Harrow NHS
Primary Care Trust

Harrow Primary Care Trust

Primary and Community Care Strategy

2008/9 – 2012/13

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1. Introduction

This strategy document sets out Harrow PCT's vision for Primary and Community Care over the next five years. The plan describes the current services, a case for change, identifies the key areas for development and outlines the model for delivery.

The strategy relates to all areas of primary and community care including general medical (General Practice) services, community pharmacy, NHS dentistry, primary care optical services and the full range of community based services predominantly delivered by community nurses, health visitors and allied health professionals. The strategy focuses upon the delivery of 'out of hospital' services through a model of integrated care that ensures high quality and local services are available to residents when they need them.

Implementation of the PCT's Primary and Community Care Strategy is integral to the delivery of the PCT's Commissioning Strategy Plan (CSP) for 2008/09 to 2012/13. The vision and goals set out in this document are aligned to those of the Strategic plan and the enhanced quality and scope of primary and community care is a pre-requisite for the delivery of the PCT's strategic initiatives to:

- Enhance choice and control for Harrow residents
- Enhance maternity services
- Improve services for children and young people
- Reduce the incidence of vascular disease and cancer
- Deliver high quality treatment of vascular disease
- Target services to meet the needs of the most vulnerable groups
- To ensure responsive community services for those with learning Disability or Mental illness
- To ensure choice of high quality and timely services at the 'End of life'

This strategy recognises the important role effective primary and community care services must play in reducing health inequalities, reducing demand on acute services and enhancing the patient experience. In line with the CSP for the PCT it aims to:

- Promote health improvement and the well being of local residents in primary and community care settings
- Deliver localised care wherever possible, ensuring residents only have to access more centralised or hospital care when it is absolutely necessary
- Ensure equity of access to all services regardless of geography, gender, ethnicity, age or physical ability and help address inequalities where they exist
- Deliver seamless health and social care services to local residents through the integration of service delivery models
- Deliver an enhanced quality of service making the best use of available resources

2. Background

Harrow PCT currently commissions a full range of primary and community care services for residents. Primary and Community care is provided by:

- 38 general medical practices
- 48 dental practices and three NHS orthodontic practices
- 58 community pharmacies
- 34 Opticians
- A range of community services (including community and specialist nursing, health visiting, urgent and intermediate care)

Harrow can be justly proud of our primary and community care services and the dedication of the staff who work in these services, providing high-quality care to patients. More than 90% of all patient contacts with the NHS take place outside hospital with staff that work in the areas listed above.

However, we need to ensure that high-quality care is a consistent part of everyone's experience of primary and community care. Services need to evolve to reflect the changes in healthcare and society, rising expectations, advances in treatments, the changing nature of disease and the evolving nature of the workplace described in the Next Stage Review - High Quality Care for All (Department of Health, 2008).

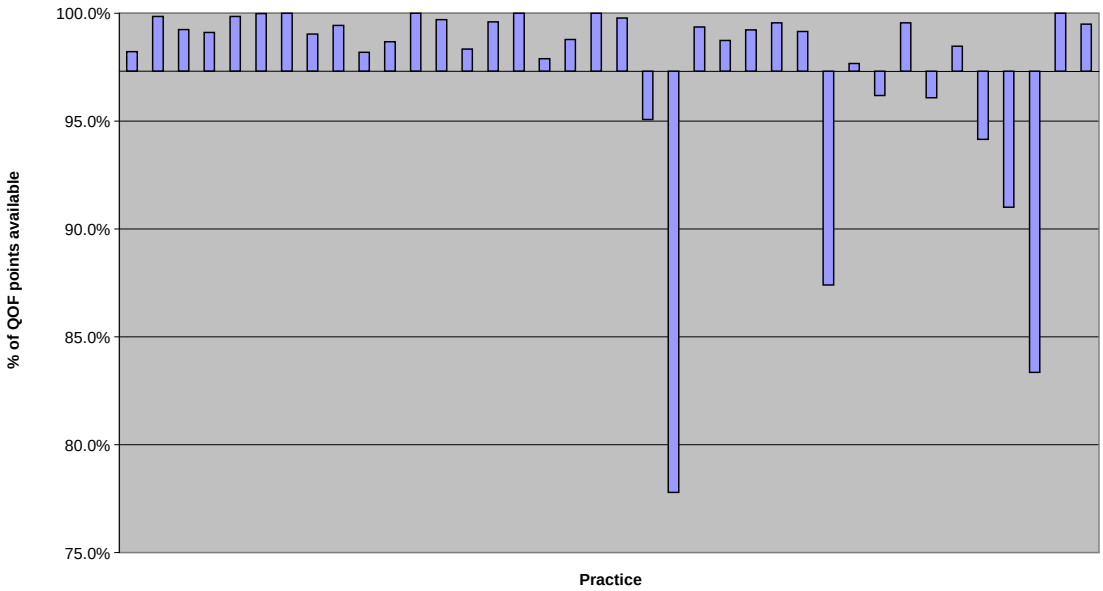
Current models of care within Harrow have been influenced by a number of factors, not least the geographical position of the borough allowing relatively easy access to NHS services across boundaries in Hillingdon, Brent, Ealing and Hertfordshire, and to a number of major teaching and specialist hospitals in central London. Default use of hospital based services has been compounded by the patchy development of high quality services within community settings. There is a compelling case for change - primary and community care services are under developed, not well integrated and the variation in the quality of provision is too high.

2.1. Current Service Provision

Harrow is 'well-doctored' with comparatively low levels of GP vacancies and consistently achieving well above average levels of QOF performance. Practice list size ranges from 1,600 to 15,000 and eleven practices are currently single-handed. The PCT also commissions a 'Greenfield' general practice service for 'Hard to Reach' groups.

At present only eight practices work from purpose built accommodation and smaller practices are largely based in poor quality buildings leading to historical inequalities in terms of accessibility and service provision. Even larger practices have limited space to develop additional services.
Despite high levels of QOF performance (97.6% in 2007/08) and good reported access to services (24/48 hour access targets), other markers of quality (screening rates, immunisation targets, data quality) and surveys of patient experience suggest that quality is variable in both clinical and non-clinical areas. Table 1 shows the performance of Harrow practices against the average performance for 2007/08.

Table 1- General Practice QOF performance in 200708 compared to the average (97.6%)



The variation in key measures of performance is significant. Table 2 provides one example of the variation in clinical performance in the treatment of diabetes.

Table 2 – Percentage of diabetic patients with an HbA1c of 7.5 or less, recorded in the previous 15 months

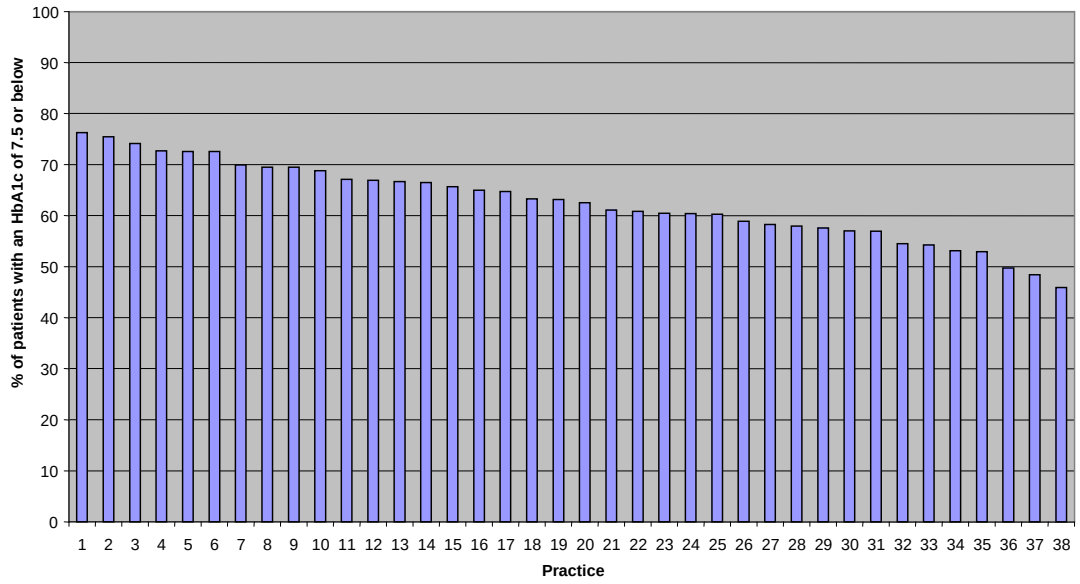
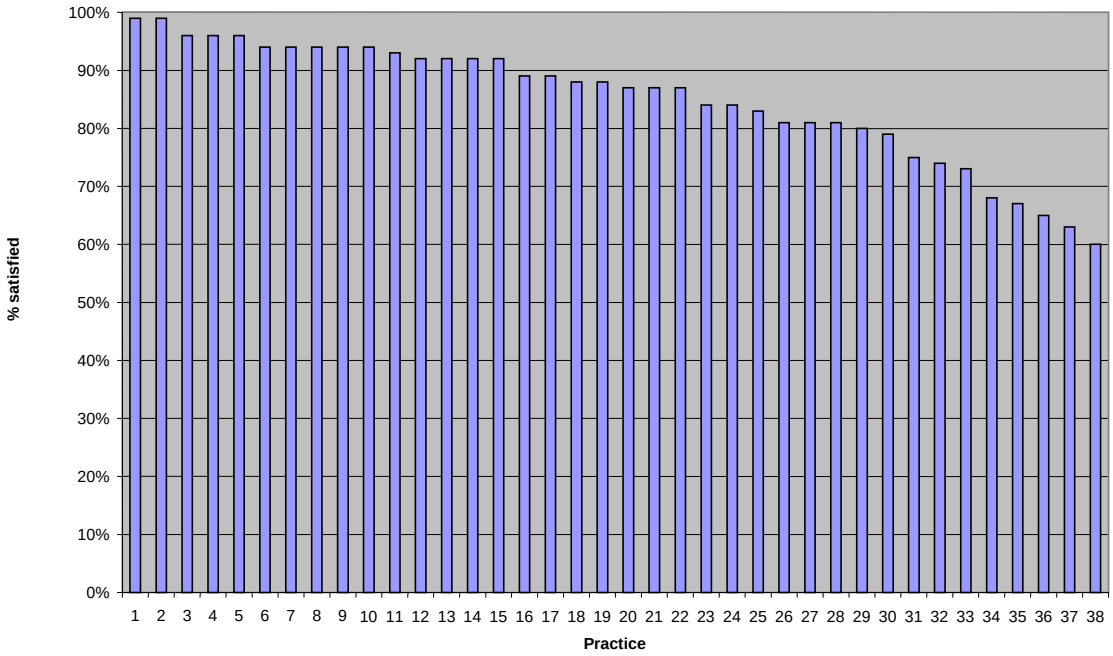


Table 3 shows the variation patient reported access to services:

Table 3 – Percentage of patients able to book an appointment within 48 hours



In 2008/09 the PCT prioritised the development of a balanced scorecard of general practice performance. The scorecard provides a method of assessing general practice through a performance framework that brings together a range of new and existing performance indicators. The information in this performance framework will guide the PCT and practices in the development of primary care services that deliver the highest quality general practice to all Harrow patients.

The scorecard is updated quarterly and the 2008/09 Quarter two summary Scorecard is displayed in Appendix One. Again this demonstrates real variation in performance across practices, with several practices achieving well above the expected standard across the board and others failing to meet the minimum standards in the majority of indicators. Variation is particularly marked in the indicators relating to access, patient satisfaction and screening rates.

Despite this variation, the patient guarantees within the new GMS contract have not delivered the expected levels of patient mobility and generally there has not been a large shift of patients from low quality to high quality practices. General practice has been extremely stable and Harrow, like many other areas, has seen GPs continuing to practice and own practices for longer. Patients should be able to access information about the quality of provision in order to make choices about their care. This scorecard is publicly available and represents a first step in facilitating that choice.

Access to NHS dentistry is good with the majority of practices accepting new patients and short waits for appointments. The Harrow Community Dental Service provides specialist care from the Alexandra Avenue Health and Social Care Centre in South Harrow for children and adults with complex needs and learning or physical disabilities. Services are also available through North West London Hospitals NHS Trust for people with special needs who require treatment in an acute setting.

However, uptake of NHS dentistry has decreased in the last ten years with only 50% of the resident population reported as accessing dental care in June 2008. In addition, oral health of children, particularly those 5 years and under is poor, in Harrow with the rate of decayed, missing and filled teeth (DMFT) at 1.96, higher than both the rates for London (DMFT 1.6) and England (DMFT 1.45) (Pitts NB et al, 2007).

Harrow's pharmacies provide the full range of essential services (such as dispensing or repeat prescribing). In addition most provide, or have the capacity to provide, more enhanced services like medicines management or weight management across the borough. However their integration or joint working with other services such as general practices or social care has been limited to date and the PCT must take action to maximise the potential of community pharmacy to deliver the integrated patient centred care described by the Pharmacy White Paper (Department of Health, 2008) and the Next Stage Review (2008).

Like many areas in the country commissioning of Optical services is not well developed. Opportunities to provide extended services as an alternative to secondary care referral have been developed on a pilot basis and the PCT has taken steps to better engage with and develop priorities for this area of provision. From August 2008 all Opticians in Harrow who wish to provide NHS optical services must have a contract with Harrow PCT. Similarly, from August 2008 any Optician who wants to work in Harrow must be required to be on our Performers List or that of another PCT. This is a new responsibility for the PCT which has been implemented over the last six months.

The majority of community services within the borough are provided by the PCT's provider services. 255 wte staff provide services from five community clinics, an intermediate care unit, in acute settings, from General Practices and in people's homes. These services include a wide range of nursing services - school nursing, health visiting, district nursing (including older people's health advisory service and a residential home nursing team) and a specialist nurse team for Diabetes and Coronary Heart Disease. Intermediate care is provided through a rapid response team (HART) supporting prevention of admission and facilitated discharge and through the provision of a small number of community beds.

In addition Harrow's Physical Disability Support Team, community learning disability service, podiatry, community dentistry, community specialist HIV/AIDS Nursing, Continence advisory service, Tissue Viability service, Palliative Care Service and the Harrow's Falls Service are all delivered through the provider arm. Community mental health services are provided by Central and North West London Mental health Foundation Trust and Community paediatrics, therapies and family planning are provided by the local acute provider, North West London Hospitals NHS Trust.

2.2. The Case for Change in Harrow

Although PCT operating and strategic commissioning plans have described and delivered an enhanced scope of primary and community care through increased allocations in these areas (see Tables 4 and 5) and service redesign, there is a compelling case for a step change in the commissioning of primary and community services if local services are to reduce health inequalities, enhance the quality and range of services delivered out of hospital and meet the rising expectations of modern healthcare services.

Table 4 - Primary and Community Care Allocations

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Primary Care	26,720,786	28,810,698	29,563,686	30,007,141	30,457,248	30,914,107	31,377,819
Dental	6,843,150	7,261,482	8,098,999	8,220,484	8,343,791	8,468,948	8,595,982
Pharmacy Contract	1,115,000	1,417,403	1,897,000	2,048,760	2,212,661	2,389,674	2,580,848
Prescribing	29,795,000	30,232,597	29,977,000	32,375,160	34,965,173	37,762,387	40,783,378
Community Services	21,909,000	21,912,000	15,253,000	15,680,084	16,119,126	16,280,318	16,443,121
Total Allocation	86,382,936	89,634,180	84,789,685	88,331,629	92,098,000	95,815,433	99,781,147

Please note – Reduced allocation in community services from 2008/09 onwards following transfer of wards to another provider

Table 5 - Primary and Community Care Investments in 2008/09

Primary Care Investment	£'000
Premises	240
UCC	900
Access Development	250
LES Health Promotion/Screening	330
MMR	30
HP Vaccine	18
Total	1,768

Community Investment	£'000
Harrow Learning Diifficulty Team	100
Case Management	50
Intermediate Care	200
Continuing Care - Older People	50
HP Vaccine	44
Total	444

Harrow can point to key strengths and pockets of service excellence within local services. The PCT has developed GPSI roles and extended scope practitioners in seven major specialities and has moved more than £1.4 million of outpatient activity into primary care through the development of a Clinical Assessment Service (CAS). Patients are triaged and where clinically appropriate seen by primary care teams at a choice of community locations for Dermatology, Cardiology, Neurology, Ophthalmology, Gynaecology, Urology and Gastroenterology. The PCT has also invested in the clinical skills of general practice teams in Diabetes and Cardiology to allow for enhanced management of these conditions in the community supported by specialist nurse teams.

In 2008/09 the PCT established an Urgent Care Centre at the Northwick Park Hospital site that is regularly seeing 100 minor attendances each day. This activity is re-directed from the front door of the A&E department by a 'Navigator Nurse' successfully relieving the burden on the A&E department. The PCT has successfully extended the opening hours of 80% of general practices allowing for opening in the evenings and at weekends and has developed a series of enhanced services to incentivise the clinical activity over and above QOF upper thresholds of performance and to improve the uptake of vaccinations and screening programmes.

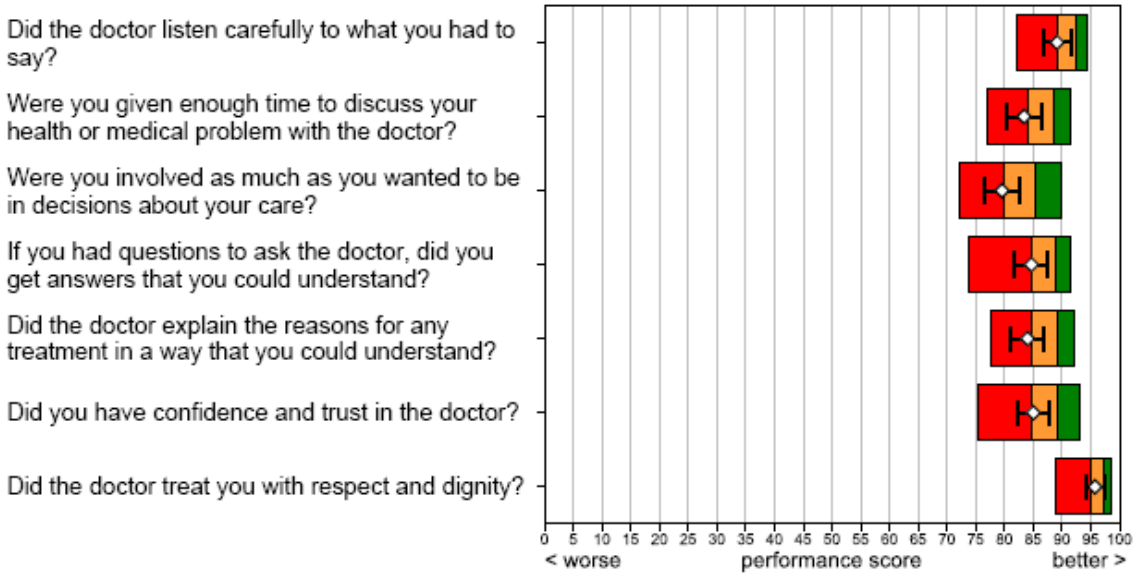
In community services the PCT is currently piloting a Single Point of Access (SPA) to better co-ordinate the use of community services to avoid unnecessary admission to the Acute Trust. The PCT has also invested in enhanced intermediate care provision increasing the capacity of the HART team and introducing 12 new intermediate care beds into the community.

In addition Harrow was successful in its application to become an early implementer of the development of the first Polyclinics in London - a Polyclinic facility will provide a full range of integrated primary and community care services to the population of South Harrow. In addition the PCT will open a GP led Health centre in Pinner, Harrow co-locating the full range of independent contractors and community services. Opening in April 2009 both facilities will provide extended access to urgent care facilities, diagnostics and outpatient services in the community as well as seeing patients regardless of where they are registered seven days a week between 8am and 8pm. The establishment of these facilities alongside the development of existing general practice in South Harrow will represent the first phase of delivery of the PCT's poly-system model of care for prioritised areas of the borough (see section Five).

There are however a significant number of challenges for the next five years. The PCT has worked with stakeholders to better understand the quality and performance of services, the financial sustainability of existing models of care and the views of residents upon the services they receive. This review, when taken together with the need to deliver the prioritised goals of the PCT's Strategic plan, highlight clear reasons for change.

Although patients report some areas of high satisfaction with primary and community care services it is clear that services are not yet meeting patients' expectations. The Balanced Scorecard for General Practice (Appendix One) shows a marked variation between patient feedback between practices and Table 6 shows that satisfaction with GP services overall do not compare favourably with other PCTs - Harrow scoring amongst the worse performing 20% of trusts in a number of areas.

Table 6 – Benchmarked report for satisfaction with seeing the GP



Healthcare Commission National survey of local health services 2008: Harrow PCT Report

Patients have, however, expressed how much they value the personal relationship and continuity of care they receive from their doctor and highly value the 'cradle to grave' experience general practice offers. This strategy is committed to preserving this relationship between the GP and patient.

Satisfaction with pharmacy services is also comparatively low. In the 2008 PCT Survey when asked about any advice received from pharmacists about medicines, only 60% of patients were entirely satisfied with the advice received compared to 70% nationally

In contrast, satisfaction with NHS dentistry is high in Harrow. In the 2008 PCT Survey less than 10% of patients reported having difficulties in getting an appointment within three weeks compared to 17% nationally. Similar satisfaction levels were achieved in the 2007 Patient and Public Involvement Dentistry Watch survey with 98% of patients reporting that they were happy with the treatment they received at their dentist.

It is clear that expectations of primary and community care are changing. People value the personal service they receive but also:

- Have far higher expectations of the quality, accessibility and personal competence of our local independent contractors and community nursing.
- Expect a greater degree of seamlessness between services and help with navigating the health and social care system.
- Are increasingly happy to exert their right to choose and be better health care consumers but need supporting advice from someone they know and trust.
- Want to take more interest in their own health and well-being and expect a service that will help them to take care of their diet, levels of physical activity and mental health.

The PCT's CSP outlines priorities for the prevention of ill health, health promotion and the quality of interventions particularly for vascular diseases. Although primary and community care services have played a clear role in these areas the level of intervention described by the PCT will require the commissioning of new and enhanced interventions in areas such as screening or smoking cessation. There will also be a requirement to change the model of care for many patients with long term conditions to ensure an integrated service response that secures health improvement. Also an emphasis on preventative healthcare, screening and self care delivered through primary and community care services will help identify and manage disease earlier and allow patients to take responsibility for their health too.

Current commissioning of primary and community care does not adequately develop or make full use of the skills and capacity of the available workforce and it is clear that variation in the performance of providers must be addressed if inequalities are to be addressed. High quality community services are particularly well placed to address health inequalities in the population, since they are often able to target resources to groups most in need, adapt care packages to meet individual needs and provide opportunistic health promotion in a timely manner or at times of greater receptiveness.

Primary and community care services have a key role to play in the demand management of acute activity to ensure patients are seen in the most appropriate setting for their care and that only the most cost effective pathways and services are commissioned.

Local and sector wide review of unscheduled care across the sector has shown a continued and high dependence on A&E, despite the PCT's interventions and the establishment of the UCC. Co-ordination of care in the community to avoid admission and facilitate discharge has often been poor. Audit and local comparison indicates that a large proportion of emergency activity could be better dealt with in the community.

Table 7 - Appropriateness of Emergency Admissions

PCT	% admissions for ambulatory care sensitive conditions (ACS)	% admissions 0 and 1 day length of stay
Brent	10.7	50.8
Ealing	11.7	52.4
Hammersmith & Fulham	11	53.5
Harrow	10.9	51.8
Hillingdon	10.1	55.6
Hounslow	11.3	51.8
Kensington & Chelsea	9.3	47.7
Westminster	10.2	50
Best performing PCT in London	8.5	40.8
Worst performing PCT in London	13.6	59.7

The ACS indicator in Table 7 shows the number of avoidable admissions by North West London PCTs; a low percentage represents good practice. This analysis indicates that Harrow is some way off the lowest level in North West London (9.3%) and suggests there is greater scope for reducing avoidable admissions in the borough. A high percentage of 0 and 1 day length of stay (LOS) admissions may indicate patients being admitted unnecessarily and that those patients might have been appropriate for community management. Again Harrow is some way from the lowest rates in the sector. In planned care it is clear that general practice in particular has been engaged in the delivery of new pathways and the use of a clinical assessment service to manage demand for outpatients. However this activity has only related to a relatively small number of pathways and there is clear and available evidence to suggest that the introduction of more one stop clinics and the delivery of more outpatient services in the community can be achieved.

Demand management for planned and unplanned care will be dependent upon the availability of services in the community and the infrastructure to support them. Primary and community teams will need appropriate access to diagnostics and to be networked into multi-disciplinary teams of professionals that will allow for the management of patients in this setting.

Essential to the delivery of a wider range of services in the community, is having high quality, modern facilities in places local to peoples homes. In a recent survey of all PCT and GP sites one third of general practice premises did not meet the DDA requirements while only a small number of GP and PCT sites were identified as having potential for substantial increases in capacity if they were modernised or re-developed. It is clear that the PCT needs to identify new and existing sites for development if it is to achieve the expansion in services

planned. This is particularly important for the integration of community teams and other primary care teams – a relationship that is limited by the availability of contact points for those services. The development of a Polyclinic in South Harrow and a GP led Health centre in Pinner, Harrow will begin to allow new models of care to be delivered in modern facilities but the PCT has a far wider challenge to establish this level of infrastructure and integration across the borough.

Changes described in this document aim to preserve and exploit the known strengths of local services whilst driving for improvement to address gaps and challenges. They also recognise that the separation of PCT commissioning and provider functions provides scope to formalise contractual relationships and to use contractual levers to secure change in service delivery, quality and performance. This step change in the performance and capacity of Primary and Community care is a necessary pre-requisite for the wider change the PCT describes in its Strategic plan for 2008/09 to 2012/13. The implementation of this strategy seeks to ensure the effective contribution of primary and community services to the delivery of the overall Strategic goals and initiatives of the PCT.

2.3. The Next Stage Review – High Quality Care for All

Our Health, Our Care, Our Say (Department of Health, 2006) outlined a vision for primary and community care services available to people in their local communities or in their own homes, avoiding unnecessary trips to hospital whilst making services more personal and effective. The Next Stage Review went further producing 'Our vision for primary and community care' (Department of Health, 2008). This document acknowledges the strengths of current services but is equally clear about the challenges for the future, summarised below:

Strengths	Challenges
• Personal continuity of care and strong ties to local communities	• Services do not fit together and are confusing to navigate
• Professional ethos and high level of patient trust	• People want more involvement in their health and care
• Improvements in the quality of care (e.g. for the treatment of Long Term Conditions)	• Unwarranted variability in quality and access to services
• Progress in bringing together health and social care	• Changing public expectations, technology, demographics and the nature of disease

The vision outlined by the review calls upon PCTs to work with local stakeholders to lead work to ensure that:

- People shape services
- Action is taken in promoting healthy lives
- We continuously improve quality

In addition the Next Stage Review sets clear expectations for the leadership of local change, both for PCT's as World Class Commissioners and through Practice Based Commissioners harnessing and using clinical leadership and engagement to full effect.

The strengths and challenges identified nationally are particularly relevant in Harrow and they give emphasis to the PCT's role as strategic commissioners of health and healthcare, committing to stronger partnership with the London Borough of Harrow and our clinicians as professionals and practice based commissioners of care.

2.4. Healthcare for London

Healthcare For London - A Framework for Action (NHS London, 2007) sets out the need to develop new models of community based care at a level that falls between current GP services and the traditional district hospital. Part of this vision is to ensure patients get treated at the right time, by the right clinician, in the right place. By providing more care closer to home and enhancing primary and community provision, the role of the local hospital will change.

Two areas of the framework for action are particularly relevant to the development of this strategy - Polyclinics are identified as a providing part of the solution to more flexible care by offering a much wider range of high-quality services, over extended hours, to the community – reducing the need for patients to visit hospitals and other services. As an early adopter Harrow PCT will ensure patients receive enhanced access to integrated primary and community care services at the Alexandra Avenue for Health and Social Care before establishing further facilities across the borough in future years.

Healthcare for London has also established an unscheduled care project which has reviewed unscheduled care arrangements in a number of PCT areas in London alongside analysis of key policy and literature documents and discussions with stakeholders to establish a firm case for change along the following areas:

- Earlier intervention and support could prevent people choosing to enter or defaulting to the unscheduled care system to have their needs met
- Access to care needs to improve and be more responsive to patients' needs and expectations
- The system needs to be less complex and easier to understand and navigate for patients
- Standards and quality can be more consistent and improved across the spectrum of care in community and hospital services
- Improving the way that the unscheduled care system works as a whole will improve care and patient experience and make better use of resources; the system should be designed around patient's not organisational boundaries or institutions.

The Framework for Action specifically proposed that improvements in accessing urgent care could be achieved by enhanced face to face contact, by establishing urgent care centres at the front end of hospitals and in community settings.

The vision developed by Healthcare for London is reflected and developed by the recommendations of North West London's Clinical Reference Group. Both are reflected in this document, the Collaborative Commissioning Intentions for the sector and the PCT's CSP.

3. A Vision for Primary and Community Care in Harrow

Harrow residents will be able to choose and experience high quality health care services provided in modern, clean and accessible environments. Services will be integrated and responsive; they will place greater emphasis on prevention and self management and will be delivered closer to home.

Primary and community care services will work closely with social care to minimise existing health inequalities and give priority to promoting health and well-being across the borough. When people do fall ill they will have easy access to consistently high quality responsive primary and community based services. These services will cover a broader range of services than at present, expanding to include more diagnostic tests, enhanced management of all long term conditions; one stop outpatient clinics and integrated health and social care provision. This expanded set of services will be provided by a range of providers which will increase choice and ensure patients are seen by the most appropriate clinician or practitioner. As a result patients will only attend acute hospitals when their care necessitates surgical, inpatient or medical facilities that primary and community services cannot provide.

This vision will be achieved by taking action to secure:

- Health improvement
- The quality of health services
- Better access to and choice of services
- Enhanced integration of service delivery
- Better infrastructure to support delivery

Sustained delivery of service excellence in each of these areas will be underpinned by a robust model of co-ordinated local care and will only be achieved by innovative and effective local leadership for change.

Consultation with the public, service users and where relevant specific patient groups will continue to ensure that services are structured to meet their needs, create simpler pathways and deliver sensible service integration.

4. Initiatives

The vision set out by this strategy will require a step change in the organisation, delivery and performance of primary and community services. This will be achieved through effective commissioning to deliver change in the following five key areas:

4.1. Health improvement

People can expect to receive services that help them to stay healthy or become healthier and fitter. Harrow's primary and community care services will work in partnership with social care and the third sector to ensure residents can lead as full a life as possible and regain control of their lives following ill health.

The PCT's primary and community care services play a critical role in preventing ill-health today, providing programmes of immunisation, screening, counselling and health promotion advice. In line with the PCT's CSP that gives particular priority to the prevention of vascular disease and cancer and the health of Harrow's most vulnerable groups, commissioning of primary and community care will now place even greater emphasis on creating opportunities to promote health and well being.

Over the next five years the PCT will recognise the central role that these services should play in promoting healthy lives for our population by taking action in the following areas in support of the PCT Strategic initiatives:

Primary Care

In 2008/09 the PCT established a portfolio of enhanced services to be delivered by primary care teams to enhance health promotion and screening activities. These included established enhanced services focused upon obesity, Chlamydia and CHD risk registers in addition to the new enhanced services outlined below. The PCT will align the current portfolio of enhanced services to ensure they reflect the initiatives outlined by the CSP and will work with practices to ensure the delivery within those services.

The enhanced services established in 2008/09 are:

Heart failure - Practices will hold and maintain a register of patients diagnosed with Heart Failure and will be rewarded for the number of patients with a current diagnosis of Heart Failure due to LVSD who are treated with a beta-blocker.

Alcohol - Practices will be required to screen newly registered patients aged 16 and over using either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire. When relevant patients are identified the practice will deliver a brief intervention to those identified as drinking at hazardous or harmful levels. Dependent drinkers will be referred to specialist services.

Learning disabilities - Practices will have collated and aligned their patient registers with those held by the Local Authority and will attend a multi-disciplinary education session. They will then have to provide an annual health check to patients on the register covering health promotion, chronic illness and systems enquiry, a physical examination and other specific checks.

Osteoporosis - Practices will compile an audit of the proportion of women aged between 65 and 74 years with a history of fragility fracture in the previous 12 months who have had a diagnosis of osteoporosis confirmed by a DEXA scan, the proportion of women aged between 65 and 74 with a positive diagnosis of osteoporosis who are receiving treatment with a bone-sparing agent and the proportion of women aged 75 and over with a history of fragility fracture in the previous 12 months who are receiving treatment with a bone-sparing agent.

Ethnicity - Practices will record the ethnicity and first language of all patients on their list. This will include children and babies where ethnicity and first language will be as defined by the parent or guardian.

These nationally prescribed areas are of particular relevance to our local population and will support the delivery of CSP initiatives. In addition the PCT will use the Primary Care Balanced Scorecard to incentivise enhanced levels of performance for those practices that achieve the highest levels of performance and target support and development at those who do not achieve expected levels. These arrangements will focus upon areas of health promotion and preventative interventions.

New primary and community care services will also be commissioned in direct support of the CSP initiatives:

- A national programme of vascular risk assessment for people aged between 40 and 74 is currently being developed. Harrow PCT will work with GPs, pharmacies and other services in partnership with community or user groups to agree how best to deliver these checks in a range of community settings. In this way we will ensure that the programmes rolled out over the next three years are accessible to all patients. Primary and community care services will work collaboratively to provide access to individually tailored programmes that help people manage the risks identified through the checks, from lifestyle advice to preventive treatments.

- In addition to delivering the Learning Disabilities Directed Enhanced Service described below, the PCT will work with partner organisations to improve access to primary and community care services for people with learning disabilities and their carers while making those services easier to navigate.

- The PCT will continue to work with community pharmacists over the next five years to commission enhanced services that Pharmacists may deliver from their own facilities or to certain groups in the community with particular needs. This will include supporting immunization campaigns, screening and the choosing health priorities. In addition the PCT will develop a minor ailment scheme at the Alexandra Avenue Health and Social Care Centre for future role out across Harrow to support reduction in A&E attendances.

- Finally in order to promote better oral health the PCT will make full use of social marketing, publicising the accessibility of NHS dentists in Harrow and the benefits of attending one. The PCT has committed to increase the numbers of people attending dentists over the next five years. The PCT is investing in additional capacity to ensure the increased demand is met and good levels of access are maintained.

In order to improve the oral health of children in Harrow and especially that of the five years olds and under, we have launched the “Brushing for life” Scheme in partnership with the Local Authority through Harrow’s children’s centres, our health visiting services and oral health promotion services. This programme seeks to teach children and families good oral hygiene skills and the importance of attending a dentist regularly.

To maximise improvements in oral health we will adopt a common risk factor approach, by integrating oral health promotion to other priority health activities as follows:

- Incorporating oral health messages in the promotion of healthy eating and food policies for people of all ages and particularly for pre-school and school age children, in practices, at home, in school and at the work place
- Use health visitors, school nurses and health trainers as oral health promoters giving consistent messages re oral health & access to appropriate services
- Identify opportunities for oral health and general health promotion at nurseries, schools, children’s centres, etc, encouraging low-sugar diets, e.g. promoting five-a-day, healthy schools initiatives, restriction/control of foods in vending machines in or near schools

- Involving pharmacists in the promotion of oral health as part of the promotion of sugar-free medicines, smoking cessation and other health promotion initiatives that also benefit oral health

Community Care

The development of the new Child Health Promotion programme will integrate services for children by multi-professional groups working together more effectively for the benefit of the family. The role of the Health Visitor will be pivotal in the new child health promotion programme.

School nurses will increase their input into the implementation of the National Healthy Schools scheme aimed to improve, personal, social & health education, healthy eating, physical activity, emotional health & wellbeing. At the other end of the age spectrum Health Advisers for the Elderly will develop more targeted approach to identifying older people who would benefit form advice and support to maintain independence and well being.

Five Year Strategic Plan 2008/09 – 2012/13

Interventions within this initiative link directly to the delivery to the implementation of the PCT Commissioning Strategy Plan initiatives:

- Choice and control
- Vascular / cancer prevention
- Vulnerable Groups
- Children & young people
- Vascular treatment
- Learning Disabilities & Community Mental Health

4.2. The quality of health services

Patients will experience a consistently high quality of performance from our local primary and community care organisations and experience less variation in the performance of those services.

Better commissioning of primary and community care services will secure high quality services that demonstrate continuous improvement in response to patient needs, expectation and feedback.

The Professional Executive Committee of the PCT will play the lead role in the clinical development of services and the PCT will invest in PEC associate roles to take responsibility for and champion the re-design of services in line with this strategy, pro-actively visiting practitioners, case-managing performance issues, sharing good practice. These roles will work with the Medical Director and the clinical governance team to ensure the commissioning of related training and education programmes to drive up standards each year. The first PEC Associate roles will also take lead roles for specific clinical areas, starting with:

- Stroke and Older People
- Maternity Services
- Cancer

Primary Care

The PCT has already invested in local enhanced services to enhance the quality of general practice services, rewarding performance where achievement exceeds QOF targets. The PCT will implement the revised strategy for the Quality and Outcomes Framework (QOF) outlined by the NHS Next Stage Review (2008) as a recognised tool for driving up and sustaining quality improvements in general practice. This will include the new Patient Outcome Measures (PROMS).

The PCT will also build upon its commitment to develop best practice in primary and community care. The PCT will continue the enhanced level of investment in the primary care training budget agreed in 2008/09, across the next five years. The PCT will continue to support and enhance best practice / networking forums for independent contractors (including practice managers) and will invest in the primary care contracts team to employ a dedicated best practice facilitator across general practice.

The PCT's balanced scorecard of performance for general practice will allow benchmarked analysis of performance and will inform the commissioning and contracting of general practice allowing the PCT to focus resources on key and identified areas of development whilst ensuring appropriate remedial action is taken to address poor performance. In this way the PCT will pro-actively seek to understand variation in performance and address those outliers where variation can be shown to be unwarranted. This work will include an analysis of resources in each independent practitioner's contract, the monitoring of activity measures for primary care organisations for value for money and quality measures that reflect the concerns of professionals and patients. The balanced scorecard will focus on general practice in the first instance, rolling out to the full range of primary care providers over the next five years.

These performance assessment tools will also support the PCT and practices in preparing for the accreditation scheme that is currently being developed by the RCGP, due for roll out in 2010. The PCT's Medical Director will lead this process and the accreditation scheme will rigorously assess the systems used by GP practices to ensure safety and quality of practise and will identify areas where practices have most scope to improve quality.

Looking further into the future both the local performance assessment tools and the accreditation scheme should place practices in a better position when they become subject to regulation by the Care Quality Commission.

The PCT will use the new optical contractual regulations in force since August 2008 to develop a balanced scorecard for optometrists in order to monitor compliance and inform the range of training that will be made available to our optometric contractors.

In February 2007 the optical bodies jointly launched a clinical governance initiative called Quality in Optometry (QiO) which in turn produced a Clinical Governance toolkit for optometry. The PCT will be working with local optometrists to implement this toolkit from 2009.

The PCT has always been responsible for the safe provision of primary care to its population. We will continue to use our contractual powers to monitor the standards of primary care so as to identify and rectify poor performance as soon as possible, where this is not possible, remedial action will be taken.

Community Care

The introduction of the new NHS contract for community services will be used from 2009/10 onwards. This will strengthen the PCT's commissioning of these services, providing levers to improve business processes of community providers, strengthen accountability and improve performance. This will be achieved by introducing:

- Activity planning and review
- Demand management requirements
- National and locally-agreed quality standards
- Requirements on information flows and provision
- Dispute resolution arrangements
- Contractual Control mechanisms.
- Sanctions and / or incentives for performance on a small number of priority issues
- Locally-defined service specifications

A balanced scorecard approach for community services will also be developed, with Harrow PCT provider services being a pilot site for the Department of Health's information models

and community metrics programme. This will enable local services to contribute to the development of a scorecard and also gain early benefit from national developments.

Five Year Strategic Plan 2008/09 – 2012/13

Interventions within this initiative link directly to the delivery to the implementation of the PCT Commissioning Strategy Plan initiatives:

- Choice and control
- Vascular Treatment
- Vascular / cancer prevention
- Vulnerable groups

4.3. Better access to and choice of services

Over the next five years Harrow residents will have access to responsive services and will be encouraged to exercise their choice in terms of where they access care and from whom.

Primary Care

Patients can expect to have a greater choice of when and how they 'get into' local services and care. In general practice the PCT will move, over the next five years to commission services that ensure all registered patients will be able to access a GP of their choice between 8:00 am to 8:00 pm Monday to Friday.

By April 2009 patients will be able to access bookable and walk-in appointments between these hours seven days a week whether they are registered, unregistered or registered somewhere else at two community locations. The PCT will actively commission this level of service from an extended set of locations across the borough during the period served by this plan (See section five).

Consequently the PCT will seek to ensure that services that complement general medical practice like pharmacy or family planning services are also available during those extended times. We will commission from existing and new independent providers to achieve these extended services across Harrow and patients will have access to the balanced scorecard for performance of general practices in order to inform their choice of service provider.

The PCT has already developed services that support a reduction in A&E attendances e.g. LES for extended practice hours. Currently 80 % of practices offer extended hours. These services are in addition to the current provision of an Urgent Care Centre at the Northwick Park Hospital site which allows patients with minor conditions to gain access to primary care where that is most appropriate for extended hours (8am – 11pm) everyday. (HfL: A Framework for Action para 160)

Practices are monitored for the number of patients attending walk-in centres, the Urgent Care Centre (UCC) and A&E departments to identify outliers and additional support offered where appropriate. The development of a single point of access (see below), polyclinics and GP led health centres gives additional opportunities to improve access to care, both in and out of hours. Patients will be able to book appointment at times that are more convenient to them with appropriate clinicians in locations close to their homes. (HfL: A Framework for Action para 124-135)

Although, Harrow has many providers of NHS dentistry, the PCT will also work to make those services available at more convenient times so that patients wishing to access those services can do so at a time that suits them. We must ensure that all adults and children with physical disabilities, learning disabilities, and complex medical needs have access to NHS dental services in appropriate clinical environments, whether that is at NHS dental practices, community dental services, hospital settings or in their homes by April 2009.

Improved access is not just about opening hours. It includes a wider range of services that are more closely aligned to each other to ensure the patient pathway is as smooth and seamless as possible. The PCT will commission services aimed at a closer integration of care. The organisation of services will better link primary care teams, such as GPs and Community pharmacists to community health and social care teams ensuring a co-coordinated response from district nursing, specialist nursing, social care, community rehabilitation and community mental health services. These will need to be aligned to ensure that the patient's needs are the focus of the multi-disciplinary team effort and not just a partial slice of care. These standards will equally be applied to community midwifery, community based care of elderly, palliative care support, End of Life care, Stroke and the management of urgent care.

The PCT has developed a single point of access (SPA) pilot for community services, designed to provide information to GPs and nursing homes and to support the prevention of admission in appropriate cases. The service will be developed to provide longer opening hours available to all providers and include patient information, advice and triage. The SPA will have the ability to direct patients into the most appropriate unscheduled care service, book patients for appointments with a range of clinicians and will be supported by a community based prevention of admission team. (HfL: A framework for Action para 175)

This team will be led by a Care of the Elderly Consultant and include specialist nurses and therapists. The team will act as a 'flying squad' to support patients to stay in their own homes where appropriate and design packages of care around the patient. In addition an elderly care assessment centre will be developed in the community offering holistic assessment including diagnostics where appropriate. (HfL: A Framework for Action para 176)

These developments will be provided to the highest standard and will continue to improve quality, choice and access. Co-ordinated working practice will be supported by the co-location of these services with easy access to diagnostics, specialist opinion and clear links back to general practice (section five).

In ensuring the PCT commissions a real choice of primary care services for Harrow residents it is important that we recognise that many care providers often commit their entire careers to a locality and as a consequence are able to offer great insight into local communities as well as the longer term health requirements of the community. This is an enormously rich resource for the PCT and provides a welcomed stability to future planning.

Independent small practices have provided health care to the population of Harrow since the inception of the NHS and have worked together to provide efficient and high quality services for the residents of Harrow for both health and dental care. However as the PCT commissions an increased range of services from independent practitioners it is anticipated that it will be increasingly hard for smaller practices to work in isolation. The PCT will recognise this and encourage and support practices in working together to provide extended services (e.g. opening hours). This is already happening in some areas with the most recent example being the re-provision of community based anti-coagulation services. We anticipate that there will be increased need for a more sophisticated and skilled practice management of these larger groups of practices. To support this we will be setting aside funding to develop practice management skills, recognising this development as a critical success factor.

The models of care outlined by the PCT's CSP do require significant levels of change and innovation and the PCT will seek to stimulate greater choice and innovation into the market where appropriate. There will be services which the PCT will commission through a competitive process, via the open market to ensure the PCT is driving up standards, supporting innovation and ensuring value for money.

Key to achieving these aims is capturing feedback from patients, carers and potential users of services through early consultation, patient satisfaction surveys and working with user groups or patient forums. In this way patients can help shape the services, guide integration and ensure that services are regularly reviewed and improved.

Five Year Strategic Plan 2008/09 – 2012/13

Interventions within this initiative link directly to the delivery to the implementation of the PCT Commissioning Strategy Plan initiatives:

- Choice and control

4.4. Enhanced integration of service delivery

Within five years local people will experience a pattern of services that is a closely knit network of publicly funded services, and partly self-funded services; provided by a mix of different suppliers.

The PCT will drive a step change in the integration of primary and community care services across the borough. Integrated provision should, in all cases, bring together NHS, third sector and social care staff into virtual teams that look after the same clients.

Models of care in Harrow must recognise and reflect the following while prioritising effective case management and addressing unscheduled care needs:

- That a client receiving social care will be well-known to their local GP / Practice Nurse; and may also be receiving care from a community nurse or therapist.

- That community teams will work to ensure patients are able to stay at home and will seek to avoid hospital admission wherever possible. Most people in this category have a chronic illness / end of life need related to diabetes, respiratory illness or heart disease, and are increasingly being case-managed by a Community Nurse and /or receiving support from the third sector.

- That if patients are encouraged to leave hospital as quickly as they are able to, and only to use Accident & Emergency in an emergency, the primary care and general practice teams must be able to call upon effective community services (District Nurses, Social Workers, Therapists supported by Home Carers) to care for patients at home.

- Patients often do not see health and social care support as separate needs and hence the strategy has to ensure we create the environment for a seamless service. This is in line with the transforming social care agenda.

Local service reviews are required to ensure that services such as discharge teams, community nursing and community mental health services are organised to reflect these challenges, recruiting to existing vacancies, and new posts required to support demand management plans (See section five). Such teams will be expected to work on co-located sites and these centres, or hubs, will need to have access to a full range of services as well as dedicated community mental health provision. For more and systematic integration between health and social care to succeed there needs to be a significant workforce redesign project, led at a senior level by Social Services and the PCT, to focus on creating integrated provider teams that support primary care's generalist, risk management role. (HfL: A Framework for Action para 175)

The PCT will increasingly work with the London Borough of Harrow to achieve an integration of service teams and to pilot Individual Budgets held by patients for their integrated care needs as part of promoting independence and well being. The PCT will equally develop its work with the third sector as a key partner in providing care to a number of patients particularly those who are vulnerable e.g. elderly, mental health patients.

The PCT has taken significant steps in developing its third sector commissioning of community and voluntary organisations over the last year. We have committed additional investment inviting bids across a range of service areas, issues and initiatives. The PCT will support further integration of services moving this area of commissioning within its mainstream commissioning process. Commissioning and contracting will be appropriate to the size of the contract but will focus on outcome measures, quality and develop the strengths of the organisations, adding value and helping to integrate at the interface between the medical and social models of services and interventions. The investment process has encouraged smaller organisation into the market place and networked partnerships between small and medium organisations encouraging shared learning. The PCT is committed to on-going investment to the 'Third' sector.

Five Year Strategic Plan 2008/09 – 2012/13

Interventions within this initiative link directly to the delivery to the implementation of the PCT Commissioning Strategy Plan initiatives:

- Choice and control
- Vascular / cancer prevention
- Vulnerable Groups
- End of Life Care
- Children & young people
- Vascular treatment
- Learning Disabilities & Community Mental Health

4.5. Better infrastructure to support delivery

Over the next five years patients will receive services from highly skilled, well trained and well motivated staff acting as champions for health and well-being. Where those services need to be delivered outside of the home they will be delivered in high quality estate within close proximity to patient's homes.

Although Harrow PCT is not an under doctored area (Information Centre for Health and Social Care: 61.5wte per 100,000 weighted population, above the threshold of 57.89wte per 100,000) and has established community services teams it will clearly need to commission additional capacity to respond to increases in demand as more services are provided closer to patients' homes. This, along with improvements in the care of long term conditions and other factors like increased patient choice and more access will be fed into workforce planning projections.

Workforce, Human Resources and Organisational Development

The future challenges for primary care demand that the PCT steps up its support and commitment to skills development of all primary care staff. To this end we will commission a detailed skills audit of our local GPs; how they would like to develop their portfolio and how this matches with the expected changing pattern of health care provision. From this piece of work we will develop a clinical sponsorship programme to ensure our existing clinical staff have the skills to deliver against the new clinical models of care. This will also help local GPs in the preparation for the future RCGP accreditation programme plan.

A similar exercise will be undertaken for our practice nurses as they also need investment in their clinical capability and capacity. Their training needs are not just about clinical skills which enable the practice to offer a wider range of services, but about basic training for safe working (Health and Safety, infection control, anaphylaxis) and skills towards clinical leadership (teaching, audit, committee work).

As the challenges to primary care continue and demands increase, practices need to be able to ensure they are fit for purpose. The role of the practice manager is critical in achieving this successfully. However the provision and quality of practice management is patchy across the PCT so we be offering a one day a week seconded role for an experienced Practice Manager

to work with practices on mentoring, developing and sharing the expertise that Practice Management can bring to the success of primary care. The PCT will also look to work with networks of practices on how they can jointly develop and improve the overall business management of groups of practices as part of supporting a federated model of primary care.

The role of the practice receptionist is very important in this experience. The standard of receptionists varies and as they are often the first point of contact for the patient, the PCT will commission a customer care training programme for all practices. We are looking at ways to ensure all practices support their staff on such programmes.

Additional training will also be available to community pharmacies to underpin an expansion in the range of enhanced services they will provide and increase their involvement in the practice based commissioning agenda.

Our dental practices already have access to training in areas such as infection control, clinical governance, staff appraisal and others but more training will be made available in specialist areas of dentistry to support the development of dentists with special interests to improve access to such services in the community.

Over one third of Harrow's GPs will be of retirement age within the next 10 years. The PCT will engage with GPs on a 1:1 basis to develop insight to individual's retirement plans. Where retirement is expected we can begin a succession plan to ensure we do not have gaps in provision. This will run in parallel with recruiting more GPs and nurses to respond to the demand for Long Term Conditions to be managed in the community both within and outside core hours.

The challenges facing a traditionally run general practice are immense and should not be underestimated. Independent practitioners are being asked to work in very different ways that traditionally many of them will not have done before. For some the change is an opportunity but for many it is a threat. The PCT will commission specific Organisational Development programmes to work directly with practices to understand and respond positively to the changing environment around them in order to achieve the vision set out in this strategy.

Information Management and Technology (IM&T)

To support practices, community pharmacy and dentistry to work more smartly and efficiently in the future we will need an increasingly sophisticated IM&T system. The PCT has started discussions with two of the major providers of IM&T in primary care – VISION and EMIS and we are aware of the development of web based primary care IM&T system which we will develop plans for potential implementation over this planning period.

The PCT is fully committed to the development of NHS NPfIT and accepts that for primary care to develop the IM&T in Harrow will have to be of a high standard. We are also working to see how professional groups can work together so that pharmacists can communicate with GPs and the future primary care groups can communicate directly with GPs. The implementation of phase one of the electronic prescriptions programme is complete and phase two is due to start roll out in 2009.

At the moment the PCT is working with the Acute Trusts so that there is easier transfer of information with regard to prescriptions, discharge summaries and pathology results from the hospitals to primary care and back again. The PCT's IM&T strategy has highlighted that support to independent practitioners as a key priority area and has identified additional capacity to make this possible.

Part of the IM&T strategy is to improve the data capture and analysis to support PBC in achieving World Class Commissioning standards and allow local practitioners to be actively understanding and managing local activity rates. The ongoing and expanded use of the RiO community system will be prioritised as critical tool for the development of the commissioning and contracting of these services

Estates

The enhanced quality and scope of primary and community care services described by this strategy will require modern and fit for purpose facilities across the borough. In order to establish integrated and effective community services the PCT must take action to make full and appropriate use of the current estate and consider the establishment of new facilities. A map of the existing community sites is provided at Appendix Two.

In order to inform the development of community facilities the PCT must develop a clear picture of the geographical areas of highest need, understand the potential of existing facilities and engage stakeholders to ensure the best configuration for new and existing facilities. To this end the PCT commissioned an independent survey of all general practice and PCT community sites to assess the level of Disability Discrimination Act (DDA) compliance, existing capacity and potential for expansion and the distribution of sites. The results of this survey were then considered alongside the wider context of health needs and provision within the borough to identify areas of most need and commissioning principles have been developed as a result.

The independent review of facilities also informed the identification of areas in Harrow where, if needs are to be met by the level of services described by this strategy, development of new and existing sites should be prioritised.

Given our intention to develop enhanced services across the borough there is a clear need to establish DDA compliance and potential of existing estates and develop principles for commissioning decisions as a result. The assessment confirmed that approximately one third of sites require further development to be DDA compliant and a large number have limited potential for expansion. As a result the following principles will be applied:

- The PCT will not commission new enhanced primary care services from sites which are either not DDA compliant or do not have the identified capacity to provide them. The PCT will prioritise commissioning of services at sites that fall within a PCT prioritised development area (See below)

- Where a site could, with reasonable levels of investment, become DDA compliant and has the potential to increase capacity to provide services, the PCT will consider investment provided there is a commitment to provide enhanced levels of service in line with the requirements of this strategy. The PCT will develop a site improvement scheme in 2009/10 to support minor improvements where these criteria are satisfied. DDA compliant sites with potential for expansion will be considered for development within the model of care described in section 5.1. Again service developments will be prioritised at sites that fall within prioritised areas.

- However where it is clear that premises are not DDA compliant and are unlikely to be able to become DDA compliant then the PCT will seek to commission extended services from alternative premises and practices.

- Prior to commissioning extended services the PCT would also expect that sites meet NHS guidelines for room size and to have adequate facilities (e.g. for hand hygiene, to ensure infection control and patient safety).

Given the level of local service integration described by the strategy it will be necessary to organise services according to smaller geographical areas, where local needs are understood and patient access can be improved. Given the context of Harrow (outlined in the CSP), what we know about transport links, natural communities and population density across the borough, and through discussion with the local authority to understand local planning the PCT has identified the following areas as prioritised development areas:

Harrow East - This area has high health needs, high prevalence of chronic disease and moderate to high deprivation. Services are currently delivered through smaller practices which are either not DDA compliant and/or have limited scope for expansion. The PCT has

taken a decision to close the local clinic due to the poor condition of the facility and will consult upon the future delivery of services from that site (Kenmore). In addition the recent closure of a local practice site has required the PCT to consult on the future delivery of services for that registered population (Mollison Way). Transport links to the area are reasonable but travel within the area can be difficult due to current public transport routes.

Harrow town centre - This is an area of high deprivation, it has a highly mobile population and higher disease prevalence than other parts of the borough but again services are delivered from smaller sites with little opportunity for expansion. This area offers very good transport links and is to be an area of population growth given a number of large housing developments.

Wealdstone - again is a highly deprived area with high health and social care needs but poorer access to a more limited range of primary care services.

Harrow South – This is an area of moderate to high deprivation with high health and social care needs. The south of the borough has a higher number of teenage pregnancies and babies of low birth weight. Transport is good in this area although parking can be difficult.

In general terms the development of new and existing sites in the borough will seek to ensure services are provided from larger, modern and accessible buildings with access to a range of health and social care services available.

Review of existing estate and potential areas for development indicate that this might best be achieved through a combination of enhancing existing clinics and practices, either through minor refurbishment or expansion, and the development of new and larger community sites. In doing so the PCT would have scope to re-locate and co-locate primary care services currently provided in poor facilities, and develop those existing sites with scope for development.

This combination of 'fit for purpose' sites of varying size would allow the PCT to network facilities in each prioritised locality whilst recognising that the economic viability of some services will require commissioners to secure their provision on differing scales (i.e. the provision of some basic diagnostics maybe at each site in a locality and that each site will have links to more complex interventions at one larger locality facility only). The PCT must also ensure the increased availability of contact points for community services in particular and this will require commissioners to seek and exploit opportunities for co-location and appropriate accommodation

In developing any potential new facilities the PCT would wish to ensure that where possible the facility will provide:

- Accessible, safe, flexible and adaptable accommodation to meet changing needs
- The potential for integration with the local environment and promote regeneration
- Provide a high quality internal environment to support health and well being for users
- Reduced levels of pollution / waste and efficient use of resources
- Good links to public transport (where access proves to be a problem for people with limited mobility problems, the PCT will actively consider how best to provide community transport for those that need it)

To support the development of existing or new sites, the PCT will work with the local authority to identify issues with planning, upcoming development opportunities and potential joint developments, which would underpin the co-location and integration of health and social care services in the future. To this end the PCT has agreed a protocol with the local authority on the application of section 106 agreements where planning permission is requested for large developments which would secure some funding or facilities from the prospective developers to improve health infrastructure.

Reconfiguration of facilities will be planned according to a model of care for primary and community outlined in Section five.

Five Year Strategic Plan 2009/09 – 2012/13

Interventions within this initiative link directly to the delivery to the implementation of the PCT Commissioning Strategy Plan initiatives:

- Choice and control
- Vascular / cancer prevention
- Vulnerable Groups
- Children & young people
- Vascular treatment
- Learning Disabilities & Community Mental Health

5. Delivering a robust model of care

5.1. Hub and Spoke – Poly-systems of care

This strategy describes the integration of enhanced services delivered closer to local communities focused upon their needs. In considering the options for the configuration of services the PCT worked with the provider of the independent estates review to map options that would cover differing population groups to achieve these goals.

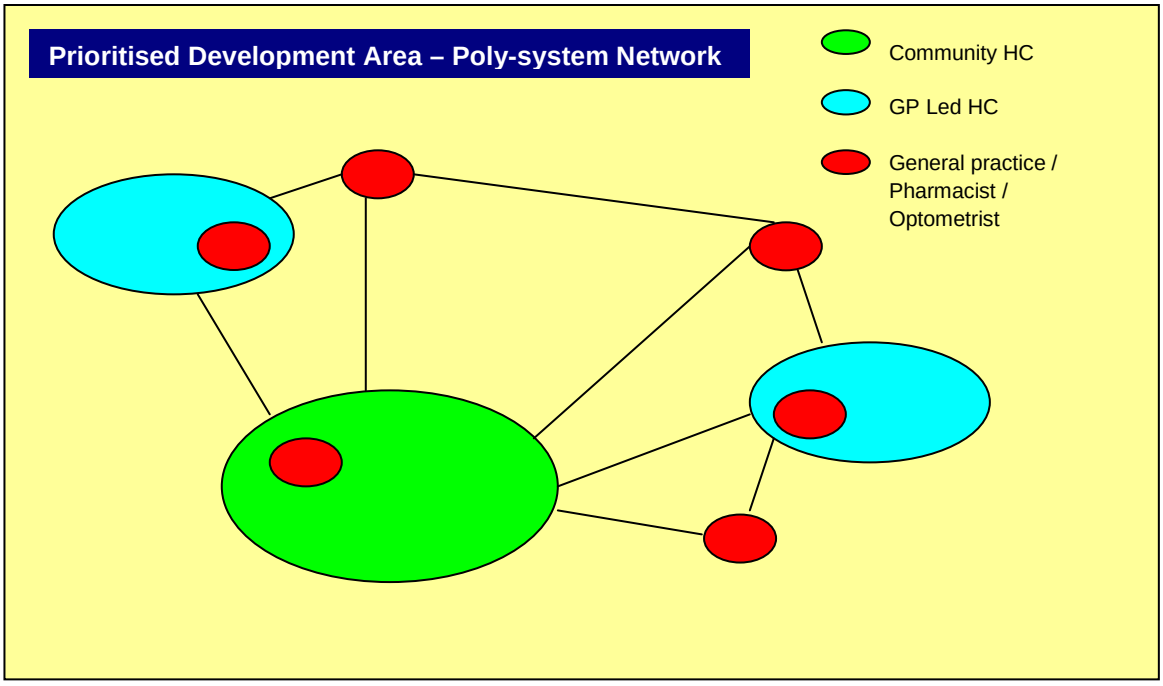
The survey suggested planning models where larger sites or polyclinics could be located in Harrow in order to adequately service the local population. An illustrative map of the first option is provided at Appendix Three. This described four population groupings providing services to approximately 50,000 patients. A second option was mapped for illustrative purposes that would provide a larger number of centres or hubs catering for approximately 20,000 patients each and this map is provided at Appendix Four.

Feedback from patient groups, local clinicians and other studies (Liverpool PCT Commissioning Strategy and the Picker Institute Survey) have all advised against compelling patients to travel longer distances to access primary care services. Local and national patient feedback has confirmed that both patients and GPs value the personal 1:1 relationship that GPs build up with their patients and the continuity of care this offers. Moreover discussions with practice based commissioners have not focussed upon the need to develop larger buildings to serve larger populations but have given focus to services needs and prioritised the availability of diagnostic or specialist support in the community.

Given these considerations and our wider strategic intentions (both for services and in developing estate) the PCT will pursue a Poly-system model for each of our four prioritised development areas (each serving populations of between 40,000 and 60,000). Each system will offer a networked model of existing practices in improved premises, GP led Health centres providing general practice alongside a wider range of community services to more of the local population, and larger community healthcare facilities that will provide a wider range of services that could be accessed by the whole population of a prioritised development area.

These larger hubs would provide the full range of services outlined by the Polyclinic model giving localised access to more specialist services and diagnostics in addition to the full range of primary care services. Each Poly-system will provide a model of care designed around the needs of that population. Work upon the model for Harrow South has given particular focus to children's services for example while early work upon the East is likely to prioritise more vascular services.

A Poly-system for each prioritised development area will represent the commissioning of a federated model of primary and community care, organising new and existing services around a series of 'hubs' across the borough, each being linked to the other viable primary and community care services in that area as spokes. A graphic illustration of the proposed poly-system model for a prioritised development area is shown below:



This model is consistent with Healthcare for London which emphasises localised and personalised care where possible, maintaining close geographical proximity to the patient's primary care provider is a critical part of achieving this objective. The vast majority of primary care needs are managed within the GP environment, however when patients do require a specialist opinion or a diagnostic test they are currently, on the whole, requested to make long and often multiple journeys to do so. This model will seek to address this whilst recognising that the economic viability of different services requires them to be provided on a variety of scales.

Within each Prioritised development area a Poly-system model will consist of:

'Hubs' – GP led health centres or larger community facilities that will provide general practice services to their immediate locality but equally provide additional services for the wider locality. Smaller 'Hubs' will provide a wider range of community services (phlebotomy or dentistry) as well as basic diagnostics and other extended services to populations of approximately 20,000. Larger Community Health centres will provide the same services but equally provide access to outpatient services, X-ray and other more specialist services to the whole development area. All hubs will be open between 8am and 8pm, 365 days a year and will be linked to each other within each development area and their '*Spokes*'.

'Spokes' will be individual general practices that will be commissioned to deliver high quality services that promote improved access and choice to patients within the minimum of the 8:00 am to 6:30 pm (moving to 8am to 8pm) delivering contractual requirements and essential, additional and locally enhanced services. A '*Spoke'* might also be a community pharmacy working to enhanced services or a local community clinic.

Each hub will develop in response to the identified needs of its specific local population. However it is expected that each hub will have the following functions as a minimum:

- They will provide general practice services to a minimum of 20,000 patients (please note this would comprise a smaller number of patients registered at the 'hub' whilst others will access these services because, for example, their practice is not open or they are not registered at all).
- They will provide a base from which a wider range of services can be offered to those registered with a GP at the hub and to the local GP spoke practices operating around the hub.

- Community services delivered by teams commissioned to provide services as part of that network.
- They will provide health promotion and prevention activities and programmes.
- Hubs will be open between 8am and 8pm seven days a week, and depending upon location and proximity to other services they will provide extended unplanned urgent care services for the locality – e.g. An Urgent Care Centre
- A health and community resource which will engage the local community in its health and health services.

Larger '*Hubs*' will also provide access to a wider range of diagnostics, outpatient services and will provide a base from which other health and social care and voluntary services will be able to add value to health based interventions, e.g. Citizens Advice, social services linked to help at home, housing advice, fitness and exercise schemes.

The PCT will adopt a phased implementation plan for the development of these new models, which will enable lessons to be learnt and proper evaluation prior to further role out. Application of the Poly-system approach to each of the prioritised development areas will be based upon the development of a specific poly-system model of care for that locality. The exact number, function and location of 'Hubs' and 'Spokes' will be determined by that process, which will be led by a Programme Board for Poly-system development and the establishment of Clinical Reference Groups for each area under consideration.

The development of each network model will take full account of economic viability and will take into account the existing estate in each locality to determine the right combination of smaller and larger hubs. Our work to date has indicated that, when all four areas are taken together, there is a need for between eight and ten 'hubs' across Harrow. This total number will compromise larger and smaller centres.

The PCT will have begun this process for all prioritised development areas by December 2009 although the timescales for each area will be phased and will be different dependent upon the existing infrastructure and circumstance in each one.

Planning work for each area is already underway and timescales and potential locations for each area are indicated in the text and maps below:

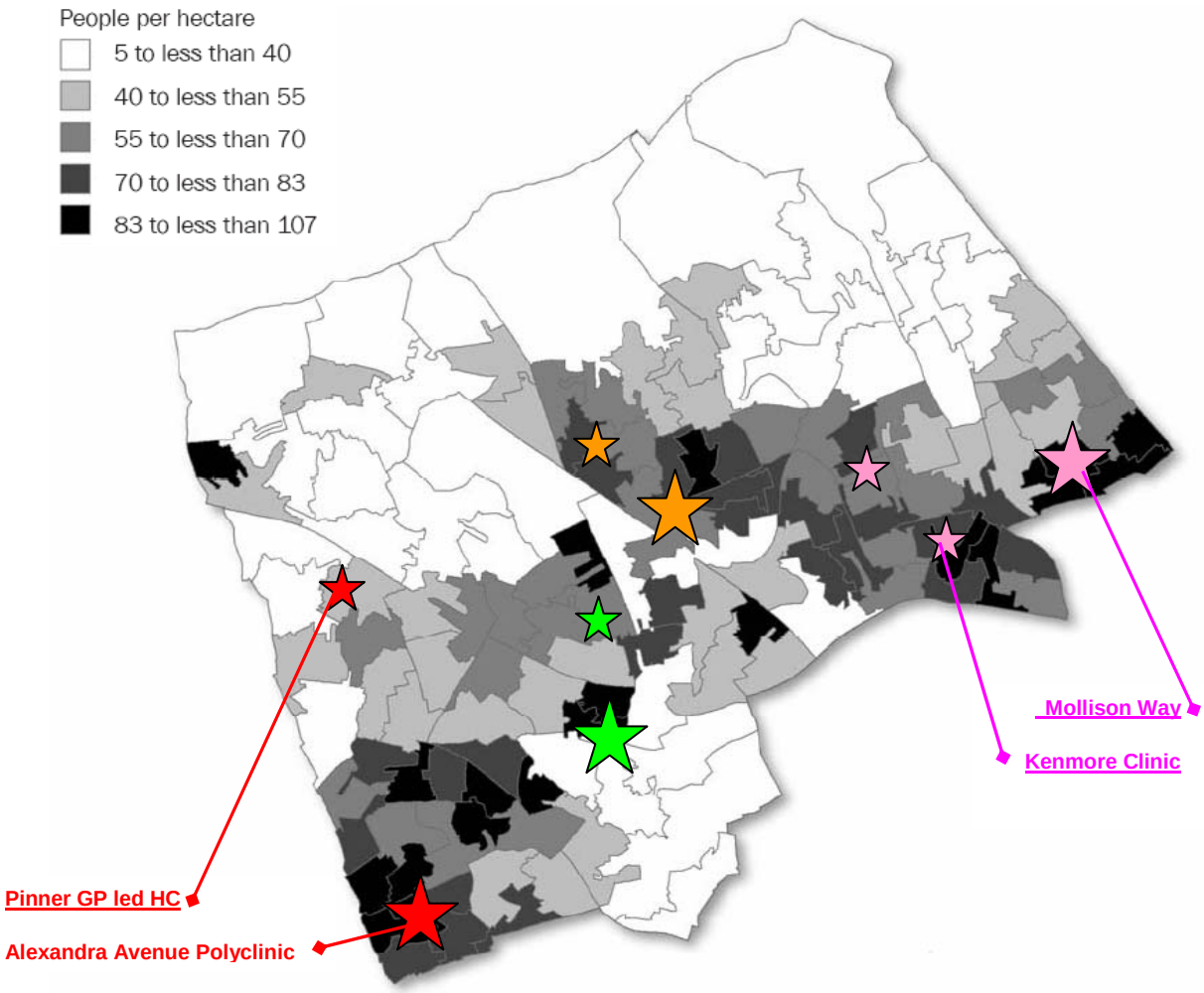
Harrow South - In April 2009 the PCT will open one of London's first five polyclinic facilities at the Alexandra Avenue Centre for Health and Social Care. This development will provide a larger 'hub' of a developing Poly-system for Harrow South. This Polyclinic development is detailed in Appendix Five. A GP led Health centre in Pinner, Harrow will also open in April 2009 and both facilities will link to existing primary and community care providers in the locality. Services become operational in **Quarter One 2009/10**

Harrow East - In April 2009 the PCT will complete the Outline Strategic Case (OSC) in order to undertake consultation on that model of care in April 2009. Proposals will build upon the establishment of a GP led Health centre in the east of the Borough by November 2009 (Mollison Way) and will include proposals for the potential re-development of existing clinic sites (specifically the Kenmore Clinic site). The existing infrastructure for this area is particularly poor and it is expected that a new model of care would require some element of new build. Services are expected to become fully operational in **Quarter One 20012/13** although significant elements of this system will become available across the planning period.

Harrow Town Centre and Wealdstone - In December 2009 the PCT will complete the Outline Strategic (OSC) in order to undertake consultation on a model of care for both these areas in the last quarter of 2009/10. The service model and timescales for delivery will be worked up in partnership with the Local Authority given their plans for development in these areas. Given current assessments of the facilities in these areas the PCT would seek to secure the delivery of services under a new model of care in **Quarter Three / Four 2011/12**.

Key	Prioritised Development Areas
	Harrow South - Polyclinic and new GP led Health centre (April 2009) and option appraisal for a third Poly-system hub to begin in 2009/10
	Harrow East – Public consultation on Poly-system model of care in 2009/10 (including development of Kenmore site and Mollison Way)
	Harrow Town Centre – Outline strategic case to be developed alongside local authority re-development of this area
	Wealdstone - Outline strategic case to be developed alongside local authority re-development of this area

= Larger Community Centre (Hub) = GP Led Health centre



Please Note: Star locations provide an indication of location (Unless labelled).

The delivery of the new models of care described above will support the enhanced integration of services and the delivery of the PCT's overall strategic plan. New models of care will allow for the development of collaborative networks of provision, based upon the following principles:

- Multi-disciplinary Primary Health Care Teams with clear service specifications that secure the shift from treatment to promotion, prevention, early detection and intervention in the community
- Integrated working across these teams through the establishment of service networks rather than co-location and designated links alone. Commissioning of primary and community based services will emphasise the sharing of skills and locally based services to specific populations designed around their needs
- Integration of the Primary Health Care Teams with local authority provision, acute and mental health services in community settings, with clear access routes to secondary care and specialist services

Integral to this work is the commissioning of improved and sustainable of the community services currently provided by the PCT provider arm following their establishment as Autonomous Provider Organisations (APO) followed by formal externalisation from the PCT. This will be a commissioner led process delivered through the mechanisms described by the PCT's Market Management and Procurement Strategy.

Section 5.2 outlines the demand management plans for the PCT and the resulting shifts in activity are outlined in the PCT's Strategic Plan 2008/09 to 2012/13. These require a significant shift of activity to community settings and the development of poly-systems across the borough will play and central role by providing planned and unplanned care in each locality.

'Hubs' will provide a more accessible and appropriate setting for the treatment or minor injury and illness through Urgent Care Centres with diagnostic support. Larger 'Hubs' will house multi-disciplinary admissions avoidance teams and access to support services to reduce the increasing levels of unscheduled activity currently seen in local acute trusts, whilst the relocation of outpatient services and minor surgery will shift activity currently undertaken by Acute Trusts as the default providers of this care.

'Spokes' will provide enhanced opening hours to patients regardless of registration and their ability to access a network of care will allow for the improved management of long term conditions and the co-ordination of care for those most in need.

5.2. Demand management and Investment

The development of enhanced primary and community care will require significant investment. Re-current investment will, in large part, be derived from a reduced level of investment in more expensive acute care settings secured through the management of demand for those services by effective community services. The savings to be derived from demand management are outlined in the Commissioning Strategy Plan (and the Finance and Activity Plan for the PCT). The investment in primary and community care services to support that demand management are outlined in table 8 below.

Table 8 - New Recurrent Investement 2009/10 to 2012/13

	2009-10	2010-11	2011-12	2012-13
Outpatients				
GPSI	50	0	0	0
Diabetes in Community	77	0	0	0
Total	**127**	**0**	**0**	**0**
Admission Avoidance				
Stroke	270	270	0	0
COPD	150	0	0	0
SPA	273	0	0	0
Day Hospital	285	0	0	0
Total	**978**	**270**	**0**	**0**
A&E				
GP Lead	478	320	158	0
UCC	166	0	0	0
Total	**644**	**320**	**158**	**0**
Polyclinic				
Development & WIC	760	1443	714	0
Total	**760**	**1443**	**714**	**0**
Total Receurrent Investment	**2509**	**2033**	**872**	**0**

Demand management initiatives will focus upon four key areas:

Outpatients

Primary and community services will reduce the demand for hospital outpatient appointments through the development of existing and new pathways of care. The PCT will develop the use of Clinical Assessment Services for major outpatient specialities alongside the development of one-stop services that will allow for the provision of services in the community by multi-disciplinary teams with access to diagnostics and specialist opinion in the community. In 2009/10 redesigned pathways will result in reduced acute outpatient activity in the following areas:

- Cardiology
- Dermatology
- Ear, Nose and Throat
- Gastroenterology
- Neurology
- Ophthalmology
- Paediatrics
- Urology
- Diabetes
- Trauma and Orthopaedics
- Gynaecology

This shift in activity will be commissioned from Any Willing Providers of community based specialist services. A number of these pathways are currently in place and require review. New pathways will be agreed with clinical leads prior to April 2009/10. (HfL: A framework for Action para 161-2)

Admission avoidance

This strategy described the introduction of enhance community services and case management to allow for a significant reduction of admissions. Integration of new and existing community based services will provide community alternatives to hospital admission. These will be co-ordinated by a Single Point of Access and will be developed alongside enhanced management of long term conditions, timely access to diagnostics in the community and improved levels of case management in the community. (HfL: A Framework for Action para 175)

A&E Attendances

The PCT will build upon the UCC model developed at the Northwick Park Hospital site and provide a series of UCC facilities across the borough. These services will be co-located with,

or complimented by extended opening hours at general practices and within community 'Hubs'. (HfL: A Framework for Action para 124-135)

Direct Access

Enhanced access to diagnostics in the community combined with more efficient use of current facilities will result in a reduction in the use of Acute based facilities. The PCT will actively test the market for cost effective provision of these services where local provision is not cost effective or responsive. (HfL: A Framework for Action para 165)

Demand management of acute activity will result from the enhanced use of accessible and high quality community facilities supported by networked primary and community care teams. The PCT will continue to work with and support Practice based Commissioners to redesign local services and to make savings on indicative budgets that can be re-invested in services for their populations.

6. Effective local leadership for change

6.1. Practice based Commissioning

Practice based Commissioning (PBC) has the potential to transform services by putting clinicians at the heart of PCT commissioning and strategic planning and allowing groups of family doctors and other community practitioners to develop better services for their local communities. Harrow PCT has a strong working relationship with its four local PBC group and the primary and community care strategy aims to ensure this grows and is strengthened.

In order to deliver the interventions described by this strategy the PCT will work to develop practice based commissioning to ensure it achieves the outcomes established and agreed between practices and the PCT as set out in the Harrow PBC Governance Agreement. The outcomes will drive:

- Improvements and standardisation of a range of services across the PCT through the introduction of new care pathways focused upon the needs of local populations
- Performance management of providers by comparing acute commissioning information across all Practices - then using peer review to evaluate causes for different referral rates, acute emergency admissions and other areas of activity.
- Demand management and in particular admission avoidance and active case management of these patients to prevent readmission of vulnerable patients
- The development of more corporate behaviour amongst the independent practitioners as commissioners and budget holders
- The development of an extended portfolio of local services that reflect PCT and PBC priorities
- The provision of support for poor performers to improve via peer review.

Although the PCT has worked to align the PCT commissioning, public health, finance and information teams' capacity and capability to support the expansion of PBC we recognise that this has not been adequate to date and further support is required. As a result the PCT Organisational Development plan identifies additional investment in the PCT's PBC support unit. Three additional posts will be recruited with a specific remit to directly support practices. The PCT has also enhanced its public health resource and this team will play a key role in assisting practices to assess and take commissioning action to address local need.

As practice based commissioning develops the PCT will work to ensure a greater focus upon health promotion and preventative interventions with PBC plans. The PCT will link PBC incentives to these areas directly and ensure the re-investment of budget savings are directed to prioritised areas within the PCT's CSP.

Finally the PCT will work with practices to ensure they are empowered to work as a network of locality commissioners of local health and social care provision. They are considered the key drivers to ensuring locality groups are formed around natural communities and common health care needs.

6.2. Fit for purpose Community services

An important step towards achieving improved community services will be to create commissioner / provider separation by achieving Autonomous Provider Organisation (APO) status for the provider arm, and beyond this to plan for externalisation. This will enable more robust commissioning arrangements aimed at driving up quality and efficiency and create a

sustainable service delivery vehicle that frees community clinicians to develop models of care that are responsive to the needs of the local population.

Four PCTs (Harrow, Brent, Ealing & Hillingdon) have agreed, through a shared project, to undertake an assessment of the benefits and risks of allying the four provider arms, in order to improve the probability of creating a viable and strong APO, prior to the likely end point of externalisation. From a Harrow perspective this has been entered into following an initial assessment of other options indicating that an alliance arrangement provides the best medium term solution to achieving commissioner/ provider separation.

The four PCTs have engaged a Programme Director, to scope the options for creating an alliance and support the PCT boards in deciding whether an alliance is a feasible option. If agreement on an alliance between at least two PCTs is reached, then the programme will support decision-making, consultation and implementation of the establishment of the alliance. The intention is to seek agreement in principle from PCT boards during December 2008, identifying a preferred configuration. The PCT is committed to achieving provider commission separation by April 2009.

Irrespective of the model chosen there remains a commitment to deliver services on a borough basis and reflecting the new model of care outlined by this document. Integrated delivery with primary care and social care will be a critical factor in improving quality and patient experience.

7. Milestones

Levels of investment are included within the Commissioning Strategy Plan and the Activity and Finance Plan.

7.1. Initiatives

Health Improvement

Priority	By When
Establish and support practices to deliver new Directed Enhanced Services for: • Heart Failure • Alcohol • Learning Disability • Osteoporosis • Ethnicity	December 2008
Develop Local Enhanced Services to support performance over and above QOF (stretch targets – balanced scorecard)	April 2009
Develop local enhanced service to support vascular screening	2009/10
Develop commissioning plan for enhanced services - community pharmacy	September 2009
Establish programme of social marketing to increase the uptake of NHS dentistry	December 2008
Delivery of the Child Health Promotion Programme	March 2010

The quality of health services

Priority	By When
Establishment of PEC Associate roles in • Stroke and older people • Maternity Services • Cancer • Mental Health and Learning Disabilities	April 2009
Development of performance frameworks (balanced scorecards) each independent practitioners contract.	Annual Roll Out
Introduction of the new NHS contract for community services	April 2009

Better access to and choice of services

Priority	By When
Establishment of GP services offering appointment 8am to 8pm seven days a week	April 2009
Development of the Single Point of Access (SPA) to support better integrated care services	April 2009
Improved access to NHS dentistry for patients with physical disability, learning disability or complex medical needs in the most appropriate setting	April 2009

Enhanced integration of services

Priority	By When
Development of models of care that ensure seamless integration of	See Section 5.1

services.	
Work with London Borough of Harrow to pilot Individual Budgets	2009/10
Move third sector commissioning into mainstream commissioning to ensure a better integration of services for patients.	2009/10

Better infrastructure to support service delivery

Priority	By When
Develop a clinical sponsorship programme based on a skills audit of local GPs and practice nurses.	January 2010
Develop a secondment programme for local practices managers to spend one day a week share expertise and experience across Harrow.	October 2009
Commission a customer care training programme for practice receptionists	April 2009
Develop training programmes for dentists and pharmacists to develop skills to support the delivery of a wider range of enhanced and specialist services	September 2009

7.2. Risks and mitigating actions

The key risks to delivering the initiatives in this strategy and so the realisation of the PCT's vision for primary and community care services have been identified and mitigating actions have been agreed for each risk. These are summarised below.

Risks	Mitigation
Destabilise main acute provider	Full consultation; collaborative approach with Brent; whole health economy assessment
Polyclinic programme destabilises GP services	Full consultation and stakeholder engagement; inclusive of existing provider network; whole health economy assessment will be required
Acute SLA overspend	Demand management programmes to be established in 2008/09 to provide a full year effect in 2009/10. Further development of and support for PBC.
Skills and capacity not made available within PCT	Organisational Development Plan addresses

8. Summary

This strategy sets an ambitious vision for the future of primary and community care services in Harrow. The Strategy recognises and seeks to preserve the strengths of the current system in Harrow whilst describing actions to address key challenges that will ensure commissioning in these areas realises the full potential of primary and community care.

The strategy outlines a vision for primary and community services; that Harrow residents will be able to choose and experience high quality health care services provided in modern, clean and accessible environments. Services will be integrated and responsive; they will place greater emphasis on prevention and self management and will be delivered closer to home.

This vision will be achieved through commissioning action in five key areas, underpinned by the commissioning of a federated model of primary and community care:

Health Improvement

People can expect to receive services that help them to stay healthy or become healthier and fitter. Harrow's primary and community care services will work in partnership with social care and the third sector to ensure residents can lead as full a life as possible and regain control of their lives following ill health.

Quality Health Services

Patients will experience a consistently high quality of performance from our local primary and community care organisations and experience less variation in the performance of those services.

Better Access and Choice

Over the next five years Harrow residents will have access to responsive services and will be encouraged to exercise their choice in terms of where they access care and from whom.

Enhanced Integration of Service Delivery

Within five years local people will experience a pattern of services that is a closely knit network of publicly funded services, and partly self-funded services; provided by a mix of different suppliers.

Better Infrastructure to Support Delivery

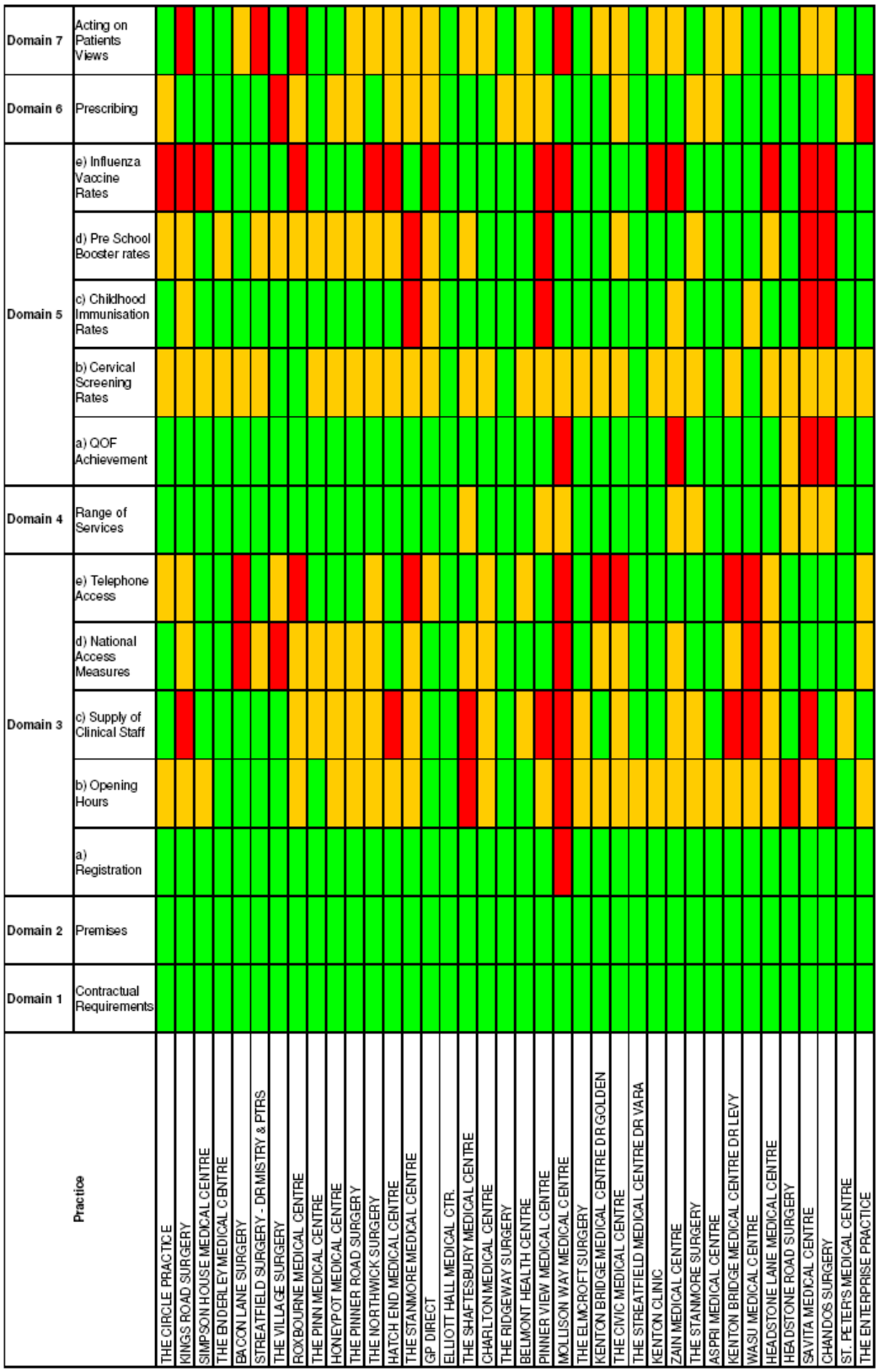
Over the next five years patients will receive services from highly skilled, well trained and well motivated staff acting as champions for health and well-being. Where those services need to be delivered outside of the home they will be delivered in high quality estate within close proximity to patient's homes.

9. Declaration of Board Approval

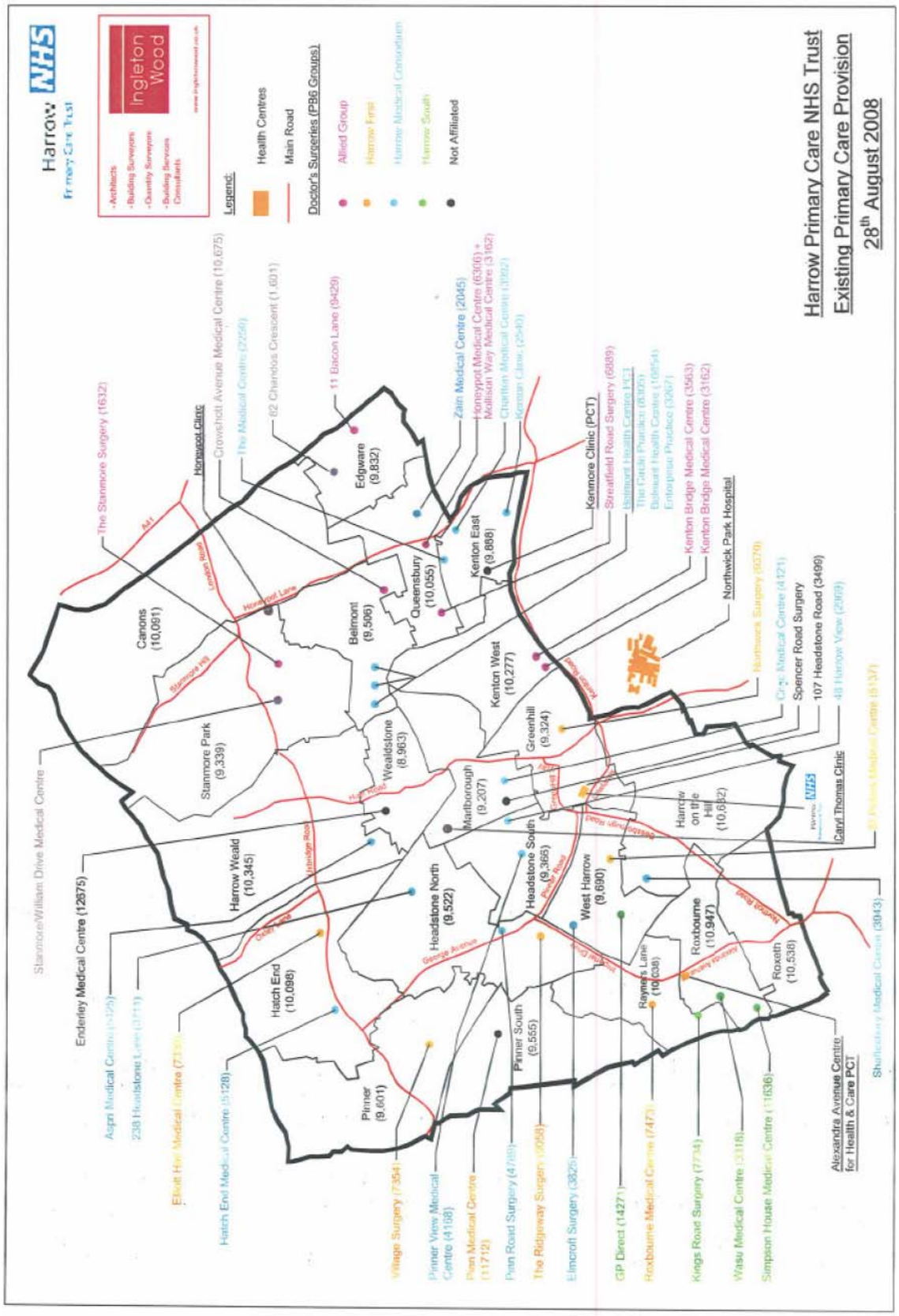
This report and the related appendices were reviewed and approved by Harrow Primary Care Trust Board at a meeting held on 18 November 2008, at their offices, The Heights, 59-65 Lowlands Road, Harrow, Middlesex, HA1 3AW.

The Board have been fully involved in the preparation of all the documents, and have agreed formal review across the planning period.

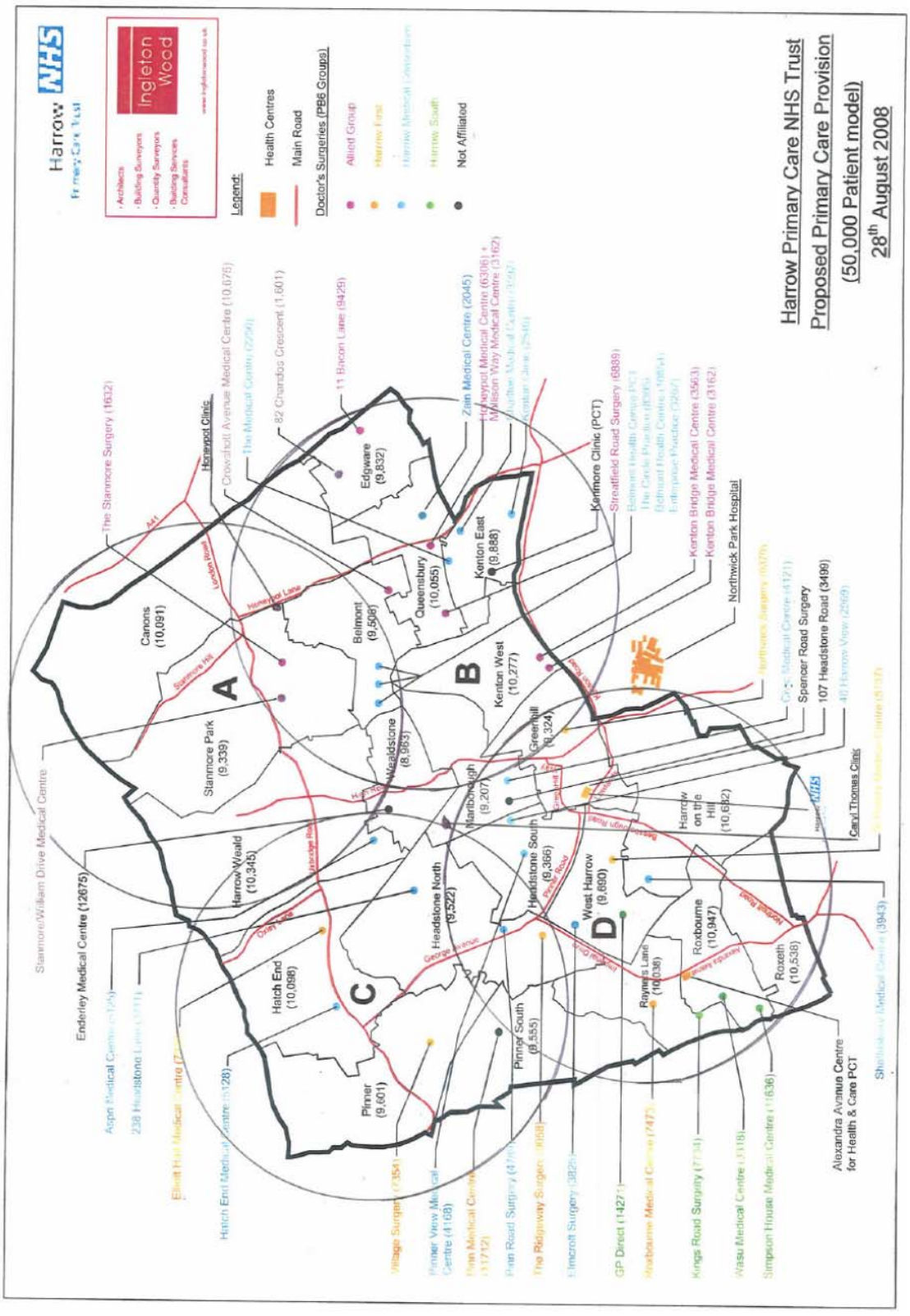
Appendix 1: Balanced Scorecard of General Practice performance Q2 200809



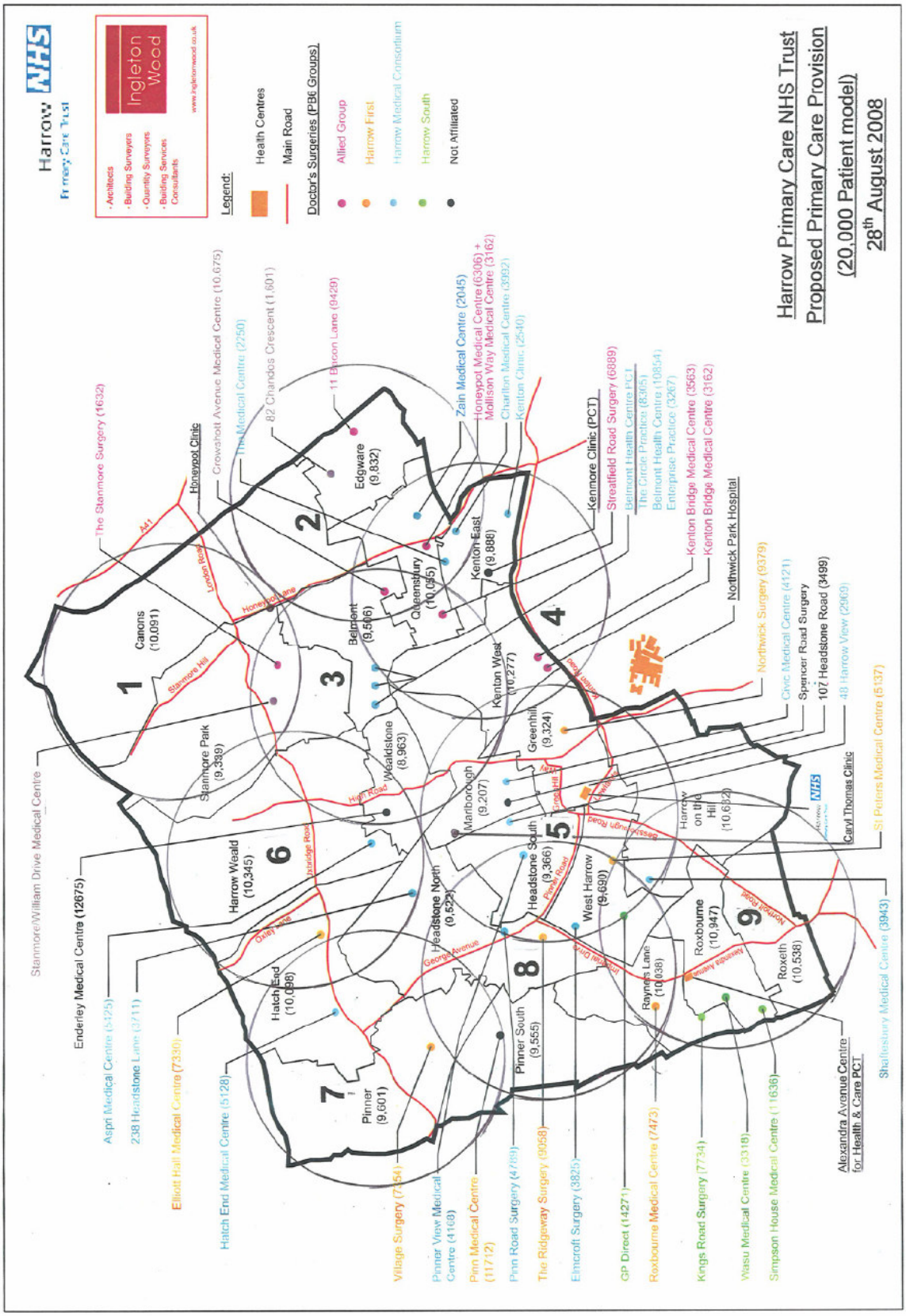
Appendix 2: Premises site map one (2008/09)



Appendix 3: Premises site map two – Configuration example (2008/09)



Appendix 4: Premises site map three – Configuration example (2008/09)



Appendix 5: Polyclinic Development – South Harrow

ALEXANDRA AVENUE HEALTH & SOCIAL CARE CENTRE – HARROW'S FIRST POLYCLINIC

Background

Alexandra Avenue Health and Social Care centre was a new LIFT scheme build in South Harrow which was completed in 2005. The centre is 2620sqm, over 4 floors and currently houses primary and community care services, tier 2 services, CAMHS, paediatric services and administrative functions. These services are provided by PCT provider services, NWL Hospital Trust, CNWL Mental Health Trust and the Local Authority.

The centre currently offers services 8am until 5pm, 5 days per week with some services offering limited later sessions e.g. family planning.

The building has a shared reception to welcome patients accessing any services but the services themselves are not integrated to any great extent.
Harrow PCT gained approval for the centre to be the site of an early implementer polyclinic model in September 2008 to realise the full potential of the centre as a community asset providing integrated services shaped around the needs of the local population, building on the developments in service that had already been achieved there.

The centre will become a full polyclinic model from 1st April 2009.

Population Needs

The population of South Harrow wards is 65,000. However, projections following housing growth, indicate and increase to 70,000 within 5 years. These South Harrow wards have the highest density population but some of the lowest household incomes in the Borough.

The centre sits on the borders of Roxbourne and Roxeth wards. The residents there have a highly diverse population and a significant reported refugee and asylum seeker residency. Over half the homes have dependent children and a third have at least one vulnerable occupant. Roxbourne has the highest rates of teenage conception with 65% being terminated.

Prevalence of diabetes, CHD and asthma all exceed SHA and Harrow averages, with the lowest levels of recorded physical activity in the PCT.

The most recent primary care patient survey in South Harrow records 40% waiting too long for appointments, 70% with difficulties making contact by telephone and 39% being put off being seen because of inconvenient opening times.

Ealing and Hillingdon A&E departments in neighbouring PCTs but near to the South Harrow borders were visited for 1,016 minor conditions when 60% - 80% could have been managed within Primary Care. Enhanced primary provision could also have managed 60% of 3,300 under 16's attendances at A&E.

Vision for South Harrow Hub and Spoke Model of Care

The Alexandra Avenue Health and Social Care centre will be the hub for a hub and spoke model of care serving the population of South Harrow, with the 6 local GP practices acting as spokes.
The services located at the centre will work together under an agreed memorandum of understanding to integrate the services there and create new care pathways to ensure that patients accessing them experience a seamless service.

The diagnostic services available at the centre will have greater availability to patients at times more convenient to them. (HfL: A Framework for Action para 166)

The PCT will be bringing a general medical practice into the centre that will offer services to both registered and unregistered patients from 8am to 8pm, 7 day per week. In addition, enhanced pharmacy services will be available offering an alternative to GP appointments for minor ailments.
Due to the make up of the local population and in response to patient feedback the centre will have a paediatric focus but the services generally available at the centre can be accessed by any local person or clinician sited at a spoke.

A full list of the services planned for the centre is below:

Harrow PCT
- GPSI Services: Minor Surgery; Gynaecology; MSK; Cardiology (with Imperial); community paediatrics; dermatology; non-obstetric ultrasound
- Nurse led CHD and diagnostics including ambulatory ECG, ECHO and BNP
- Dental Service for children and adults with special needs
- Health Visitor / well baby clinics
- Diabetic retinal screening
- Wheelchair Service (via Hillingdon PCT)
- School Nursing Clinic
- General Medical Services for registered and unregistered patients, 7days/week, 12 hours per day
- Urgent Care Services
- Enhanced Pharmacy Services

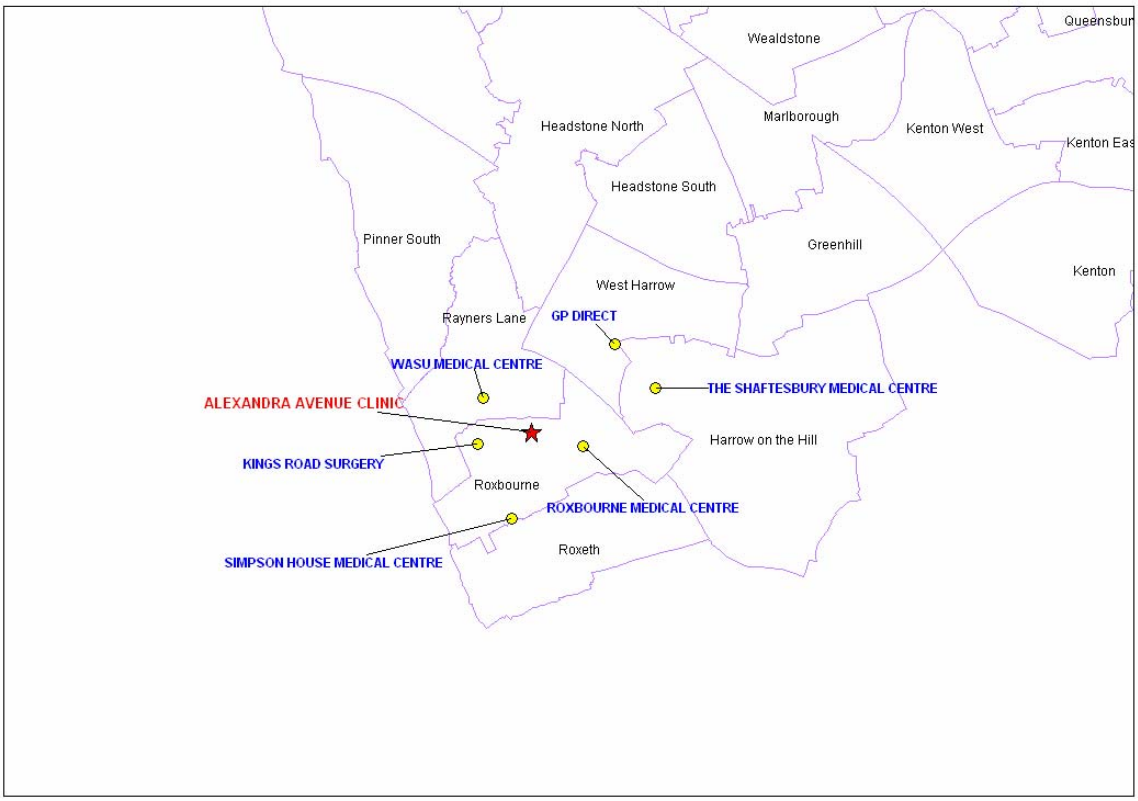
London Borough of Harrow
- Social Service Administration
- Children with disabilities
- Educational Psychology
- Early Years Support
- Special Educational Needs

North West London Hospitals NHS Trust
- Paediatric and adult physiotherapy
- Speech & language therapy
- Audiology
- Paediatric occupational therapy
- Child development clinics
- Joint paediatric / CAMHS clinics
- Paediatric and child health teaching clinics
- Community midwives - antenatal for teenage pregnancies and postnatal support

CNWL Mental Health Foundation Trust
- CAMHS
- Adult Mental Health

The current services at the centre and the planned expansion of the availability or further diagnostics e.g. x-ray support the PCTs aims
- to bring more care out of hospital and into the community
- to provide patients with unscheduled or urgent care at venues outside hospital
- to focus the needs of the population at a very local level and shape services around those
- Achieve service integration across primary and community, health and social care and tier two services.
- To reduce health inequalities and ensure that all people have access to high quality, responsive care that it shaped to their needs.

Alexandra Avenue Health & Social Care Centre Hub and Spoke map



Appendix 6: Equality Impact Assessment form

Equality Impact Assessments are intended to examine the aims, implementation and effects of policies, practices and services to check that no groups are receiving or are likely to receive differential treatment or outcomes that are discriminatory or unfair in nature. This form should be used to assess new or reviewed policies and changes to service provision, to ensure they do not disadvantage any people within the community.

Department:	**Harrow PCT**	**Assessor :**	**Julie Taylor**
Policy/Service Title:	**Strategic Plan 2008/09 to 2012/13 –** **Primary & Community Care Strategy**	**Date of Assessment:**	***17.11.08***

1. Briefly describe the purpose of this policy or function.	The strategy document sets out Harrow PCT's vision for Primary and Community Care over the next five years. The plan describes the current services, a case for change, identifies the key areas for development and outlines the model for delivery.
2. What are the intended outcomes of this policy or function?	1. Promote health improvement and the well being of local residents in primary and community care settings 2. Deliver localised care wherever possible, ensuring residents only have to access more centralised or hospital care when it is absolutely necessary 3. Ensure equity of access to all services regardless of geography, gender, ethnicity, age or physical ability and help address inequalities where they exist 4. Deliver seamless health and social care services to local residents through the integration of service delivery models e. Deliver an enhanced quality of service making the best use of available resources

SECTION 1

Initial Screening

Please identify if the policy or function is likely to, or may possibly, have an adverse impact, or disadvantage any groups:		
Yes ☐	No ☒	Please give details of why: One of the main aims of the strategy is to reduce/remove inequalities, ensuring that all people regardless of their age, gender, race, ability or place of residence have access to responsive, high quality primary and community care services.

If you answered 'No' to the above question you may conclude the assessment here, should the answer be 'Yes' please continue to section 2.

Details of where to return the form can be found towards the end.

SECTION 2

Impact Assessment

Please complete the following list and identify if the policy or function is likely to have an adverse impact, or disadvantage any groups:			
a) On grounds of race, ethnicity, colour, nationality or national origins	Yes ☐	No ☐	If you have answered yes please give details: ....

b)	On grounds of marital status	Yes ☐	No ☐	If you have answered yes please give details: ....
c)	On grounds of gender	Yes ☐	No ☐	If you have answered yes please give details: ....
d)	On grounds of religion or belief	Yes ☐	No ☐	If you have answered yes please give details: ....
e)	On grounds of disability or physical / sensory impairment	Yes ☐	No ☐	If you have answered yes please give details: ....
f)	On grounds of age	Yes ☐	No ☐	If you have answered yes please give details: ....
g)	On grounds of sexual orientation	Yes ☐	No ☐	If you have answered yes please give details: ....

h) On grounds of criminal history	Yes ☐	No ☐	If you have answered yes please give details: ....
i) Deprived groups	Yes ☐	No ☐	j) If you have answered yes here, please give detailed steps taken to address Health Inequalities (use a separate sheet if needed): : ....
k) The dignity and Human Rights of our patients or staff	Yes ☐	No ☐	If you have answered yes please give details: ....

SECTION 2

Modifications
1. If you stated that the policy/ function has or could have an adverse impact on any group, how could you modify it to reduce or eliminate any identified negative impacts? ....

2. If you make these modifications, would there be impacts on other groups, or on the ability of the initiative to achieve its purpose? ....

SECTION 3: New or Amended Policy / Function Assessment

For new or amended policies, please complete Section 3 in addition to Sections 1 & 2

Will a consultation take place? Yes ☒ No ☐
1. Who will be consulted? The public and key stakeholders such as the Local Authority, local GPs, pharmacies, dentists, opticians, the third sector. There will be consultation on specific parts of the strategy e.g. procurement of new polyclinics or GP led health centres, moving services into the community or changing pathways. There will also be stakeholder/public involvement around issues such as the roll out of the vascular check programme in terms tailoring the programme to patient needs.
2. How will the consultation be undertaken? (Timescale, methods, responsibilities) Consultation will usually be formal. However, when patient/stakeholder involvement is only needed, then relevant community groups and users would be canvassed to help design or tailor services to patient needs.
3. How will consultation outcomes be fed back into the process? By building feedback into service specifications, care pathways and access requirements.

Monitoring and Review
1. How will the impact of the policy / function be monitored? Through Performance Management targets reviewed by the PCT's Delivery Committee and the Primary and Community Care Group.

2. When is the review date?

Six monthly

Public Availability of Report/ Results
Please provide details of publishing arrangements All reports to these committees are reported to the Board and made publicly available as a result.

Please return the completed form to Human Resources, The Heights, Lowlands Road.

The form will be considered by the Equality and Diversity Group and further contact will be made if necessary.

Legal context:

The Race Relations Act 2000 requires public authorities to conduct race impact assessments on any proposed policy to pre-empt the possibility that any measures could affect some racial groups unfavourably. Since December 2006, impact assessments have to be carried out to ensure that disabled people suffer no disadvantage from proposed policies impacting on service provision and employment and in December 2007, this duty will extend to gender issues as well.