with our commissioning colleagues to ensure new models of care in line with the 5 Year Forward View, the multi-year STP and the development of greater integrated health care systems have quality at their core.

This model embraces the NHS definition of quality as defined under Section 1 of the Health and Social Care Act 2015 – Reducing Harm in Care, the NHS Outcomes Framework and the CQC inspection protocol that has been further developed and refined since 2015.

7b. Our Quality Principles

Harrow CCG will ensure these following principles are embedded within the CCGs everyday quality and safety assurance systems and processes;

- Use a systematic approach to monitoring and improving quality with the patient at the centre.
- Use Quality Improvement methodologies with providers to improve quality of care.
- Identify and address any organisational barriers which hinder quality of care.
- Foster an open and transparent culture across the local health system.
- Maintain a systematic and proactive approach to early identification of service quality failures.
- Ensure there are robust links between commissioning priorities, the strategy and transformation plans and quality.
- Prioritise our quality assurance and improvement efforts developing an integrated approach with social care to reflect the Better Care Fund plans.
- Drive effective engagement with key stakeholders across Harrow to achieve the delivery of robust measurable outcomes that reflect “what matters most to patients”.
- Ensure evidence based guidance and learning from assurance processes across Health and Social Care underpin and inform the design of outcomes to support Place Based Care (Integrated care).

- Commitment to gain feedback from patients, their families and carers which will be used to inform indicators and outcomes when redesigning services and measures. This is in line with NHS England Policy.
- To embed the application of Quality Impact Assessment (QIA'S) methodologies within Harrow CCG, this in turn will support the Quality, Innovation, Productivity and Prevention (QIPP) service model changes and financial plans.

From our engagement sessions we have learnt that the following are key priorities for our patients and carers:

Key priority for our patients and carers	What We Will Do
Be open and transparent and be honest when things do not go as planned	We continue to undertake audits and to manage complaints we receive robustly. We monitor provider quality through our Clinical Quality Groups and constantly review whether we are seeking sufficient and appropriate assurance of the quality they are receiving, something we obtain through direct and indirect patient feedback as well as a range of quality indicators.
Ensure care is delivered with compassion and that it is personalised to the needs of each person	We will monitor and review the trends and themes from our provider patient experience teams which includes; complaints, friends and family test results and patient surveys. Any concerns in relation to these will be explored via the Clinical Quality Review Group.
Ensure providers continue to have a safe and skilled workforce that feel valued in their work	We will continue to monitor the providers' safer staffing reports and their staff surveys via the Clinical Quality Review Groups and seek assurances and actions when there are concerns raised in relation to the workforce.

10.1 Our Quality Principles

The CCG Quality and Safety team apply the following principles to all of the work done within the CCG:

We will:

- Ensure these principles are embedded within our everyday quality and safety assurance systems and processes.
- Use a systematic approach to monitoring and improving quality with the patient at the centre and in the line of sight.
- Address any organisational barriers which hinder quality of care.
- Foster an open and transparent culture across the local health system.
- Maintain a systematic approach to proactive and early identification of service quality failures.
- Ensure there are robust links between commissioning priorities, the strategy and transformation plans and quality.
- Prioritise our quality assurance and improvement efforts developing an integrated approach with social care to reflect the Better Care Fund changes.

- Drive effective engagement with key stakeholders across BHH to achieve the delivery of robust measurable outcomes that reflect "what matters most to patients".
- Build work streams to define robust integrated quality & safety indicators that will deliver agreed Place Based outcomes.
- Ensure evidence based guidance & learning from assurance processes across Health and Social Care underpin & inform the design of outcomes to support place based care.
- Ensure "I statements" from patient's, families and carers engagement events are reflected in indicators and outcomes when redesigning services and measures.
- Ensure that governance and assurance mechanisms are appropriate to support "Place based" commissioning between the local authority and the CCG including: integrated pathways, integrated contractual monitoring (CQRG), integrated assurance visits, and shared quality improvement plans.
- Embed the application of Quality Impact Assessment methodologies across Local Authority and CCG QIPP **(**Quality, Innovation, Productivity and Prevention) & financial plans including commissioned providers.

Everything we do is focused on delivering high quality care for the population we serve and these Commissioning Intentions have been written to align with our vision, priorities and principles.

10.2 Homelessness

According to the latest Combined Homelessness and Information Network (CHAIN) data, 33 people were seen sleeping rough in Harrow in 2017/18, the third lowest in London, of which:

- 29 people were new (or sleeping rough for the first time) and 4 were returning to rough sleeping – this is actually the highest proportion of new rough sleepers in London (88%) but this may be partly explained by the overall reduction by 10 since 2016/17
- 18 were UK nationals, 6 from Asia, 4 were from Central or Eastern Europe, 2 from elsewhere in Europe, 2 from Africa and 1 person's nationality was unknown
- 8 had an alcohol need, 8 had a substance misuse need, 15 had a mental health problem (some will have had two or all three) and only 9 had none of these needs – broadly in line with the rest of London
- 8 were female, 25 male
- 19 were aged between 18-35, 11 were between 36-55 and 3 were over 55

According to the Ministry of Housing data, there were 825 households in LA arranged temporary housing in Harrow, the 11th lowest of the London Boroughs

To support the CCG will help by increasing access to health services and support wider efforts to prevent and relive homelessness. In summary, this includes:

- Training member general practice staff, using the HLP training package, on homelessness and the important role they can play in ensuring access to primary care for people experiencing homelessness

- Distributing the 'right to access' primary care cards to treatment centres and winter shelters across the Borough, to help homeless GP registration and access to primary care
- Working with the Council to better identify and support the health needs of people who are homeless, through conducting a homeless health needs assessment as part of the JSNA (using the HLP Toolkit) and through making connections between community services and the Council Outreach Team
- Supporting Urgent Treatment Centres in the Borough as well as Northwick Park Hospital to meet the new Homelessness Reduction Act Duty to Refer people at risk of or experiencing homelessness to the local housing authority, by sharing the guidance (I will send separately) and supporting connection as necessary with the Council.

10.3 Promoting Self Care in Harrow

Empowering individuals with the confidence and support to self-care wherever possible and visiting their family doctor only as required can give people better control of their own health and wellbeing. Many long term conditions may not be curable but can be better managed by patients through self-care, preventing ill health in the long-term.

A Self-Care Steering Group has been established with the aim of developing and sharing self-care and prevention activities across Harrow and aligning these with the local evidence gained via the recently launched Patient Activation Measure (PAM), an evidence-based tool which will measure an individual's skills, confidence and knowledge to manage their own health. These initiatives will ensure a Harrow wide approach to self-care to enhance the ability of all health, social care and third sector practitioners to promote and provide self-care.

The Self Care Steering Group is developing a work programme and will identify initiatives working with health, social care and third sector partners to further support work on promoting effective self-care across the communities in Harrow. 2018. During 2017 NHS Harrow CCG developed the Health Help Now app for smart phone and tablet PCs to assist patients in accessing care. The scope of the app has now widened to support health information and self-care advice on a wide range of health problems including diabetes. During 2018 the CCG intends to link the Health Help App to the NHS 111 service, increasing the scope for patients to self-manage their ailments. Additionally, the health Help App will be incorporated into the Integrated Care model during 2018 and 2019, giving access to third sector / voluntary sector service information to the public.

10.4 Safeguarding

The CCG commissions Providers to provide high quality care, which will include a strong focus on the principles of safeguarding and the actions required to keep the children, young people and adults at risk free from harm or abuse.

Harrow CCG has comprehensive and robust roles, systems and processes in place to protect and safeguard vulnerable children, young people and adults at risk. There is a Safeguarding Strategy and Safeguarding Policies available via the CCG website for further information. The CCG has a robust governance structure for safeguarding with a direct route from the Designated Professionals to the Quality Safety and Clinical Risk Committee.

The CCG will work with its providers during 18/19-20/21 to enhance the safeguarding arrangements that support the safe delivery of local services.

Harrow CCG is committed to the future safeguarding children arrangements that have been discussed as a result of the change in legislation with the Children and Social Work Act 2017.

The CCG has opted to support Model 2 which has a senior Strategic Group comprising of the 3 main partners, CCG/LA/Police and a Multiagency Safeguarding Children Panel. The proposal supports combining children and adult safeguarding within the Strategic Group, and having a Children's Panel and Adult Safeguarding Board separately but combining some of the sub-groups where there are issues pertinent to both adult and children's safeguarding. The CCG supports the reviewing of the new arrangements after a period of two years with the aim to encompass the work of Safer Harrow into the safeguarding arrangements across the borough of Harrow.

The CCG commits both financial support and payment in kind to ensure the proper functioning of the new arrangements to ensure children and young people are protected from harm and abuse. The CCG understands that this partnership is dependent on all partners contributing the same level of support and funding and therefore the expectation is that all of the services commissioned by the CCG will show this level of commitment.

Delivery partners and commissioners will be expected to contribute funding to support the implementation of these revised safeguarding arrangements

We will continue to:

- Ensure the statutory posts of Designated Professionals are supported in their role to provide leadership and expertise in safeguarding.
- Be active members of the Harrow Safeguarding Children Arrangements and Harrow Safeguarding Adults Board.
- Work in close affiliation with the Continuing Healthcare team who manage and support some of the most vulnerable Children and Adults in the

community.

- Ensure the findings of Serious Case Reviews/Adult Reviews/LeDeR/Child Death/ Domestic Homicides/CQC Inspections/SI investigations and Multi-Agency Audits are embedded in commissioned services to ensure better outcomes for the Harrow population.

Our Safeguarding Priorities	What We Will Do
Listening to children & young people and adults at risk	Work with Providers to ensure the voice of the child is present and considered in service provision. Making Safeguarding Personal: work in partnership with local and neighboring social care services to protect adults and promote wellbeing within local communities to ensure a personalised approach that enables safeguarding to be done with, not to, people.
Safeguarding Education and Training (Children & Adults)	Work with Providers to ensure safeguarding training for both children and adults at risk are in accordance with the Intercollegiate Documents. Will seek assurance from Providers with completion of the Safeguarding Health Outcomes Framework (SHOF) on a quarterly basis
Child Protection Medicals	Commission services to: • Provide child protection medicals of a good standard and ensure there is a timely response for children suffering harm. • Support the work carried out by the CSA Hub to ensure all children receive an appropriate service that best meets their needs.
PREVENT	In accordance with the Counter Terrorism Act 2015, the CCG will ensure all staff and providers have received the relevant levels of Prevent and WRAP training in accordance with the Prevent Training Competencies Framework. The CCG will work with Provider organisations to ensure their PREVENT policy sits alongside the organisation's Safeguarding Adults at Risk Policy and the Safeguarding Children Policy
Domestic Violence and abuse	Monitor compliance with NICE Guidance 2016 to ensure that staff are trained and that victims and families at risk are identified, assessed and referred to appropriate care. Review Provider activity including training.
Support Providers in ensuring "the Whole Family Approach"	Work with Children and Adult Services to develop a robust approach to service provision which includes links to support networks for children and adults at risk of, or suffering as a result of, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), Female

is embedded in services	Genital Mutilation (FGM), Toxic Trio, Human Trafficking and Modern Slavery.
Information Sharing	Continue to highlight responsibilities and importance of information sharing and support the CCG and Providers to share information appropriately. Adhere to the national and local Multi Agency Safeguarding Information Sharing guidance. Adhere to the General Data Protection Regulation (2018) as per the Data Protection Act (2018) which empowers organisations to process personal data for safeguarding purposes lawfully, without consent where appropriate
Young Offenders, Children Looked After and Children with Disabilities and Additional Needs	Ensure the health needs of vulnerable groups of children are met including: • Children Looked After in the borough of Harrow and those placed outside of the borough • Children with Disabilities • Children with Additional Needs • Children with disabilities, mental health and additional needs who are transitioning into adult services • Young Offenders Support the work of the Child Death Overview Panel to ensure all deaths are reviewed and any learning is shared. Ensure all deaths of children with Learning Disabilities from age 4 onwards are reported to NHSE to go through the Learning Disability Mortality Review (LeDeR process).
Reduce the incidence of Pressure Ulcers	Work with providers to reduce harm to patients and achieve an incremental reduction in pressure ulcers along with further work to prevent pressure ulcers by encouraging all health providers to adopt the DoH guidelines (2018). This will help keep people safe and reduce inappropriate safeguarding referrals to the Local Authority.
Ensure adults at risk are protected from avoidable harm	Prioritise and promote awareness of abuse and harm to ensure a positive experience of care in a safe environment. Prioritise "Best Interest" of Adults at Risk.

Section 11: List of Abbreviations Used

Term	Meaning	Term	Meaning	Term	Meaning
A&E	Accident & Emergency	AEC	Ambulatory Emergency Care	ICP	Integrated Care Partnership or Alternative Care Pathway
ACO	Integrated Care Organisation	AF	Atrial Fibrillation	AIDS	Acquired Immune Deficiency Syndrome
BCF	Better Care Fund	BHH	Brent, Harrow, Harrow CCGs		
COTE	Care of the Elderly	CCG	Clinical Commissioning Group	CSE	Child Sexual Exploitation
CQC	Care Quality Commission	CQG	Clinical Quality Group	CYP	Children & Young People
CHD	Chronic Heart Disease	CHF	Chronic Heart Failure	CNWL	Central & North West London NHS Foundation Trust
CKD	Chronic Kidney Disease	CMC	Coordinate My Care	CHC	Continuing Health Care
CIE	Care Information Exchange	CIP	Cost Improvement Programme	CVD	Cardio-Vascular Disease
CATS	Community Assessment & Treatment Service	CAATS	Clinical Advice & Triage Service		
DES	Directed Enhanced Service	DTOC	Delayed Transfer of Care	DH/DoH	Department of Health
DNA/s	Did Not Attend/s				
ENT	Ear, Nose & Throat	EoL	End of Life	EGAU	Emergency Gynae Assessment Unit
ED	Emergency Department				

FT	Foundation Trust				
Term	**Meaning**	**Term**	**Meaning**	**Term**	**Meaning**
GP	General Practitioner	GPwSI	GP with a Special Interest	GB	Governing Body
HCCG	Harrow CCG	HAI	Healthcare Acquired Infection	HF	Heart Failure
HRG	Healthcare Resource Group	HENWL	Higher Education North West London	HWB/HWBB	Health & Wellbeing Board
IT	Information Technology	IV	Intravenous	IPP	Independent Pharmacist Prescriber
ICP	Integrated Care Programme	IAPT	Improving Access to Psychological Therapies	IM&T	Information Management & Technology
ICO	Integrated Care Organisation	IUC	Integrated Urgent Care		
JSNA	Joint Strategic Needs Assessment				
LA	Local Authority	LIS/LES	Local Incentive Scheme Locally Enhanced Service	LoS	Length of Stay
LAS	London Ambulance Service	LAC	Looked After Children	LTC	Long Term Condition
LD	Learning Disability	LBH	London Borough of Harrow	LNWH	London North West Hospitals NHS Foundation Trust
MCP	Multi Care Provider	MMT	Medicines Management Team	MSK	Musculo-Skeletal
MH	Mental Health				
NWL	North West London	NEL	Non-Elective	NES	Nationally Enhanced Service
NHSE	NHS England	NEPTS	Non-Emergency Patient Transport Service		

Term	Meaning	Term	Meaning	Term		Meaning
OBC	Outline Business Case		OOA	Out of Area	OOH	Out of Hours or Out of Hospital
PHB	Personal Health Budgets		PPC	Primary Procedure Code	PYLL	Potential Years Life Lost
PHE	Public Health England		Pt/Pts	Patient/s	PTS	Patient Transport Service
PPE	Public & Patient Engagement		PCC	Primary Care Contract		
QIPP	Quality, Innovation, Productivity & Prevention					
RTT	Referral To Treatment		RA	Rheumatoid Arthritis	RBH	Royal Brompton & Harefield Hospitals NHS Foundation Trust
SRG	System Resilience Group		STI	Sexually Transmitted Infection	SaHF	Shaping a Healthier Future
SSoC	Shifting Settings of Care		SCR	Shared Care Record or Summary Care Record	STARR	Short-Term Assessment, Rehabilitation & Reablement Service
STP	Sustainability & Transformation Plan					
UCC	Urgent Care Centre		UEC	Urgent & Emergency Care		
WSIC	Whole System Integrated Care		WTE	Whole Time Equivalent		
ZLOS	Zero Length of Stay					