Enhanced Primary and Community Care Services in East Harrow

Outline Business Case

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Version 7

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V1	18 November 2009
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EXECUTIVE SUMMARY

This document sets out the proposed strategic direction to enhance primary and community care services in East Harrow.

In November 2008 NHS Harrow published its Primary and Community Care Strategy outlining a vision for the development of these services over the next five years. The vision set out clear objectives to improve the level of choice, quality and access through service and estate modernisation. These goals were chosen in response to patient feedback obtained through our annual patient survey.

In April 2009 NHS Harrow published its Strategic Outline Case for East Harrow. Between April and November 2009 NHS Harrow talked to its stakeholders about its plans. We discussed our plans for East Harrow with the council, its overview and scrutiny committee, our GP's, providers and the Healthcare for London team. We also passed through a Gateway Review process, which examined our draft plans in detail and since then we have taken steps to improve them as a result.

We now publish our Outline Business Case, which has been approved by NHS London, and allows us to progress to public consultation stage. The Outline Business Case begins to look deeper at why we prefer the hub and spoke model for East Harrow and how we intend to fund the service improvements we envisage.

There is no doubt we need to prepare for a period of financial challenge within the NHS. To address this, we intend to invest in community healthcare provision that delivers more care closer to home and reduces demand on hospital services.

We have analysed our existing Primary Care estate in East Harrow and established that Belmont Health Centre is the only site big enough and with enough development potential to deliver a community hub with increased health services. NHS Harrow now wishes to consult the public on a new model of care for East Harrow, one which would see the redevelopment of Belmont Health Centre.

Within this document our Public Health team have carried out a detailed analysis of the health needs of the East Harrow community, which presents a picture of health that is not dissimilar to the rest of Harrow, but marginally worse in a few areas.

The business case element examines the potential level of healthcare activity that could be delivered more cost effectively closer to home. By improving the quality of primary care services, less people will need to attend hospital, both in a planned and unplanned way. This leaves hospitals with greater capacity to focus on the more serious cases.

When setting out any change agenda it is important to work in partnership with all NHS providers, to ensure a stable healthcare system, but one which is able to release its full potential. We work in partnership with all stakeholders, but perhaps most importantly

our GP's, local hospital and community service providers, to change care pathways with their agreement.

Given the current economic climate and the level of NHS Harrow investment available, NHS Harrow intends to make the best use of its existing primary care estate and facilities to deliver a new vision for healthcare.

Having appraised the health needs, our estate and financial position, we feel that the poly-system model would be the most appropriate model of primary and community care in East Harrow. This model consists of a community health centre hub, operating GP services for registered and unregistered patients, with extended opening hours 8am to 8pm, 7 days a week and incorporates other services such as pharmacy and diagnostics (x-ray for example) normally only found in hospitals. The hub seeks to incorporate a range of services under one roof to shorten waiting times and improve the patient pathway. The hub would be linked 'or spoked' to the other GP practices in East Harrow and most notably a GP led health centre, which would also operate the same extended opening hours as the hub. The most suitable way to deliver this model would be through a community health centre development at the current Belmont Health Centre site and a GP led health centre on Mollison Way.

In assessing the feasibility of the proposed model, other options were considered. Our assessment focused on 3 main areas, namely; potential for expansion, impact of investment and access. From our assessment only Belmont Health Centre has enough redevelopment potential to become a community health centre hub and NHS Harrow has recently procured a GP led health centre in the Mollison Way area. We chose Mollison Way following a public consultation with patients in that area, as their practice had to be closed so it made sense to procure a new service that will improve access and quality. We are pleased to launch this wider public consultation, which will not only discuss our plans for Belmont Health Centre, it will also consult the public about the services that are important to them.

Dr Andrew Howe
Executive Sponsor and Joint Director of Public Health
NHS Harrow

1. INTRODUCTION

This Outline Business Case presents a proposal of developing improved health and social care services in East Harrow. Specifically we are proposing to develop a Community Health Centre, on the current Belmont Health Centre site, in addition to the Mollison Way GP led health centre which will open in January 2010.

In November 2008 NHS Harrow, previously referred to as Harrow Primary Care Trust (PCT), published its Primary and Community Care Strategy outlining a vision for the development of these services over the next five years. These new developments will improve the level of choice, quality and access for patients in the East Harrow area which has been identified within our Primary and Community Care Strategy as a priority area.

The Outline Business Case takes the next step in refining our choice and examines the investment required to achieve these improvements. We are also now launching our public consultation to hear public views on the improvements we propose.

2. BACKGROUND

NHS Harrow's Primary and Community Care Strategy outlined a series of initiatives to be undertaken to ensure the rapid improvement of services across the borough and the development of the community care infrastructure in four prioritised geographical areas to support this change. This document provides the Outline Business Case for one of those areas, East Harrow, and should be considered in the context of the Next Stage Review, Healthcare for London and NHS Harrow's Primary and Community Care Strategy.

2.1 National and London Context

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, both of which are summarised below:

Table 1

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 collaborate 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 PCTs 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 more specifically East Harrow, they give emphasis to NHS Harrow's role as strategic commissioners of health and healthcare, committing to stronger partnership working with the London Borough of Harrow and our clinicians, both as healthcare professionals and practice based commissioners of care.

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 in *A framework for action* are particularly relevant to the development of this strategy – Poly-systems are identified as 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.

Healthcare for London has also established an unscheduled care project which has reviewed 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 (usually A&E) 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 needs not organisational boundaries or institutions.

A Framework for Action specifically proposed that improvements in accessing urgent care could be achieved by enhanced face to face contact, by establishing urgent care 'walk-in' services at the front end of hospitals and in community settings, in this case delivered through a poly-system hub.

2.2 NHS Harrow's Primary and Community Care Strategy

In November 2008 the NHS Harrow Board approved NHS Harrow's Commissioning Strategic Plan (CSP) for 2008/09 to 2012/13. This CSP outlined the NHS Harrow vision for health and health services in the borough and described the strategic goals and initiatives that commissioners would pursue over the next five years to achieve it. Alongside the CSP the Board also approved a Primary and Community Care Strategy for the same period.

That strategy sets an ambitious vision for the future of primary and community care services in Harrow and makes clear that the overall vision and goals in the CSP can only be achieved through the improved commissioning of these areas. 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 realise 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 healthcare services provided in modern 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
- Quality Health Services
- Better Access and Choice
- Enhanced Integration of Service Delivery
- Better Infrastructure to Support Delivery

<u>Hub and Spoke – Poly-systems of care</u>

This Outline Business Case focuses upon the delivery of the Primary and Community Care Strategy in East Harrow. It examines the aims of that strategy in the context of East Harrow and gives specific focus to the implementation of a poly-system of care for the area as proposed by that Strategy.

The Primary and Community Care 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 NHS Harrow worked with Ingleton Wood Ltd to conduct an independent estates review to map options that would cover differing population groups to achieve these goals.

The survey undertaken by Ingleton Wood Ltd suggested planning models where larger sites or polyclinics could be located across the whole of Harrow in order to adequately service the local population. This described options including four population groupings providing services to approximately 50,000 patients each. An option was mapped for illustrative purposes that would provide a larger number of centres or hubs catering for approximately 20,000 patients each. This survey helped us analyse our existing estate and begin to form a hub and spoke strategy for Harrow.

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 one to one relationship that GPs build with their patients and the continuity of care this offers. Moreover discussions with practice based commissioners have not focussed upon the need to simply develop larger buildings to serve our populations but have given focus to service 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) NHS Harrow is pursuing a poly-system model for each of our four prioritised development areas identified in the Strategy and including East Harrow (each serving populations of between 40,000 and 80,000). 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.

The Community Health Centre (hub) would provide a range of services 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. The Outline Business Case applies this federated model of care to the East of Harrow.

The delivery of a networked model of care in East Harrow is also integral to the delivery of the NHS Harrow demand management plans agreed with the Harrow Wide Executive. The demand management plans for NHS Harrow and the resulting shifts in activity are outlined in the NHS Harrow CSP. These require a significant shift of activity to community settings and the development of poly-systems across the borough will play a central role by providing planned and unplanned care in each locality.

'Hubs' will provide a more accessible and appropriate setting for the treatment of minor injury and illness through Urgent Care Services with diagnostic support. The hub will house multi-disciplinary admission avoidance teams and access to support services to reduce the increasing levels of unplanned activity currently seen in acute hospitals, whilst the relocation of outpatient services and minor surgery will shift activity currently undertaken by hospitals as the default providers of this care.

'Spokes' will provide some form of enhanced opening hours to suit patients 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.

2.3 Prioritised Development Areas – East Harrow

The Primary and Community Care Strategy identifies East Harrow as a prioritised development area. The NHS Harrow Board approved the launch of a Project Board to take this work forward. Subsequently timescales were agreed for next steps at the January 2009 meeting of the Board that would see the development of the Strategic Outline Case for consideration and approval by the Board in April 2009. The Strategic Outline Case for East Harrow confirmed detailed plans to inform this Outline Business Case. We had planned to consult the public during the summer months, but an unstable financial landscape and developments in the poly-system model led to a delay. We are now pleased to launch our public consultation through our December 2009 Board meeting.

In considering the approval for this work the Board reviewed the current provider landscape in the East of the Borough, in terms of coverage, performance and estate. The Board also reviewed the identified health needs of these residents and the extent to which our population, and as a result their needs, are changing.

In addition to these considerations the Board also took account of other developments within this part of the Borough. These were two-fold; the procurement of a GP-led health centre in the Mollison Way area (approved by the Board in December 2008) following the closure of an existing practice and a full public consultation upon the re-provision of those services; and the closure of the Kenmore Clinic site (approved at the October 2008 Board meeting).

Given its South East Harrow location the procurement of a GP-led health centre at Mollison Way clearly needs to be considered within the development of this service model. To this end the Board agreed the procurement in order to open a new service early 2010. The Board also acknowledged that NHS Harrow may wish to secure temporary accommodation for this service in order that it could proceed in a way that did not prohibit its inclusion in future developments.

Kenmore Clinic is a single storey building located on Kenmore Road in East Harrow. It was constructed using standard building materials, including asbestos, in the 1950s. The site is owned by the PCT and was inherited from the local authority as land covenanted to provide healthcare. The decision to close Kenmore Clinic was made as the building was no longer safe and it was not viewed as financially viable to continue to make regular repairs. The decision was taken with the clear commitment to undertake a full review of the model of service provision in the East to ensure that any future provision takes full account of this lost community facility. Kenmore served a predominantly local population and access was mainly by foot and bus; there was no parking on the clinic site. We appreciate some residents are keen for us to return services to the Kenmore Clinic site as a priority and we will continue to work with our GP's, other healthcare providers and the public to try and return health services to this site.

This Outline Strategic Case for a new model of service delivery for the East will not re-state the case for change to improve primary and community services to deliver NHS Harrow's strategic vision and goals but will seek to set the case for change in the context of East Harrow in the sections that follow.

3. A CASE FOR CHANGE

3.1. Population demographics and health needs

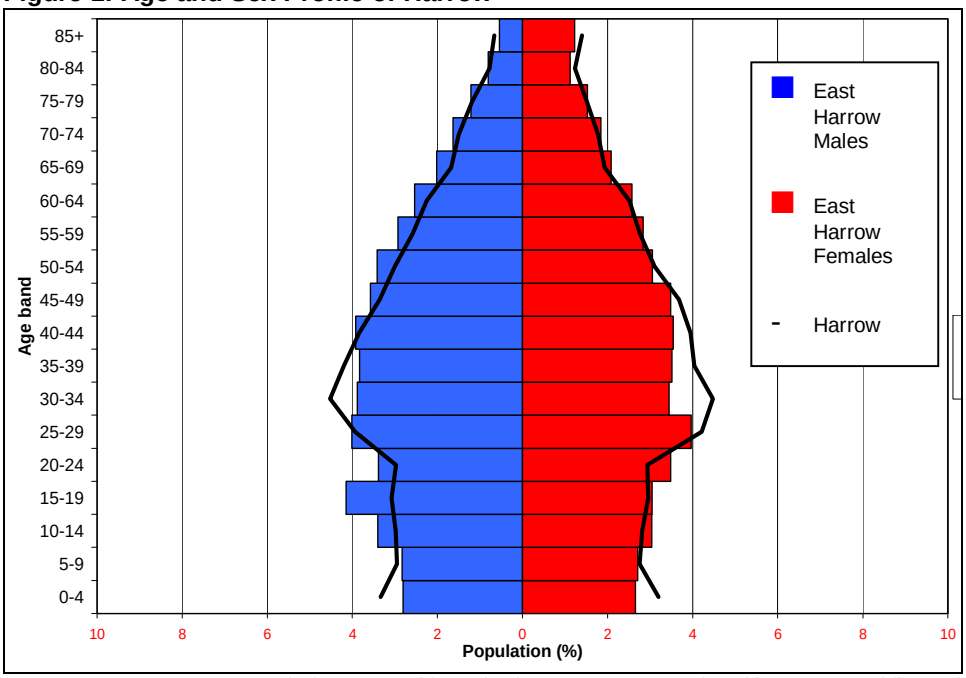
Any conclusions draw from the analysis outlined in this section will be subject to the following limitations:

- The non availability of some of the information at East Harrow wards level. Wherever, this was the case, estimates have been used or Harrow's picture has been extrapolated to East Harrow.
- This is not intended to be a comprehensive needs assessment but rather an assessment that focuses upon those conditions where maximum benefit could be obtained in terms of health outcomes and reduction in inequalities.

Demographic trends

East Harrow has a registered population of circa 83,000 people. In broad terms the age and sex profile of the East mirrors that of Harrow's population.

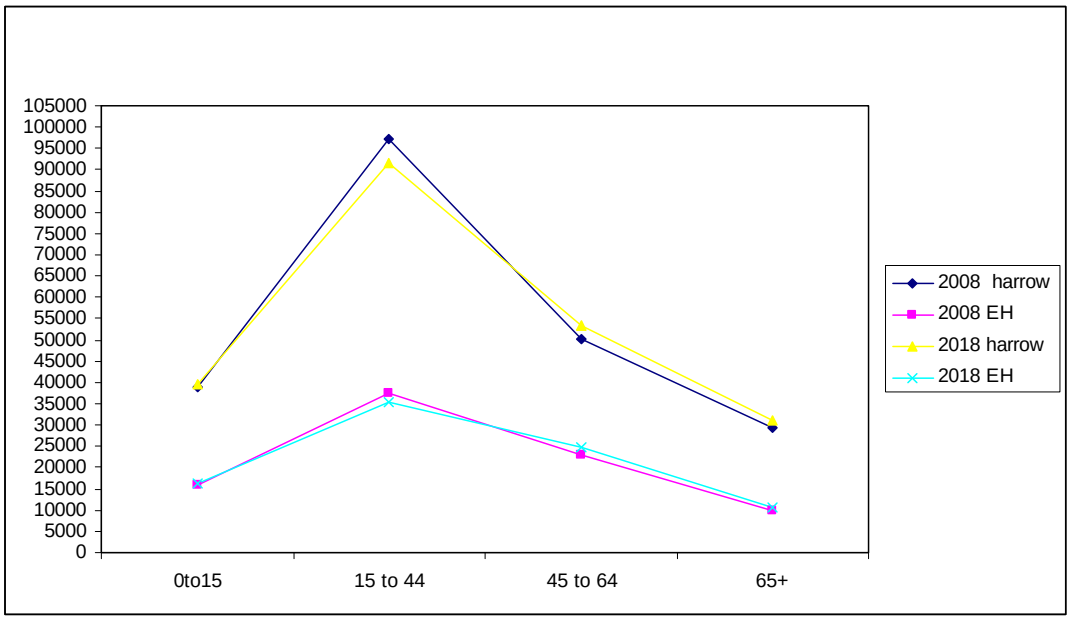
Figure 1: Age and Sex Profile of Harrow



Source Data: GLA 2007 Round of Demographic Projections – PLP Low analysed by Harrow Public Health Department

Harrow's population is expected to change with predicted growth in the 1 to 15, 45 to 64 and 65 plus age groups, alongside a significant reduction in the 15 to 44 age group. There is no reason to believe that East Harrow will be different from this.

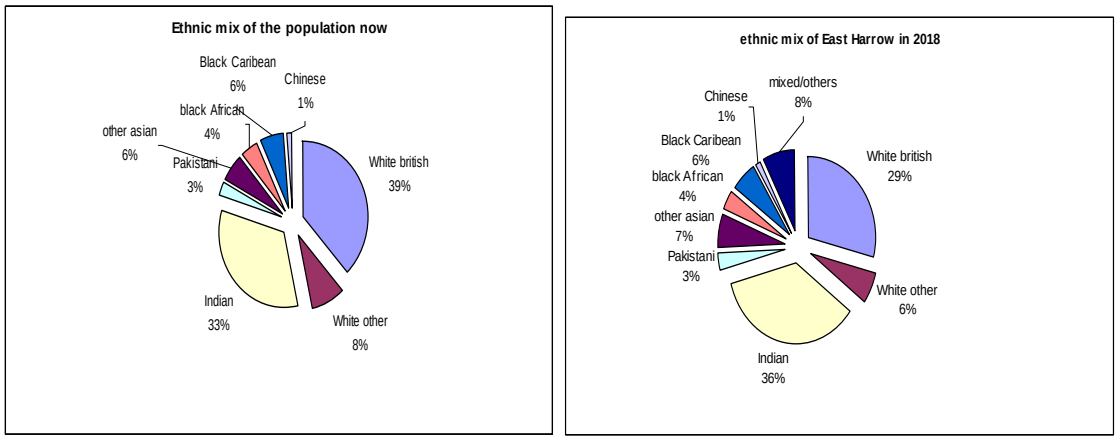
Figure 2: Population projections for Harrow and East Harrow



(The figures for Harrow has been applied to East Harrow's population)

Harrow is the fifth most ethnically diverse population in the country and this is reflected in the East, which has a higher proportion of the Black and Minority Ethnic (BME) groups at 55% than Harrow as a whole at 49%, and 29% for London.

Figure 3: Ethnic make up of Harrow and East Harrow



(Source: GLA Ethnic Group Population Projections 2007)

Population projections suggest that the population of Harrow will become more diverse over the next 10 years. The projections suggest a growth in the Asian population of 18%, in the Black population of 11%, and 2% for the Chinese population whilst the white population is projected to decrease by 17%. Applying these figures to East Harrow, by 2018, the proportion of BME groups in East Harrow would be 65%, a considerable rise from the current 55%. Certain BME groups experience a higher prevalence of some long term conditions such as diabetes and coronary heart disease. Improved Primary Care facilities would help patients manage these conditions, to avoid hospital attendance.

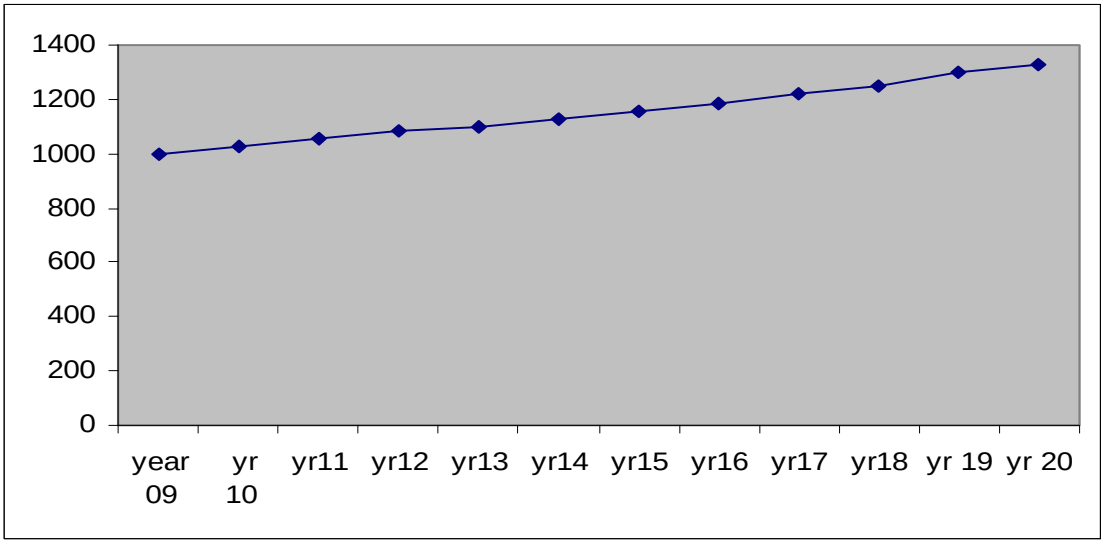
Deprivation

Harrow is one of the most affluent boroughs in London and in the country. Even though East Harrow has some of the affluent areas, it also has one of the most deprived Supra Output Areas (SOAs) in the country (Stanmore Park). Deprivation is directly linked to health inequalities. Having quality healthcare closer to home helps reinforce the preventative measures we can all take to avoid becoming unwell.

Birth rate

Harrow has approximately 3000 births every year, equating to 1000 births for East Harrow. Given that the number of women in the reproductive age group in East Harrow is lower than that of Harrow, the birth rate is likely to be lower. However we do not have exact figures for East Harrow. The projections for futures births show that there will be an increase in the number of births both for Harrow and East Harrow (fig). By 2020, there will be an additional 300 births in East Harrow.

Figure 4: Future birth projections for East Harrow



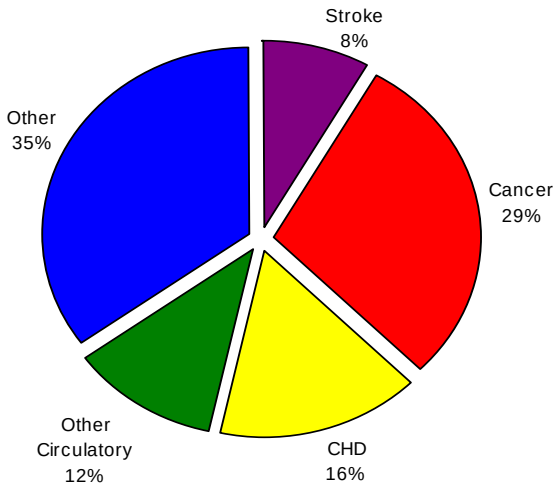
(Source: London Health Observatory LHO)

Death rate

There was a total of 1565 deaths in Harrow giving a death rate of 6.5/1000 population. Applying these figures to East Harrow, it can be estimated that there were around 500-600 deaths in East Harrow.

The most common causes of adult mortality in Harrow are cardiovascular diseases and cancers and there is no reason to believe that this is not the case for East Harrow.

Figure 5: Causes of mortality in Harrow, 2006 (Source PCT Annual Public Health Report, 2008)



Source: Compendium of Clinical Health Indicators - Accessed: June 2008

Prevalence of common health conditions

Prevalence of long term conditions, such as hypertension, obesity, asthma, diabetes and CHD, are higher in East Harrow than the rest of Harrow as demonstrated in the table below. However this needs to be interpreted with caution as the information comes mainly from the Quality Outcomes Framework (QOF) data which is likely to be incomplete. For example, the LHO estimates that only 50% of diabetics in Harrow have been diagnosed indicating a significant unmet need. Management of long term conditions would be a particular focus of a redeveloped Belmont Health Centre.

Table 2: Prevalence of common health conditions

Condition	East Harrow	Harrow (exc. East Harrow)	London	England
Hypertension	13.57%	12.47%	10.53%	12.79%
Obesity	6.80%	6.32%	6.71%	7.65%
Asthma	5.60%	5.43%	4.60%	5.75%
Diabetes	5.52%	4.86%	3.78%	3.87%
CHD[1]	3.16%	2.82%	2.26%	3.50%
CKD[2]	2.12%	2.83%	1.90%	2.94%
Stroke	1.23%	1.26%	1.03%	1.63%
Cancer	0.92%	0.99%	0.82%	1.08%
Mental Health	0.82%	0.88%	0.90%	0.73%
COPD[3]	0.70%	0.81%	0.93%	1.48%
Heart failure	0.67%	0.57%	0.51%	0.75%
Learning Disability	0.23%	0.20%	0.19%	0.27%

Source: QOF

[1] Coronary Heart disease
[2] Chronic Kidney Disease
[3] Chronic Obstructive Pulmonary Disease

QOF data suggests management of these common health conditions is variable. A considerable proportion of patients with diabetes (42%), for example, have uncontrolled diabetes (HbA1c of greater than 7.5). Similarly, more than 23% of patients with hypertension have a recorded blood pressure of greater than 150/90. This may be due to patients not accessing health care due to restricted opening hours. Moreover, the available data shows that there is a considerable number of DNA for outpatient appointments for diabetes which only strengthens the argument that access may be an issue for patients with long term conditions.

With the predicted increase in BME groups, the number of patients with diabetes is predicted to increase in the future years. It is expected that there will be an additional 500 patients with diabetes by 2020.

Table 3: Predicted growth in prevalence of diabetes

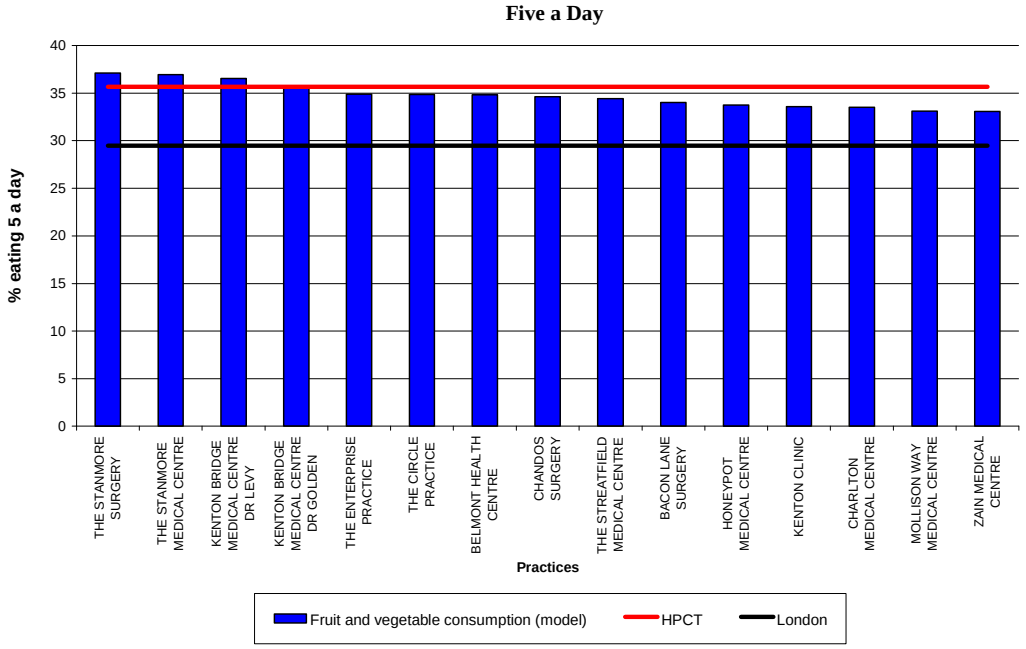
	2005	2010	2015	2020	2025t
Prevalence	5.74%	6.45%	7.15%	7.85%	8.54%
Number	12,291	13,935	15,727	17,618	19,529

Source: APHO PBS3 diabetes model

Lifestyle factors

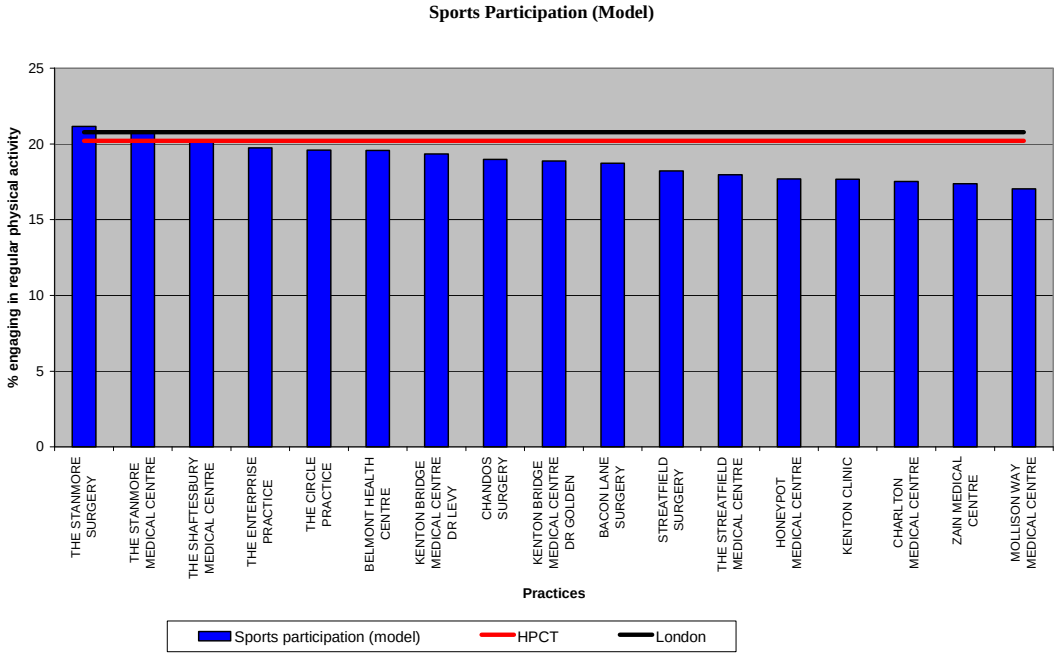
Approximately 35% of Harrow's population consume the recommended levels of fruits and vegetables and East Harrow is not different to this. While specific data for East Harrow is not available, the practice level estimates confirm this. These figures need to be interpreted with caution as they are estimates based on the national data.

Figure 6: Lifestyle factors



The participation of adult in sports in Harrow is very low at 20% (although not dissimilar to the London averages). However looking at the practice level data, while 50% of the practices have 20% of their adult population participating in sports, 50% of the practices have considerably lower levels.

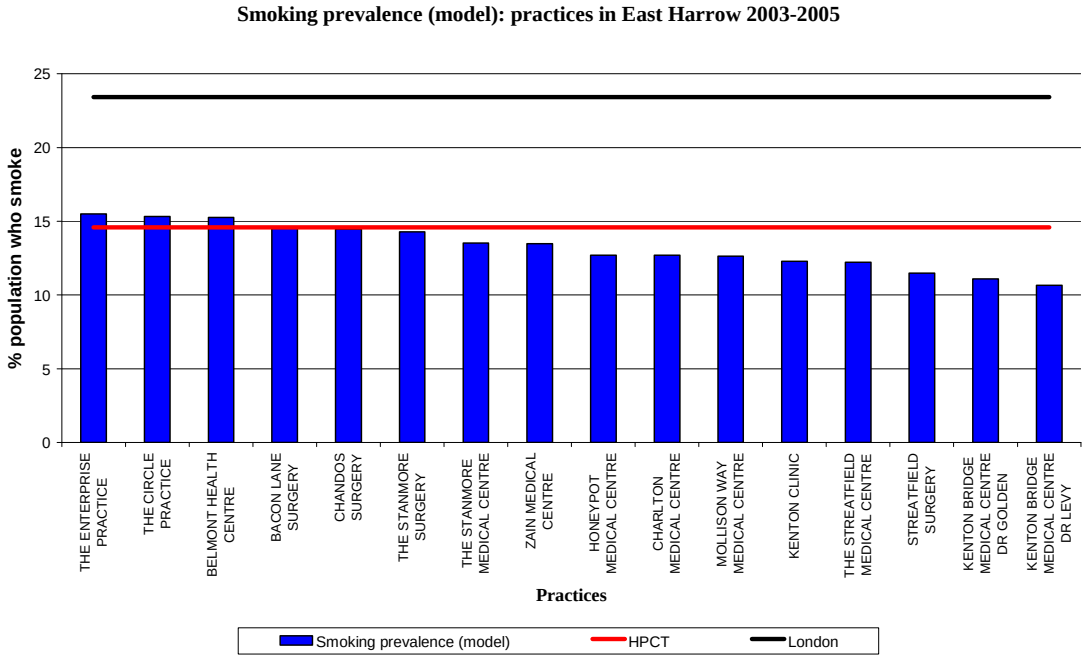
Figure 7: Lifestyle factors



Smoking

The prevalence of smoking in East Harrow is at 15%, similar to Harrow, but considerably lower than the London average (23.4%). However looking at the practice level data, more than 50% of practices in East Harrow have a prevalence of 12-13%. This reflects the higher ethnic mix of East Harrow.

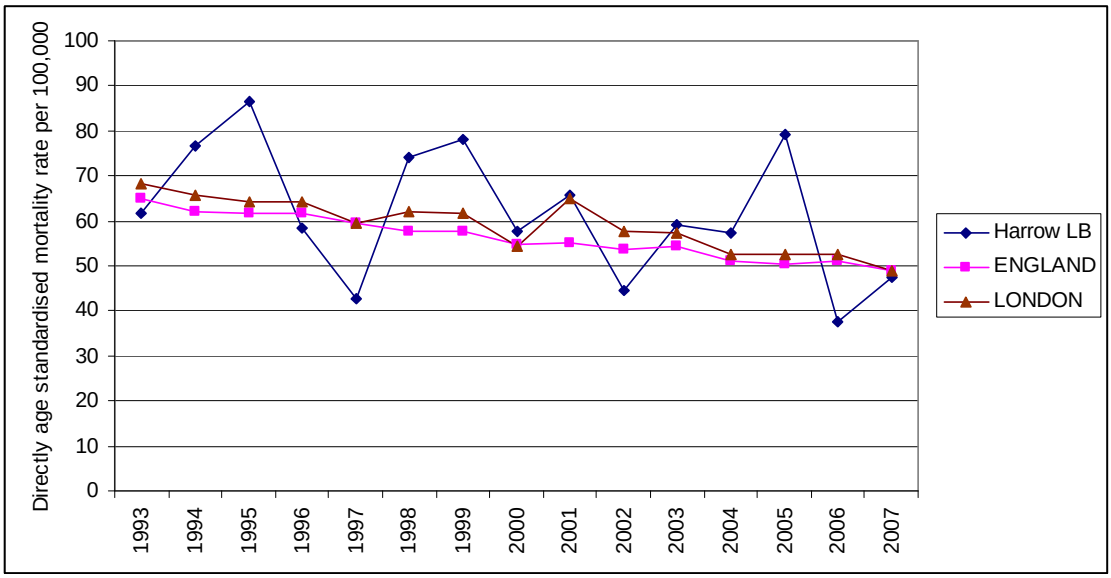
Figure 8: Smoking Prevalence



Morbity and Mortality in Children

Child mortality rates have shown a decline both nationally and in Harrow over the past decade.

Figure 9: Mortality in children under 15 years

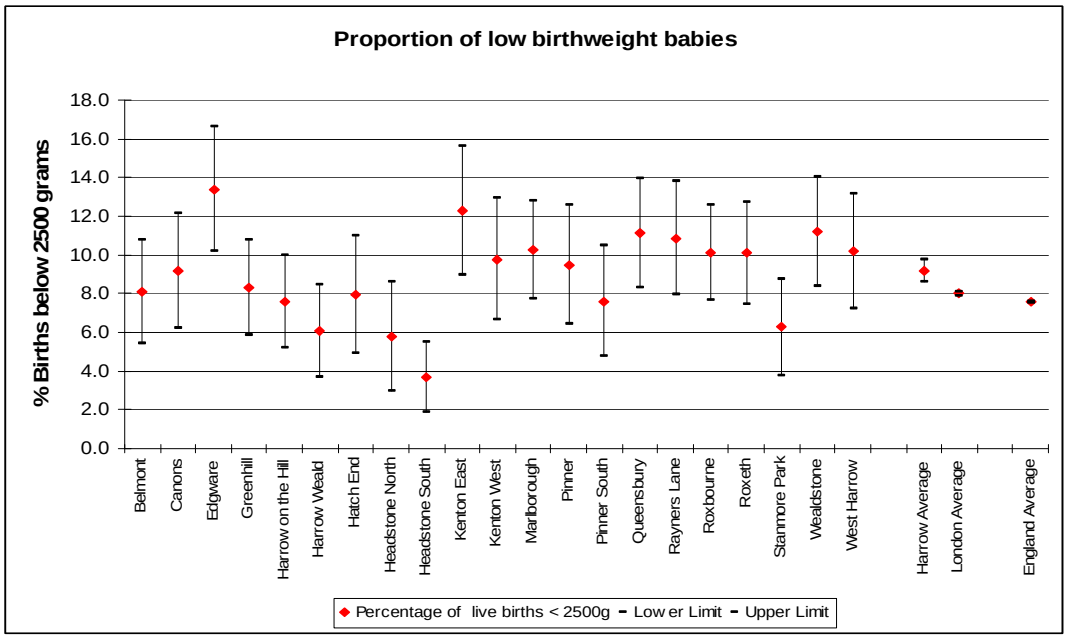


Low Birth Weight

A major cause of infant mortality is low birth weight (defined by the World Health Organisation (WHO) as a birth-weight less than 2,500 grams). Low birth-weight is also a well established risk

factor for immediate and long-term health problems. Approximately 10% of children born in Harrow have birth weights less than 2,500g. This would mean that there will be around 180 babies born with low birth weight every year in East Harrow. This is higher than the London average of 8.3% and there is also ward level variation in LBW rates.

Figure 10: Low Birth Weight by Harrow ward



Disease /lifestyle

The Health profile for Harrow (2008) shows that Harrow has a significantly lower number of physically active children and more children with tooth decay compared to the England average. Prevalence of childhood obesity is 9%, similar to the national average.

Chronic illness and Disability

The major causes of disability in children are:

1. Neuro-developmental disorders (epilepsy, learning disability, Asperger's, etc)
2. Sensory- Deafness/blindness
3. Physical/motor disability

Based on the information from the database on Disability Living Allowance Claimants, 13% of Harrow children have a disability in Harrow compared to 12% for London and 11% for the country. This would mean that there will be approximately 290 children with disability in East Harrow.

Table 4: Disability living allowance claimants for East Harrow

		East Harrow	*Harrow*	*England*
Claimants Aged Under 16 (Persons)	**Count**	**920**	**34,335**	**254,350**
	%	**13**	**12**	**11**

Epilepsy

Children with epilepsy face an increased risk of premature death, but the excess risk is concentrated in children with symptomatic epilepsy and in children with learning or physical disabilities, or both. Existing guidelines recommend that a paediatrician or a paediatric neurologist oversee the management of epilepsy in children, under shared care protocols with primary care. The prevalence of epilepsy is approximately 4/1000 population which means we would expect 80 children with epilepsy in East Harrow.

Learning disabilities

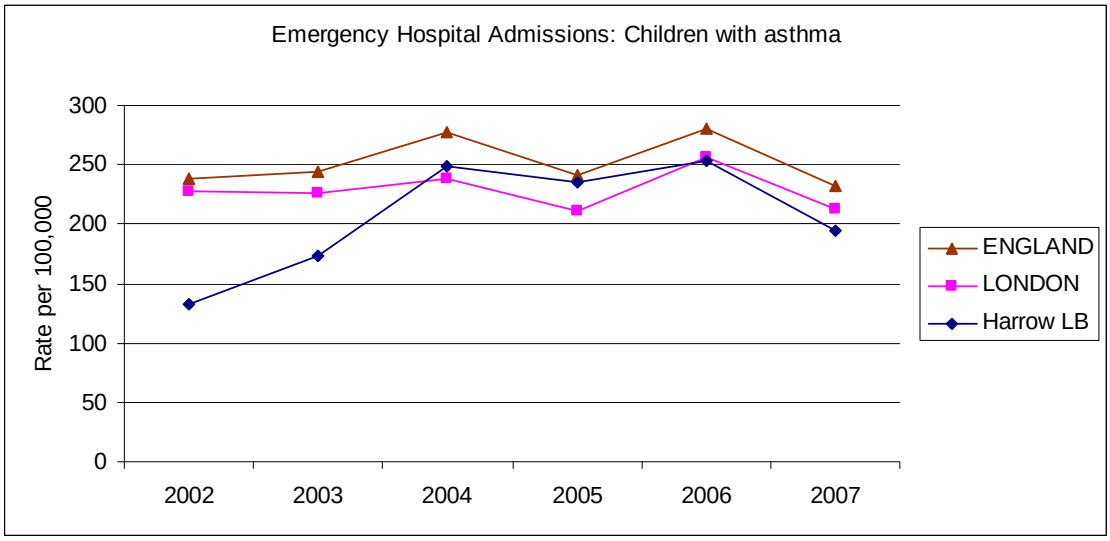
Local information suggests that there are 600 children in Harrow who are supported in schools for mild to moderate learning disability which would mean 200 children with learning disability in East Harrow.

Respiratory illness

Respiratory illness is a particular cause for concern in London and many emergency hospital admissions are related to asthma. Harrow has 900-999 hosptial admissions per 100,000 popualtion aged 1-19 years. Applying this to East Harrow, it can be estimated that there will be 180 to 200 admissions due to respiratory illnesses.

Similarly the hospital emergency admissions due to asthma in children are also showing an increase in Harrow which is likely to be applicable for East Harrow. Providing asthma clinics in the community will be able to reduce such emergency admissions in children.

Figure 11: Emergency admissions due to asthma in children under 15 years



3.2. Service Delivery and Performance

There would be 14 practices within the East Harrow poly-system; with patient list sizes in aggregate amounting to circa 83,000. A further two community clinics house NHS community provider services. There are 14 NHS general dentist practices, four of which hold child only contracts. In addition there are two orthodontic practices and one domiciliary service. The area is also served by 18 pharmacies and eight optometric practices.

Like Harrow as a whole the East is 'well-doctored' with comparatively low levels of GP vacancies and consistently achieving above average levels of QOF performance. Practice list size ranges from 1451 to 10,695 and 6 practices are currently single-handed.

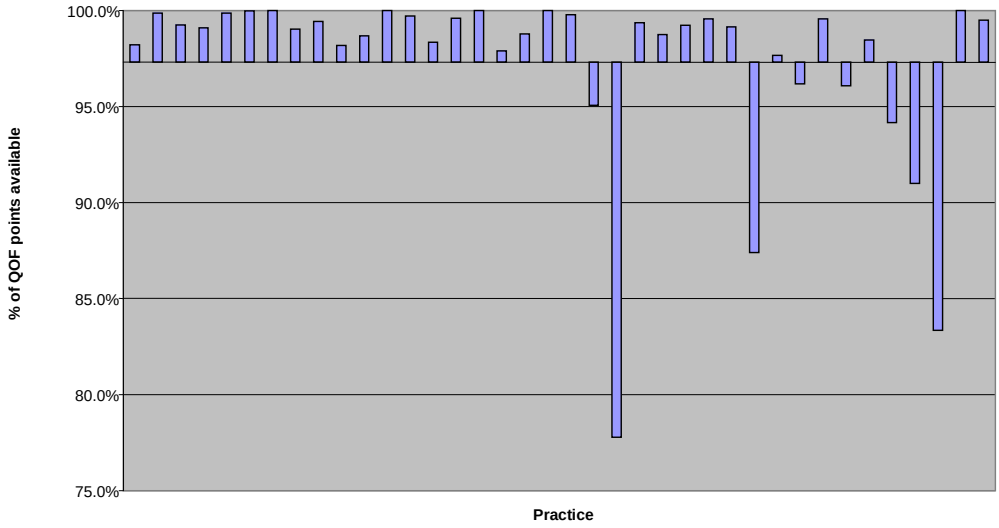
At present very few practices work from purpose built accommodation and smaller practices are largely based in poor quality buildings leading to historical inequalities in terms of accessibility and service provision. Even larger practices have limited space to develop additional services, something we must address if we are to support and treat more patients within the community.

General Practice Performance

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. The table below shows the performance of Harrow practices against the average performance for Harrow in 2007/08. Bars above the 97.6% line have better than average performance and the bars below the 97.6% line have worse than average performance. There are three practices with performance more than 10% below the average.

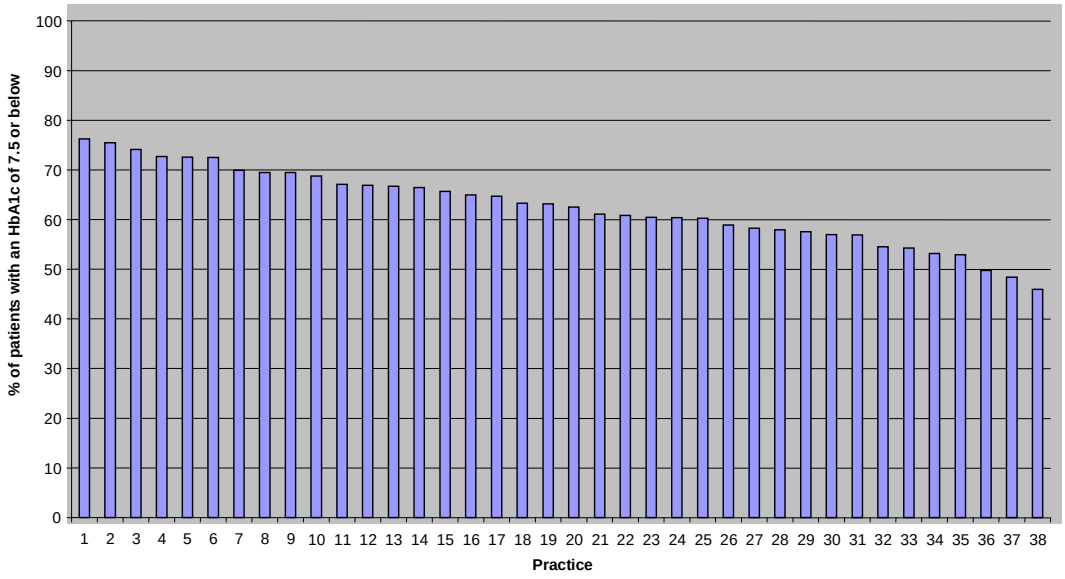
Figure 12: GP QOF performance in 07/08

General Practice QOF performance in 2007/08 compared to the average (97.6%)



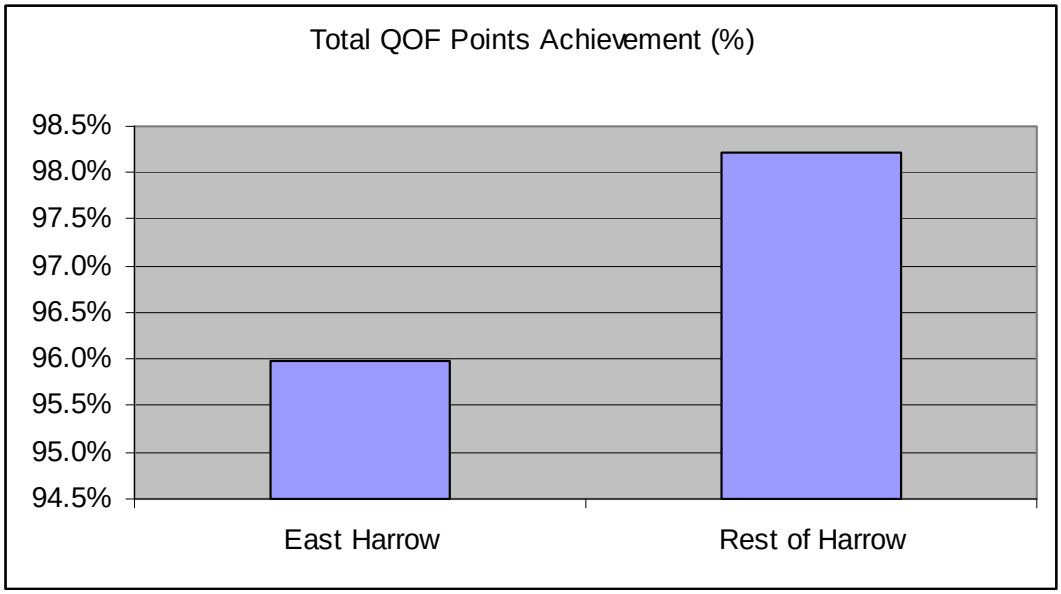
The variation in key measures of performance is significant. The chart below provides one example of the variation in clinical performance in the treatment of diabetes.

Figure 13:
Percentage of diabetic patients with an HbA1c of 7.5 or less, recorded in the previous 15 months



Reducing this variation in performance is a key driver for change in the East where variation is significant as shown in the comparison of QOF performance below:

Figure 14: Total QOF points achievement amongst Harrow GP's



Balanced Scorecard

In 2008/09 NHS Harrow 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 NHS Harrow 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 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. You can view the latest scorecard on our website at:
http://www.harrowpct.nhs.uk/gp_scorecard.html

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 Harrow Balanced Scorecard for General Practice shows a marked variation between practices. Despite extended opening hours operating at a number of sites across Harrow, we are rated among the worst in the country for patient reported access. However, the table below shows that patient satisfaction with GP services overall is about the same as other Trusts.

Figure 15: Benchmarked report for satisfaction with seeing the GP

Topics	Harrow scores (out of 10)	How this score compares with other trusts
Listening for the doctor listening carefully to them	**8.9**/10	About the same
Time for being given enough time to discuss their medical problem with their doctor	**8.3**/10	About the same
Involvement in decisions for being involved as much as they wanted to be in decisions about their care and treatment	**8**/10	About the same
Answers to questions for getting answers they could understand from their doctor, when they asked questions	**8.5**/10	About the same
Explanation for being given an explanation, which they could understand, of the reasons for any treatment or action	**8.4**/10	About the same
Confidence and trust for having confidence and trust in the doctor	**8.5**/10	About the same
Respect and dignity for feeling they were treated with respect and dignity by the doctor	**9.6**/10	About the same

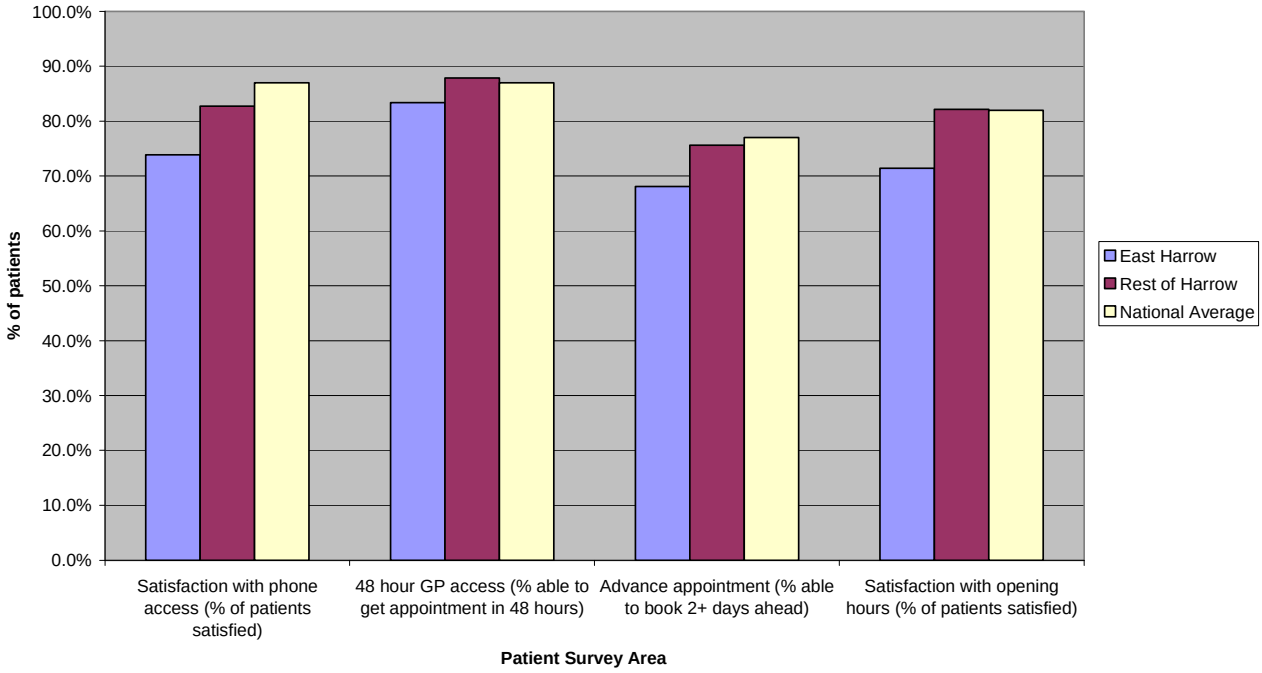
Healthcare Commission National survey of local health services 2008: Harrow PCT Report

Patients have, however, expressed how much they value the personal relationship and continuity of care they receive from their doctor. Any model of care for East Harrow should seek to preserve this relationship between the GP and patient.

Access to primary care services tends to be poorer in the East of Harrow, as demonstrated by the 2007/08 General Practice Patient Survey results. The chart below demonstrates that East Harrow practices perform worse across several survey areas than both the rest of Harrow and the national average. Patients' satisfaction with opening hours, for example, is 10% lower in East

Harrow compared to the rest. Of those patients dissatisfied with opening hours over 80% would prefer increased opening hours in the evenings and on Saturdays. This has helped inform our choice of the poly-system model for East Harrow; to include increased access to primary care services at times convenient to patients.

Figure 16: GP patient survey 2008



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.

Despite this, 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 in East Harrow and, 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. Our patient scorecard is publicly available and represents a first step in facilitating that choice. Development of accessible services right across East Harrow will be critical to ensure that choice of general practice is a real one.

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 NHS Harrow 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). Current ways of working and facilities to work from do not support this.

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 NHS Harrow 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 have a contract with NHS Harrow. 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.

The majority of community services within the borough are provided by NHS Harrow's community provider services. Our community services formed an alliance with NHS Ealing's community services last year. We are in the process of exploring an Integrated Care Organisation which would allow Ealing and Harrow Community Services to integrate with Ealing Hospital. This will lead to a sustainable provider organisation that is able to draw on both community and hospital care expertise to realize new benefits for Harrow patients.

Harrow community services are clearly accessed by East Harrow residents, although access to many of these services follows generic models of provision and is not specifically designed for the needs of each locality, including East Harrow. 255 whole time equivalent staff provide services from five community clinics across Harrow, 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.

There are a significant number of challenges for the next five years for Harrow as a whole and for service delivery in the East of the borough. NHS Harrow 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 NHS Harrow Strategic plan, highlight clear reasons for change.

The NHS Harrow 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 NHS Harrow 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 in Harrow, and equally in the East 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 unplanned care across the sector has shown a continued and high dependence on A&E, despite NHS Harrow's interventions and the establishment of the Urgent Care Centre (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 5: Appropriateness of Emergency Admissions for North West London

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 above 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 have room for development against the standards defined by the Disability Discrimination Act (DDA), 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 NHS Harrow 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. Commissioning of primary and community care in Harrow will need to allow new models of care to be delivered in modern facilities but NHS Harrow has a far wider challenge to establish this level of infrastructure and integration across the borough.

Changes described in the Primary and Community Care Strategy and again in this Outline Business Case must 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 NHS Harrow describes in its Strategic plan for 2008/09 to 2012/13.

4. DELIVERING THE PRIMARY AND COMMUNITY CARE STRATEGY IN EAST HARROW

4.1. A Prioritised Area for Development

A review of current and future health needs taken together with an outline of the services and service models in place to address them make a compelling case for change. Within East Harrow the following drivers for change are clear:

- East Harrow has a slightly lower number of people in the working age, lower number of women in reproductive age group, higher number of BME groups which is projected to increase in future years and has one of the most deprived supra output areas in the country when compared to rest of the Harrow. All these factors indicate increasing levels of deprivation in East Harrow and a widening of health inequalities in the future.

- With the projected increase in the number of births in Harrow, it is important that there is adequate provision of community paediatrics services including breastfeeding, immunisation and health visiting services.

- There are a considerable number of children with complex needs in East Harrow who would benefit from integrated services closer to home.

- Low birth weight and hospital admissions due to respiratory conditions including asthma are preventable by providing adquate diagnsotics and treatment services in the community. Childhood obesity is a growing problem which requires appropriate community services to be in place and accessible to local populations across Harrow.

- With the expected increase in deprivation in East Harrow, childhood poverty is likely to increase which may have an impact on the services in terms of increased demand in the future years.

- East Harrow has higher prevalence of hypertension, diabetes, obesity and asthma when compared to the rest of Harrow, London and the national averages. With the predicted rise in the proportion of the BME population, these numbers are likely to increase.

- The hospital admissions data show that the numbers of attendances / admissions due to conditions that can be treated at home are higher than expected for some of the conditions both for Harrow and East Harrow.

- The health inequalities are likely to increase in East Harrow unless services are redesigned to improve access both in terms of physical and geographical access. These services should especially target vascular screening including the entire care pathways for the diseases such as chronic kidney disease and diabetes within the community wherever possible.

- Services as they are currently commissioned and organised will not provide for more localised delivery of services or ensure that hospital care is only accessed when absolutely necessary. Spend on health services is locked into less efficient and more expensive models of care that do not draw upon the skills and potential capacity of primary and community care in East Harrow.

- Integrated service delivery, both between health and social care and between primary and community care teams, is not supported by the current configuration of services. Patients reported experience reflects this.

- Action is required to address inequalities in access to care and in outcomes, both within East Harrow and across the borough as a whole. A new model of service delivery that ensures consistent and high quality services is essential. This should also be supported by an enhanced choice of services in the community for East Harrow and appropriate access to information about services to allow residents to make that choice.

More than this it seems clear that existing sites of provision have limited room for expansion for service delivery to allow for enhanced integration or to support a shift of appropriate activity from secondary to primary care in support of demand management (required to allow the enhanced level of investment required in the community).

The vision and goals set out by the Primary and Community Care Strategy are aligned to the needs for change in East Harrow and the introduction of a poly-system model described by that strategy is required to achieve the following changes below for people who live in East Harrow:

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

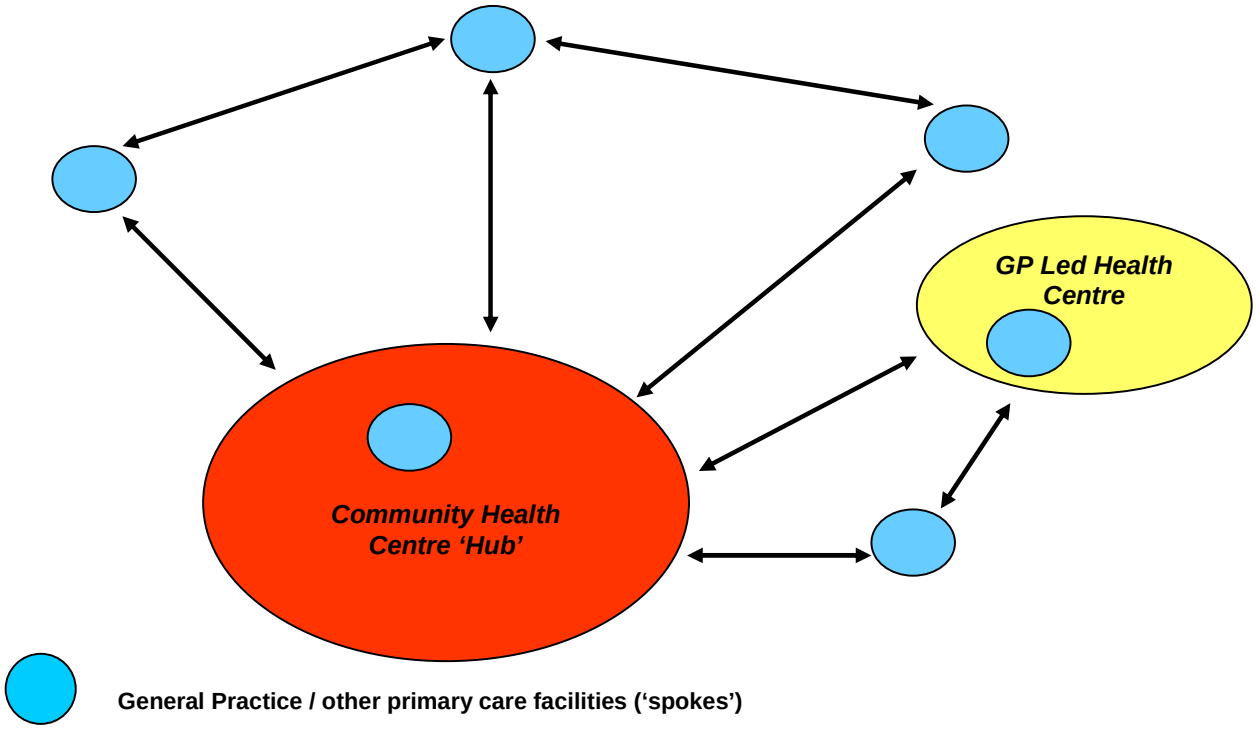
Over the next five years patients will receive services from highly skilled, well trained and well motivated staff acting as champions for health and well-being. Where those services need to be delivered outside of the home they will be delivered in high quality estate within close proximity to patient's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

The sections that follow seek to outline the new service settings and service locations that would be required in the East to support this vision and specifically go on to outline the potential estate configuration to support this.

4.2. A Poly-system model for East Harrow

A Poly-system for East Harrow would represent the commissioning of a federated model of primary and community care, organising new and existing services around a hub, with each spoke being linked. A graphic illustration of a generic poly-system model for a prioritised development area is shown below:

Figure 17: A graphic illustration of a generic poly-system model



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. 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. The size number and location of sites must take full account of the following:

- The location, quality and potential for expansion of existing local provision
- The economic viability of the particular service to be delivered (e.g. local demand)
- The accessibility of sites (taking account of transport infrastructure, DDA, parking, etc)

More than this the affordability of a new configuration of estate will ensure the best use of our existing estate is prioritised and that facilities can ensure the optimal provision of services that will support more integrated and efficient service provision and will allow for the delivery of demand management activities. The poly-system model is designed to serve a population of approximately 80,000 patients.

Taking into account the size of the population in East Harrow, the Poly-system model for this locality would consist of the following:

'Hub' – A Community Health Centre will provide general practice services to its immediate locality and additional services for the wider locality. It will provide a wide range of community services (phlebotomy or dentistry) as well as basic diagnostics and access to outpatient services,

X-ray and other more specialist services to the whole East Harrow area. The hub will be open between 8am and 8pm, 365 days a year and will be linked to the 'spokes'.

'Spokes' – A series of individual general practices that will be commissioned to deliver high quality services that promote improved access and choice to patients within improved opening hours, five days a week, delivering contractual requirements and essential, additional and locally enhanced services. A '*Spoke'* will be a facility that can be demonstrated to be fit for purpose for the effective delivery of these services for the medium to long term (5 to 10 years).

'GP Led Health Centres' – These are spokes with enhanced access and services which will provide general practice services to their immediate locality but equally provide additional services for the wider locality. The GP led health centres would be of sufficient size to provide a wider range of community services as well as basic diagnostics and other extended services. Our plans are to have one GP Led Health Centre for East Harrow on Mollison Way. This will open in January 2010 and be open between 8am and 8pm, 365 days a year.

Outline Service Profile

A Full Business Case for the poly-system model in East Harrow will describe the specific services to be delivered at the hub and this would be worked up through the project board supported by a clinical reference group ensuring that plans respond to the identified needs of each specific local population. However **it is expected that a hub development in East Harrow would have the following functions as a minimum:**

- It will provide general practice services to a registered patient list, this may 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 in Harrow at all).
- The hub 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 spoke practices operating around the hub.
- The hub will provide access to diagnostic facilities such as x-ray, ultrasound and endoscopes.
- Community services delivered by teams commissioned to provide services as part of that network.
- The hub will provide health promotion and prevention activities and programmes.
- The hub 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. a walk-in service to treat urgent minor injuries.
- The hub will provide a range of outpatient service traditionally only found within a hospital setting.
- The hub will be a health and community resource which will engage the local community in its health and health services.

The hub will also provide access to a wider range of 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. Social Services linked to help at home, housing advice, fitness and exercise schemes. We are particularly keen to work with the local authority to develop integrated health, well-being and public services access points.

The delivery of this new model of care described above will support the enhanced integration of services. This model would 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.

The delivery of these networked models of care is also integral to the delivery of the NHS Harrow demand management plans. The demand management plans for NHS Harrow and the resulting shifts in activity are outlined in the NHS Harrow CSP. These require a significant shift of activity to community settings and the development of poly-systems across the borough will play a central role by providing planned and unplanned care in each locality.

The hub and GP Led Health Centre in East Harrow will provide a more accessible and appropriate setting for the treatment or minor injury and illness through Urgent Care Centres with diagnostic support. The hub 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 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.

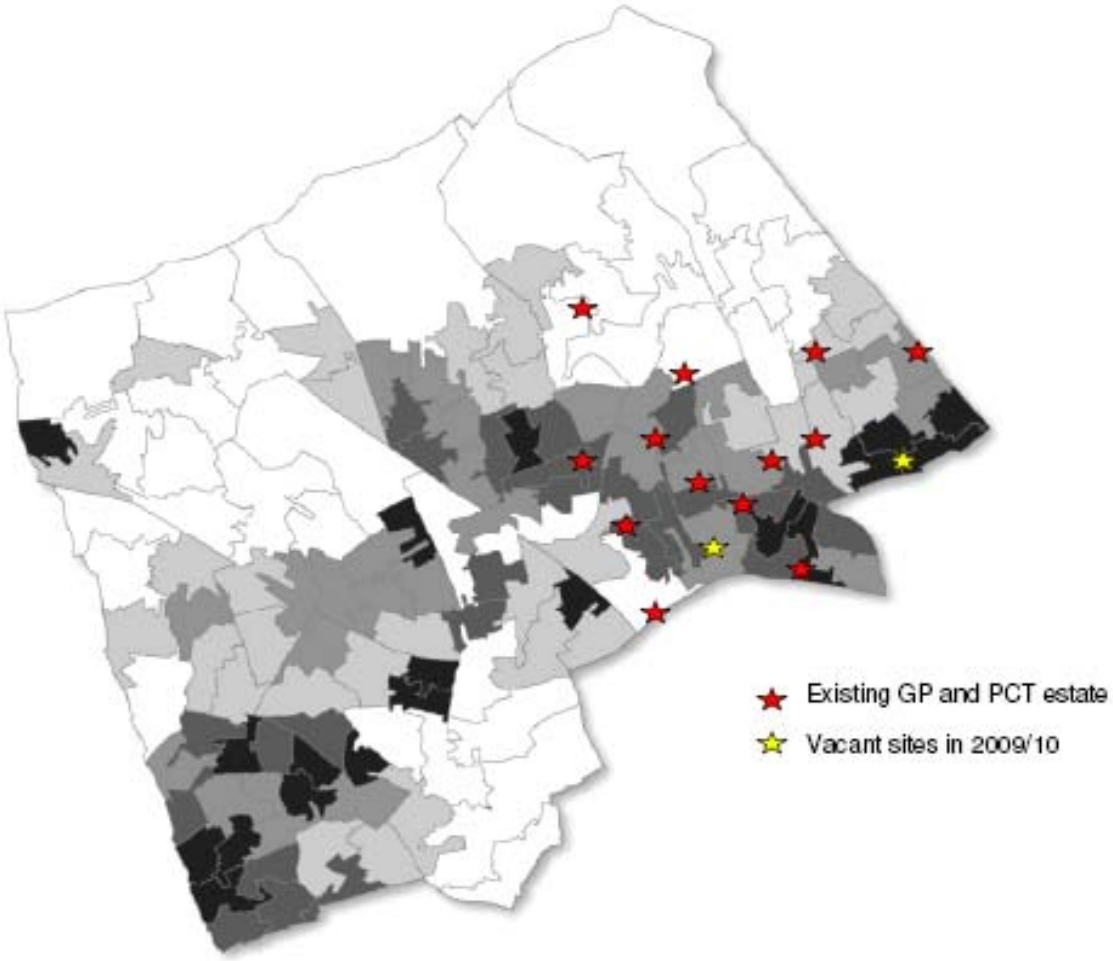
4.3 Providing Services in Community Settings

NHS Harrow currently provides the following services in the community, supported by diagnostics where appropriate: urology; gastroenterology; dermatology; minor surgery; gynaecology; MSK (rheumatology and orthopaedics) cardiology; ophthalmology; diabetes and neurology. These services are provided by a mix of providers including private sector and collaboration between NHS Harrow and two NHS secondary care trusts. The development of an East Harrow poly-system gives NHS Harrow an opportunity to develop a wider range of community based services in the East of the borough which is relatively poorly served at present.

4.4 Proposals – Reconfiguration of Estate (how we evaluated the options)

The delivery of a poly-system model will require the reconfiguration of estate to allow the enhanced delivery of existing primary and community care services and to support the delivery of extended and integrated service provision across this part of the borough. Any reconfiguration of estate in the east should be focused upon providing opportunities to house services from the best possible accommodation whilst recognising that some estate is GP owned or Local Authority owned at present. Given the current economic situation it will also be important to make the best use of the existing estate, accepting that in some cases refurbishment and re-build will be necessary to deliver the amount of clinical space needed to deliver the level of improvement we envisage.

The present estate is shown below, two vacant sites are shown, one is the Mollison Way GP led Health Centre due to open in January 2010 and the other is the vacant Kenmore clinic site. The darker areas of shading indicate higher numbers of people live in those areas:



Transport links effectively provide for two separate areas within East Harrow, broadly these are north east and south east. The south is more heavily populated and urban than the north which has more Greenfield areas. This taken together with the location of Edgware Community Hospital on the north east boarder suggest the south and central eastern areas should be prioritised for development even within East Harrow itself.

At present East Harrow primary care estate comprises 15 general practices across 13 sites and two community clinics. The estate is made up of a mixture of purpose built facilities and converted 1930s housing stock. In August 2008, Ingleton Wood surveyors completed a comprehensive report of all GP practices and clinics within Harrow, commissioned by NHS Harrow.

This section of the Outline Business Case takes the facts from Ingleton Wood's survey and analyses the results to determine which primary care premises in East Harrow are suitable to fit the proposed poly-system model outlined above. Specifically, premises are appraised to ensure that effective use is obtained from existing assets, especially given the current economic conditions and limitations on new investments.

Two phases of assessment have been applied here. The first using criteria such as potential for expansion via investment and to develop to the changing health needs of the East Harrow population and to meet patient demands of primary and community care services. The second using criteria such as transport links, parking, proximity to other services and population density/natural communities. The latter criteria would only be applied to those sites that are approved through the first.

East Harrow primary and community sites have been extracted from Ingleton Wood's report, the considerations and results being summarised on the table below and in Appendix A. In order to assess premises as potentially suitable for East Harrow primary care services the following key considerations were evaluated in the first phase:

Table 6

Key consideration	Details
Potential to Expand Premises	Premises were evaluated as to whether the existing building provides the opportunity to extend through either extending existing premises, remodelling premises, acquiring adjoining properties or major site redevelopment. Potential to expand was considered a key consideration to make best use of established infrastructure and provide the opportunity to expand services to meet increased demands from primary care services.
Premises suitability for additional investment	The state, age, design and condition of the existing premises were considered to establish whether the buildings were good opportunities for additional investment to expand and upgrade facilities over time. The objective is to identify the premises where additional investment would have the biggest impact in improving the quality of the East Harrow primary care estate, effectively making best use of NHS Harrow's limited budget.
Access and Disability Discrimination Act (DDA) compliance	Disabled access including DDA compliance was evaluated for each East Harrow primary care premises.

This initial assessment suggests the following premises fit the criteria of potential to extend, suitability for additional investment and DDA accessibility compliance:

- Kenton Clinic (GP owned)
- Kenton Bridge Medical Centre (GP rented)
- 11 Bacon Lane (GP owned)
- Belmont Health Centre (Local authority owned)
- Honeypot Lane Clinic (Local Authority owned)
- Kenmore Clinic (PCT owned).

These sites offer differing potential to expand their services and differing investment costs, timescales and complexity to realise upgraded and extended facilities. Additional weight must be placed upon the potential for expansion and capacity growth at each site. This is evaluated at each site in the following tables, set against the other relevant demographic factors.

Table 7

Site	KENTON CLINIC
Potential Expansion/Capacity increase	Very limited, expansion into loft only
PCT Control	GP owned
Scale of Investment	Relatively low, limited conversion potential
Public Transport Links	No direct access buses from central Harrow within close proximity
Parking facilities	Local street parking only
Population density	High density

Table 8

Site	KENTON BRIDGE
Potential Expansion/Capacity increase	Very limited Conversion of existing area
PCT Control	No, rented from Sainsburys
Scale of Investment	Relatively low, limited conversion potential
Public Transport Links	Good, close to Kenton Station and a range of buses stop outside
Parking facilities	Small number of off street parking spaces
Population density	High density

Table 9

Site	11 BACON LANE
Potential Expansion/Capacity increase	Dependant upon planning permission and agreement to expand into adjourning property
PCT Control	GP owned
Scale of Investment	Moderate conversion costs
Public Transport Links	Average, no direct public transport access, a bus stop within walking distance, no buses from central Harrow within close reach
Parking facilities	Local street parking only, on a congested residential road
Population density	Medium to high

Table 10

Site	BELMONT HEALTH CENTRE
Potential Expansion/Capacity increase	Excellent, larger premises with potential to extend. Most potential capacity for additional services. Could deliver at least 2,000m² of space
PCT Control	Local authority owned, PCT leaseholders
Scale of Investment	High, substantial refurbishment and rebuild required
Public Transport Links	Good, bus stop outside the complex from Central Harrow and surrounding areas
Parking facilities	Has own car park and council car park adjacent, which could be used to assist in the continuation of service provision
Population density	Medium to high

Table 11

Site	HONEYPOT LANE CLINIC
Potential Expansion/Capacity increase	Limited. Dependant upon ability to relocate existing tenants. Would require substantial internal modification to deliver an additional 300m²
PCT Control	Local Authority owned, PCT leaseholders
Scale of Investment	Moderate conversion costs
Public Transport Links	Good. Bus stops from Central Harrow within 5 minutes walk
Parking facilities	Very limited car parking apart from disabled and staff, parking available on surrounding residential roads
Population density	Low to medium

Table 12

Site	KENMORE CLINIC
Potential Expansion/Capacity increase	Rebuild potential only, medium capacity to rebuild for purpose built modern premises. A 2 storey site redevelopment could deliver 600m²
PCT Control	PCT owned
Scale of Investment	High, completely rebuild facility
Public Transport Links	No direct access buses from central Harrow within close proximity
Parking facilities	Car parking available on surrounding residential roads only
Population density	High

It is immediately clear that both the Kenton Clinic and Kenton Bridge Medical Centre only provide the opportunity to allow very limited expansion of facilities and on this basis they have not been included in any further assessment.

The following summary table considers the remaining sites and simplifies their potential to provide hub facilities within the poly-system model for the East into a red, amber or green rating. (It is accepted that each site has the potential for some expansion).

Table 13

Site	Potential Capacity increase	PCT Control	Scale of Investment	Public Transport Links	Parking facilities	Population density
11 Bacon Lane	● R	● A	● G	● A	● R	● G
Honeypot Lane Clinic	● R	● A	● R	● A	● R	● A
Kenmore Clinic	● A	● G	● R	● A	● A	● G
Belmont Clinic	● G	● G	● R	● G	● G	● G

Positive ● Green Negative ● Red Moderate ● Amber

11 Bacon Lane provides limited expansion possibilities within existing premises but could achieve this through acquiring the neighbouring premises in order to extend. However, further discussions with the local authority planning team describe Bacon Lane as sited within a residential area that could become congested with traffic and parking difficulties should use increase. The local authority also have current plans not to reduce the number of residential housing units in this area, thus limiting expansion potential. The premises are also located in the north east of the borough in very close proximity to the Edgware Community Hospital site, which already offers a large range of services.

Honeypot Lane Clinic could realise additional space through relocation of current service providers. However, it has limited expansion potential and would face extensive remodelling of the existing facilities. Only with relocated providers and substantial alterations in layout could this site deliver a small increase in size of around 300m². The costs, timing and complexity involved are considered significant to achieve the building modifications.

Kenmore Clinic site could be redeveloped into a primary and community care centre but will require major investment by NHS Harrow to achieve this. It would be a relatively small site upon which to place a central hub development, offering mainly upwards expansion. The site itself has a 0.14 acre footprint and the current single storey building is 382m², it offers a maximum development of approximately 600m² achievable from a 2 storey building. Even though the site is currently owned by NHS Harrow, the building is not fit for purpose and would have to be demolished and rebuilt. Public transport links are moderate and there is no on-site parking, which is likely to reduce expansion capacity further, if only to ensure adequate parking provision for disabled visitors. The NHS Harrow commitment to return services to Kenmore Clinic remains, although at this stage we have not found the right proposal from our healthcare providers.

Belmont Health Centre is the largest of the sites with the most room for development. The current building size is 1450m² and offers growth potential as to at least 2,000m². It currently houses three general practices and a community nursing team. The existing service profile fits with our longer term development aims. The centre has the best transport links and parking facilities. Whilst redevelopment costs would be high, our discussions with the incumbent GP's have centred around a proposal from them to buy the building from the local authority and redevelop the site. Modernisation and improvement is needed, for example it has 4 receptions, one for each service provider.

Recommendations

The development of a poly-system for East Harrow will require a configuration of estate at three separate levels and this early analysis provides recommendations for configuration of estate ahead of consultation:

Please Note: Analysis has not considered the provision of additional estate either through procurement or direct purchase. Moreover it is limited to the consideration of general practice and community sites given the proposed model will include GP services at each setting of care.

General Practice sites (Spokes)

The findings of the Ingleton Wood report taken together with the commissioning intentions of NHS Harrow would suggest that a number of existing sites will be fit for purpose for the provision of spoke services in the medium to long term. Where the report does highlight premises concerns; NHS Harrow would expect to work with all independent contractors to ensure the future delivery of primary and community care services is supported by the best possible infrastructure within the poly-system.

GP-led health centres (enhanced spokes)

NHS Harrow has procured a GP led Health Centre on Mollison Way. This is an existing commitment and will provide the GP led Health Centre within this model.

Community Health Centre (Hub)

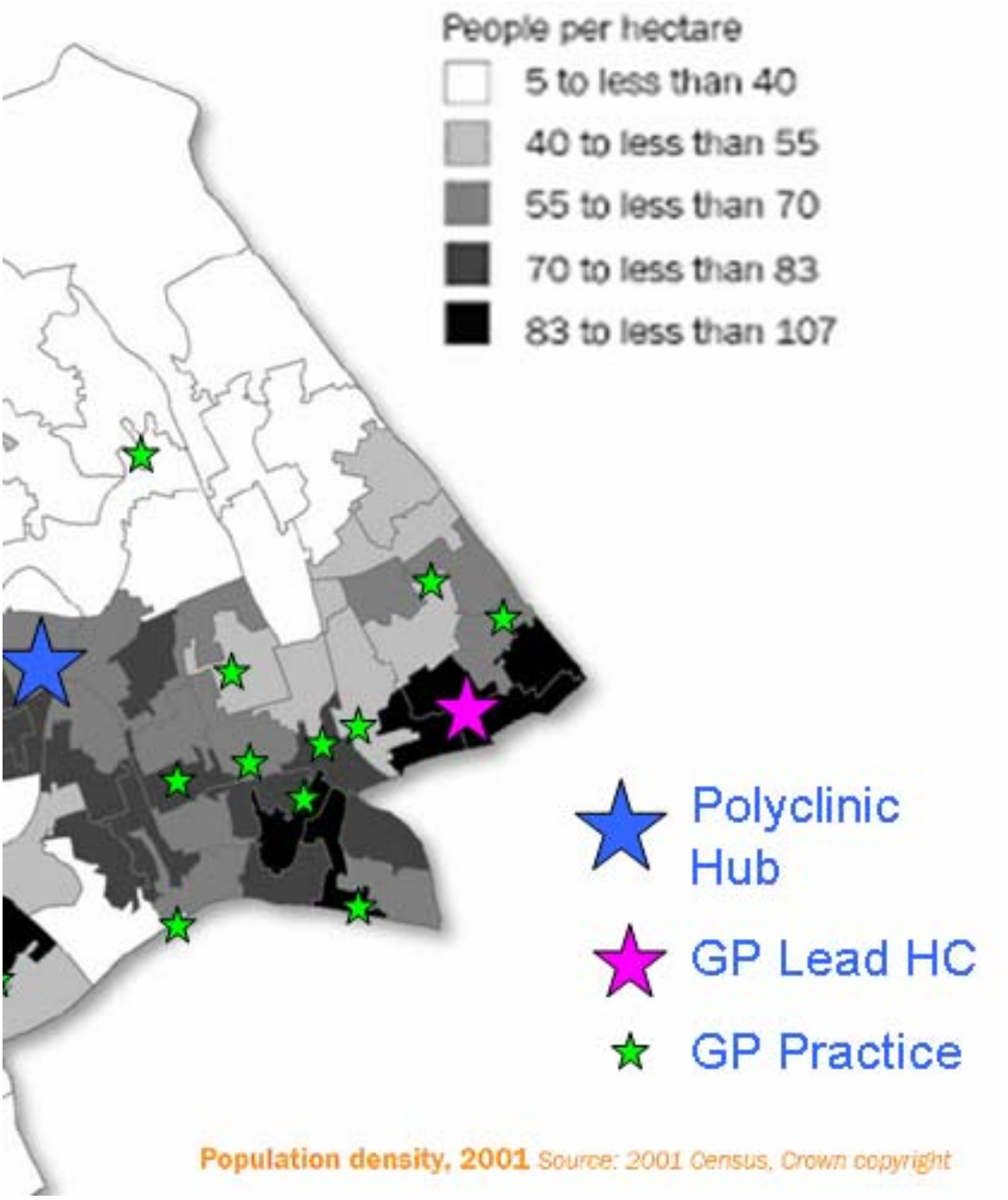
Further examination of existing sites, following the initial assessment to establish those which have the potential to support a development of this size, would suggest that at present **Belmont Health Centre is the only site with potential to become the hub**.

Our plans have changed shape over the course of the last year, due to both the financial environment and refining of the poly-system model. It is recognised that investment in 2 GP led health centres was contemplated in earlier plans. However, the current financial climate and assessment of future funding arrangements dictate that we only pursue the development of Belmont Health Centre at this stage.

4.5 PREFERRED OPTION FOR EAST HARROW

- Our Proposal: Belmont Health Centre redeveloped to be the Community Health Centre hub and a GP led Health Centre on Mollison Way (to open January 2010).

(We have 'zoomed in' on East Harrow on the map below)



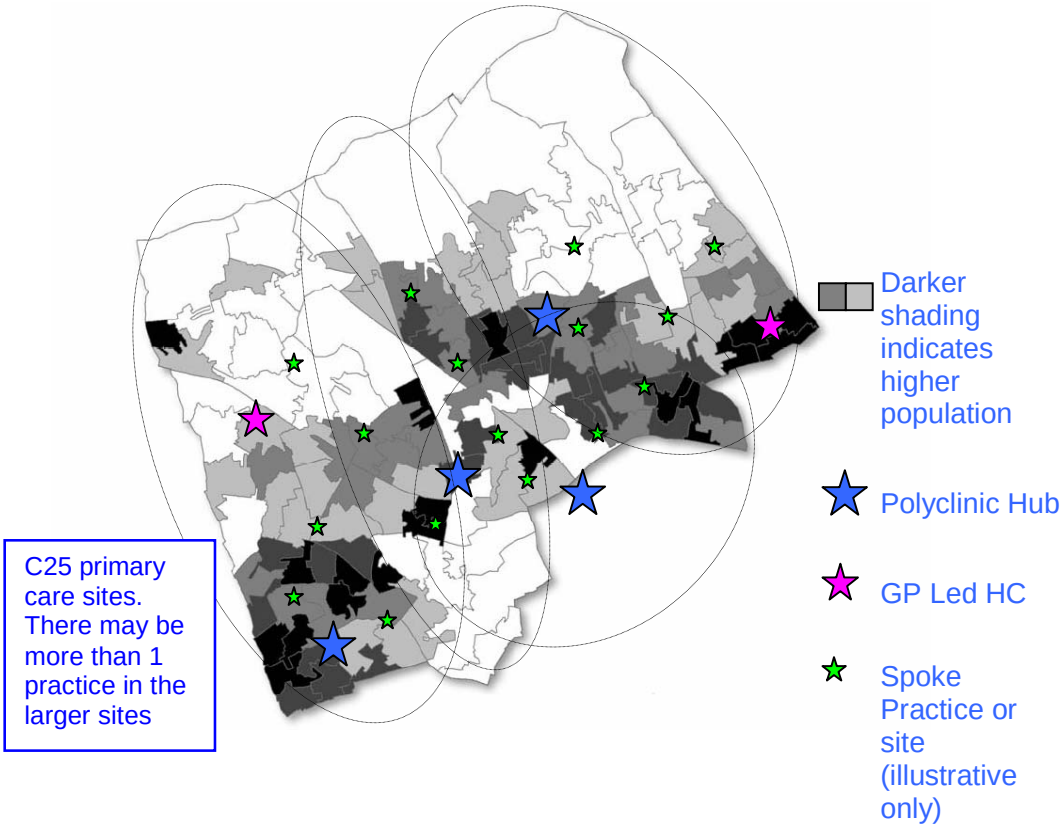
4.6 Our long-term plans for the rest of Harrow

NHS Harrow is developing similar investment plans for the rest of Harrow. Based on the poly-system model described above, it is expected that the optimum number of sites (polyclinic hubs, GP led health centres and GP surgeries) will be around 25, together providing the full range of services in a poly-system model.

These have been set out in 4 poly-systems, each having a large hub or polyclinic with GP-led health centres and practices as spokes. These health communities will provide a range of health services for a specific geographic area of Harrow. The areas have been selected based on the segmentation of the population by density, deprivation, transport links and natural communities.

The number of practices and sizes of population covered by each poly-system reflects the PCT's aspiration to ultimately move a significant amount of current hospital-based activity into the community. Up to 55% of out-patients activity (120,000 appointments for Harrow) and all A&E attendances that are appropriate for treatment by Primary Care, (up to 60% of current activity or 30,000 attendances) may be managed in poly-systems in the next 2-5 years.

The map below shows where each polyclinic (or hub) is currently or is likely to be located, along with the ideal sites of spoke sites, together with possible poly-system catchment areas.



The model will deliver more integrated services to patients and facilitate an improvement in the quality of those services across the poly-systems reducing the variation in patients' experience. The outcomes from this transformation would result in higher quality and consistent performance. Our plans for the whole of Harrow are being developed through our Commissioning Strategy Plan (CSP), which is being produced in partnership with the rest of North West London PCT's.

As these wider plans are being considered through Harrow's CSP, which is part of plans that are being developed for London, we do not feel in a position to consult the public on the other elements at this stage.

5. INVESTMENT AND BENEFITS REALISATION

5.1 Current NHS Harrow Financial Position (2009/10)

NHS Harrow is forecasting a break-even position on its Income and Expenditure position for 2009/10 compared to its NHS London Control Total of a £1m surplus. The in-year position is very challenging with a year-to-date deficit of £4.2m at month 7; largely derived from pressures on its Acute SLA budget. The PCT has in place a recovery programme to achieve a break-even position by year-end including a combination of sustaining challenges with acute providers in respect of SLA performance, additional demand management programmes and a number of other measures within the NWL sector.

However the financial pressures faced by NHS Harrow in 2009/10 reinforce the position that attainment of a financially stable position in the period of our commissioning strategy plan (5 years) is critically dependent upon firstly arresting the increase in acute spend and then reducing demand for acute secondary care services. Given that maintaining financial balance in a period of year-on-year real term growth of funding has proved challenging for the PCT, doing so in a financial context of limited or static growth will require a radical shift in how the PCT commissions health services.

The planning assumptions for NHS Harrow anticipate levels of resource growth and inflation/cost pressures e.g. the tariff for acute care, price rises for the GP contract, are based on the assumptions set out by NHS London.

The projections anticipate changes to levels of patient activity based upon Harrow's own experience in different care settings both before and after the impact of initiatives to address funding shortfalls arising from reduced income growth to the PCT.

The financial modelling has been prepared under three funding scenarios which represent different potential outlooks for funding growth from 2010/11 to 2013/14. For each funding scenario the PCT needs to demonstrate a sustainable financial plan which secures a 1% surplus for each year of its 5 year commissioning strategy plan.

5.2 Resource Assumptions for NHS Harrow

The uplift in resource allocations for PCTs for the year 2010/11 have already been published (5.2%) so this is common to each scenario, however for the years 2011/12 to 2013/14 the assumptions vary as follows:-

Table 14 - % Uplifts

Scenario	2010/11	2011/12	2012/13	2013/14
Base	5.2%	2.5%	2.5%	2.5%
Downside	5.2%	0%	0%	0%
Upside	5.2%	3.25%	3.25%	3.25%

For NHS Harrow the base case represents an increase in resource over the 4 years of £44m of which £16m is in 2010/11. Under the downside scenario, the funding increase reduces to c£16m.

5.3 Underlying Changes to Activity Growth and Cost

NHS Harrow has broadly applied the NHS London assumptions regarding underlying levels of cost and volume growth within the acute sector and also for each type of care setting. The activity growth takes account of historical trends and demographic growth. With regards to the level of the tariff this is anticipated to be negative from 2011/12.

These assumptions have been modelled and would generate increases of expenditure of £70m in baseline spend by 2013/14.

Under the baseline funding scenario this would result in a shortfall without management action by 2013/14 of c£28m and under the downside scenario a shortfall of £54m.

To counteract these forecasted shortfalls the financial plan has factored in the impact of generating saving under the following five broad headings:-

- Transformation initiatives to shift care from acute to primary care (Polysystems)/ Community settings
- Decommissioning of activity within Acute settings
- Enhanced productivity within Community/Primary Care and Mental health
- Initiatives to enhance NHS Harrow performance to London average/top quartile performance
- Increased levels of efficiency within Corporate and other areas through sharing of back-office functions, improved procurement and use of estate

The total savings identified within these categories for each area from 2010/11 to 2013/14 are:-

Table 15

Category	Base (£m)	Aggressive (£m)	Change (£m)
Shift from Acute	20.4	26.3	5.9
Decommissioning	8.9	18.9	10.0
Productivity-Non Acute	11.0	22.0	11.0
Initiatives	7.0	8.0	1.0
Other Savings/CIP	2.0	2.0	
Gross Savings	**49.3**	**77.2**	**27.9**
Costs of Polysystem Investment	**11.7**	14.5	2.8
Net Saving	**37.6**	**62.7**	**25.1**

NB: Costs of Polysystem Investment reflect the proposed three Polysystems inclusive of East Harrow that NHS Harrow is committed to develop. These reflect revenue costs only (not including facilities costs).

The development of an East Harrow poly-system will generate savings that are incorporated within the figures in the table above under the categories of “Shift from Acute” and “Decommissioning”. These identified savings will contribute towards financial balance for NHS Harrow and ensure future financial stability.

The benefits realised by the East Harrow development are analysed in the sections below.

5.4 East Harrow Benefits Realisation

The additional investment in enhanced Primary and Community Care Services in East Harrow is targeted towards securing the following improved outcomes and benefits for stakeholders:

Improved Outcomes

- Better clinical outcomes for the benefit of East Harrow patients, particularly those with Long term Conditions
- A higher quality of primary care with reduced variation between GP practices, which will set the required standard across the whole of Harrow
- Treating more people in a primary and community setting to reduce non-essential patient demands on acute facilities.

Benefits for Stakeholders

- Improved patient satisfaction through better services, “one stop shop” experience and convenient access
- Improved Value For Money to NHS Harrow through efficient and more effective use of primary care resources
- Benefit to the spoke GPs through working with the increased range of services and improved access that the poly-system model will offer
- Additional training and development opportunities for staff working in the poly-system model.

5.5 Financial Case for Change

This document contains the financial modelling which has been undertaken to date. We have based our financial assumptions on real healthcare activity, which has been delivered to patients within East Harrow. Our assumptions on what care could be delivered within an East Harrow poly-system are in line with Healthcare for London assumptions and have been supported by strong clinical leadership. Having consulted the public a full business case will be produced, which will include further economic appraisal, including the key considerations of affordability and value for money.

During the consultation period NHS Harrow will have the opportunity to engage clinical leads on the specific pathways of care that underpin services within the poly-system. Further engagement will be needed with local planners in order to firm up proposals and related financial assumptions and estimates.

At this Outline Business Case stage, investment in the proposed model has been aligned to the delivery of the NHS Harrow Commissioning Strategy Plan (CSP) and Primary and Community Care Strategy, which outlines the priorities agreed with partners by the NHS Harrow Board. Once the full cost of the new investment in the proposed poly-system is calculated it will be possible to assess the full financial implications of this new development. By releasing resources from existing budgets within Acute Care spend and allowing more efficient use of existing Primary and Community Care budgets, in a lower cost setting, we expect to generate savings in excess of the annualised revenue costs of this redevelopment option, and so improve the PCT’s overall financial position.

NHS Harrow anticipates that the movement of services into a community setting will deliver savings consistent with the Healthcare for London (HfL) strategy through the delivery of a polyclinic model of care. This will provide both increased value for money and an enhanced patient experience within East Harrow.

NHS Harrow has used its assumptions and applied them to the healthcare activity encompassed by the 14 practices within the East Harrow Polysystem to forecast the amount of savings that will be achieved. We have examined this activity with clinical professionals to ensure that the HfL assumptions on the reprovision of primary and community care are possible in East Harrow.

Although planned costs of re-providing activity in the Polysystem are drawn from HfL's unit cost assumptions as applied to Harrow's planned levels of activity to be reprovided within the community setting, we have made a clinical and financial assessment of their implications for Harrow and are confident, after some further adjustments to reflect Harrow's local conditions, that these savings can be achieved. Services offered within the hubs are expected to be delivered at tariffs lower that those of existing services and in line with current services offered within the existing Polyclinic and GP Lead Health centre in Harrow. These savings will be used to fund the proposed development of the East Harrow Hub.

5.6 Modelling Shifts

In order to plan for the financial impact of the implementation of HfL and the development of polyclinic hubs NHS Harrow has carried out high level modelling work. The work encompasses activity projections in line with HfL strategies as they apply to our local setting. We envisage a significant change in the services that are to be delivered in an acute setting, with up to 50% of Acute activity being reprovided in a community setting or decommissioned.

NHS Harrow has modelled two different saving scenarios as detailed below:

- Base Scenario based on our realistic assessment of local activity shifts into a community setting and subsequent decommissioning of activity
- Aggressive Scenario reflecting our more aggressive assumptions for activity shifts into a community setting and subsequent decommissioning of activity

The above models assume a phased approach based on 2013/14 savings which reflect the time line for the development of the primary care estate to deliver the services required.

5.7 Activity Costs and Savings

The model for Harrow wide healthcare activity shows that without Demand Management, this activity would increase as follows in the next seven year period:

Table 16

Year	Inpatient Spells	Outpatient Attendances	A&E Attendances
2010/11	46,355	202,016	63,367
2016/17	58,654	255,614	80,180

This is based on our assumption of 4% activity growth per annum.

Within the Aggressive model it is forecast that by 2006-17 6,707 Inpatient spells, 140,588 Outpatient attendances and 48,108 A&E attendances of the activity stated above can be shifted to a Primary Care or Community setting. This will be necessary to maintain NHS Harrow's financial balance.

If current services were maintained and no saving were created the model shows, given our assumptions for growth of activity and tariff inflation, the costs for this activity would increase from £108m in 2009-10 to £140m in 2016-17.

Appendix B shows the Base Scenario for East Harrow using our Base Case assumptions for service shifts and the activity of the 14 practices within the proposed Polysystem.

Appendix C shows the Aggressive Scenario for East Harrow based on our Aggressive Case assumptions for service shifts and the activity of the 14 practices within the proposed Polysystem.

To calculate both Appendix B and C we analysed activity and cost for the base year 2008-09 for the 14 practices in the East Harrow Polysystem. Our percentages of growth, shifts to the Polysystem and decommissioned activity have then been applied to calculate the saving that are forecast to be achieved for each the categories from 2010/11 to 2016/17. These percentages have been sense checked by the Public Health department, our clinical lead and tested against the HfL strategies. As a result of this, we have identified a number of specific services that NHS Harrow will need to include within the Hub to achieve these savings. The resulting tables shown in Appendix B and C depict a year by year cumulative analysis of both activity and cost savings for East Harrow practices.

The Polysystem hub is expected to be fully functional by 2013/14. A phased approach to savings has been assumed from years 2010/11 to 2012/13, based on the levels of savings calculated for 2013/14. This has been applied in both Appendix B and C. From 2013/14 and in line with the NHS Harrow Commissioning Strategy Plan (which sets out how we spend our budget), both for the Base and Aggressive Scenario we have assumed 2013/14 as the first year of achieving the full level of savings within the models. A phased approach has been applied as under East Harrow's poly-system model, we aim to make the best use of our GP capacity in East Harrow and therefore to continue to increase community provision, and thus achieve savings in earlier years.

The table below depicts the gross savings under the Base Scenario assumptions together with the CSP phasing, based on infrastructure availability. In addition the table depicts the total costs of reprovision of acute activity within the community (based on HfL unit costs, but sense checked for Harrow) and the costs associated with the development of the Polysystem Hub (Revenue & Capital) to provide these services. These assumption have been checked by our Public Health Department (please refer to section 5.9 and 5.10). The costs of reprovision of acute services have been also phased from 2010/11 to 2012/13 based on 2013/14 costs with a higher level of costs than savings as transitional costs have been assumed within these.

Table 17

(Base)	**2010/11 £**	**2011/12 £**	**2012/13 £**	**2013/14 £**	**2014/15 £**	**2015/16 £**	**2016/17 £**
Gross Saving	1,253,583	2,507,166	3,760,750	6,267,916	6,420,644	6,711,754	6,945,323
Total Costs	954,773	1,909,546	2,864,319	5,037,255	4,344,558	4,476,953	4,614,644
Net Saving	298,810	597,620	896,430	1,230,661	2,076,085	2,234,800	2,330,678

The table below depicts the gross savings under the Aggressive Scenario assumptions together with the CSP phasing, based on reprovision infrastructure availability. In addition the table depicts the total costs of reprovision of acute activity within the community (based on HfL unit costs, but sense checked for Harrow) and the costs associated with the development of the Polysystem Hub (Revenue & Capital) to provide these services. These assumption have been checked by our Public Health Department (please refer to section 5.9 and 5.10). The costs of reprovision of acute services have been also phased from 2010/11 to 2012/13 based on 2013/14 costs with a higher level of costs than savings as transitional costs have been assumed within these.

Table 18

(Aggressive)	**2010/11 £**	**2011/12 £**	**2012/13 £**	**2013/14 £**	**2014/15 £**	**2015/16 £**	**2016/17 £**
Gross Saving	1,253,583	3,876,003	6,298,251	10,181,779	10,543,937	10,919,011	11,307,463
Total Costs	954,773	2,511,499	3,703,236	5,885,374	5,226,602	5,394,279	5,568,663

Net Saving	298,810	1,364,504	2,595,015	4,296,405	5,317,335	5,524,732	5,738,801

In both scenarios savings are forecast, which can be used towards maintaining financial balance and investment in East Harrow Primary Care services. The activity (and subsequent cost) shift that have been modeled have been shared with NHS Harrow's main provider, The North West London Hospitals Trust and the North West London Sector. In order to maintain financial sustainability across the whole local health economy, the acute sector will need to reduce their cost base to match the activity and income reduction. The Sector Acute Landscape work is specifically planning this reduction in acute activity and cost to support the PCT's poly-system development. It is expected that the major consultation on this service change will take place in the autumn 2010, with services changing over the following 1-2 years. This timescale would fit well with the potential hub development at Belmont Health Centre.

In planning the transfers of activity into the poly-system, NHS Harrow has assumed that the full level of savings will only be achieved in 2013/14. During the interim period 40% of the savings in year 1 and 60% in year 2 are forecast, allowing the acute landscape changes (and cost savings) to be phased in. The PCT has assumed transitional costs for 2010/11 to 2012/13 by applying a higher cost to savings ratio.

5.8 Sensitivity Analysis

In Appendix D is a sensitivity analysis of the savings forecast for East Harrow.

The first table shows the sensitivity on the net savings achieved (after total costs which include cost of the development of the Polysystem Hub) based on the Aggressive scenario if lower percentages of activity and cost are shifted from the Acute setting into the Polysystem. This analysis shows that the maximum reduction of gross savings to maintain a positive net saving in each year to 20016/17 is 24.83% although even at a 30% reduction in gross savings a deficit only occurs in 2010/11.

The second table shows the sensitivity of net saving achieved based on the Base scenario if lower percentages of activity and cost are shifted from the Acute setting into the Polysystem. This analysis shows that the maximum reduction of gross savings to maintain a positive net saving in each year to 20016/17 is 18.80% although even at a 20% reduction in gross savings a deficit only occurs in 2013/14.

5.9 Ensuring Service Improvement Delivery

A Snapshot of Outpatient Demand Management

NHS Harrow is experienced in developing a range of community based services to support its demand management programme and strategy to provide services closer to home and out of hospital. An example of some of the schemes already in operation can be found in Appendix E. Some services have moved faster than others; both in terms of set up and throughput of patients. Some of the bigger issues that have held progress back are being addressed.

The table below summarises the action we are taken to keep pace on our demand management programme:

Table 19

Challenge	Action to address
Triage of patient referrals can lead to only a small number that can be treated within the	Currently in some services consultants are providing mentoring to specialist GP's, but not

Challenge	Action to address
community	direct patient care in the community. We are supporting more clinics with hospital consultants in the community; to address any issues with confidence in the service.
For some care pathways compliance with our Clinical Assessment Service (CAS) is low (CAS triages appropriate patient referrals to community services)	We are currently procuring a Total Referral Management service to process all non urgent referrals whether there is a community service or not.
Decommissioning of out-patient activity to avoid service duplication and double running costs	We are in regular discussion with the North West London Hospital Trust to identify service areas which could switch to a community pathway for 100% of the activity. We will be working with them to develop our plans to have a poly-system linked to the Northwick Park Hospital site, that supports a single primary care point of access
Having the right clinical space and diagnostics available within the community	Poly-systems address this, by making best use of joined up resources. We are developing more 'one stop shops' utilising community diagnostic facilities

5.10 Ensuring Clinical Delivery

Statement from Dr Muhammed Ali, Associate Medical Director, NHS Harrow.

This section provides the clinical analysis and methodology used during the financial modelling process of this outline business case.

"As the Associate Medical Director and as a local Harrow GP who knows the area, I had agreed to spend time with the finance team to ensure there was robust and clinically realistic modelling of the area.

Methodology

The methodology adopted was as follows:

1. We started by examining the Healthcare for London assumptions on the level of healthcare activity that could be delivered in a community setting, to test the delivery potential in Harrow. The assumed levels of activity were placed onto a spreadsheet into the relevant headings with the East Harrow healthcare activity against it.
2. As a GP who knows local healthcare services, I had agreed to spend dedicated time with the finance team to provide clinical input and challenge the assumptions.
3. Any clinical queries I raised would be responded to and I had in turn agreed to review this as a priority.
4. Final iterations would only be agreed if I signed off the final version.

In terms of actual process I had spent many hours and in total at least 2 whole days on no other task but this. As the document is so long and I didn't feel this was something I could concentrate on for protracted periods without losing the quality of my clinical input, I had tackled no more than 2 section areas at each visit.

At each review I had posed questions on what the definitions of the clinical areas were and wanted to see a list of what terms were used under each code. Without recalling every query I can confidently say this was in excess of 50 clinical queries raised, all of which I did review line by line.

Once the document including my queries were addressed I did become quicker and spent more time on drawing together a response as to where the saving measures are most likely to be given the nature of the area in East Harrow. I factored in local knowledge of what was convenient for patients to access, as well as considering what was clinically the most appropriate areas to focus on moving out of hospital. I categorised the East Harrow activity and assumed delivery in a community setting into the following areas:

- Yellow – I am undecided if we could take them out of hospital but possibilities
- Amber – I didn't think they could be taken out without offering additional facilities, namely endoscopy. My terminology refers here to anything requiring a scope, e.g. OGD, colonoscopy, sigmoidoscopy, etc…
- Green – I confidently feel these can be provided in a community setting. Clinically you will note these are mainly clinics with little need for a major diagnostic overhaul.
- Blue – I had in as decommissioned services. I didn't feel as confident where these could easily be as the areas are specific rather than general concepts of what the decommissioning priorities are. I would be looking to take this into some sort of priority setting group/forum.

Below is an example of what I am referring to.

Undecided

Endoscopy Suite

Reprovision in Community

Decommissioned

Results

With my local knowledge and having seen the development of our polyclinic on Alexandra Avenue, I was able to localise the Healthcare for London model so that it is specific to the needs of our population. Those needs are described in the needs assessment section of this document. There were some clinical activities that I knew were not currently possible within Harrow, without a complex change to our systems, e.g. taking out all of oncology. These were factored out of our financial modelling, to as far as reasonably possible, ensure clinical delivery. There were other areas of our modelling for Harrow, which stretched beyond the Healthcare for London assumptions (e.g. a larger proportion of expected out patient clinics in view of existing Clinical Assessment Services) and these were applied where relevant to produce a more accurate financial model that was real for the people of Harrow.

As the clinician providing the input I did leave the financial expertise to the appropriately skilled team, but I did understand the process they described. I am also aware the finance team worked closely with the commissioning team to understand some of my requests for an endoscopy suite to determine the costs of provision.

Dr Muhammed Ali (MBBS,DRCOG,DCH,MRCGP)
Associate Medical Director, NHS Harrow."

5.11 Joint work with the North West London Hospital Trust (NWLHT)

NHS Harrow provides regular updates to the NWLHT of its commissioning intentions and demand management plan. Weekly and monthly meetings are held with the Trust at which these plans are discussed. In a number of cases the NWLHT provide either clinical supervision or direct clinical support into out of hospital care, provided by other NHS providers. The Trust have had sight of this outline business case and provided the following statement:

"The Trust welcome receipt of NHS Harrow's outline business case and will discuss it as part of an Executive team on 8 December. The Trust is included in regular reviews of the PCT's demand management plans and continues to support the delivery of out of hospital care wherever clinically and financially appropriate. The Trust will provide a more detailed statement once it has reviewed the business case."

5.12 Fit for Future Purpose

The NHS Harrow Public Health department have completed a thorough needs assessment in section 3 of this document (A case for change). Below they provide commentary on how this has been taken into consideration:

While modelling the financial implications of the East Harrow Polyclinic, the future health needs in terms of increasing prevalence of certain conditions and the relevance of changes in ethnic mix were also considered.

Population projections suggest that the population of East Harrow will become more diverse over the next 10 years with the proportion of BME groups increasing to 65% from the current 55%. This means that there will be an increase in the prevalence of certain conditions such as CHD, obesity, hypertension, diabetes and stroke over the next 10 years. However, with the implementation of the NHS Vascular Checks programme, which will be delivered through our Commissioning Strategy Plan, this increase may not be significant. Other programmes such as social marketing and the possibility of free NHS Health checks may also help to reduce rising prevalence in some of these conditions.

For example, the predicted growth in prevalence of diabetes over the next five years is 1% in a do nothing scenario and the expected increase in hospital activity over the next 5 years is not huge. Moreover, the Vascular Checks programme will offset a considerable proportion of this increase in prevalence by early detection and management of diabetes.

Table 20 below shows the predicted growth in the prevalence of diabetes and the resultant level of hospital activity.

Table 20

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/16
Prevalence	6.45%	-	-	-	-	7.15%	-
Number	13,935	-	-	-	-	15,727	-
Hospital emergency activity	12	-	-	-	-	13	-
Outpatient	2127					2148	
DNA	504					509	

The financial modelling conducted within this document was based on 2008/9 activity data for patients registered with GP's in East Harrow. For the reasons outlined above, this provides an accurate picture of future activity, but will be further developed at the full business case stage.

5.13 Estates Costs

The current economic climate and NHS Harrow budgetary constraints require the investment impact to be maximised by enhancing the existing Primary Care Estate. NHS Harrow has limited funds for capital investment so any major redevelopment plans will require potentially working with a partner provider, either the NHS Harrow preferred supplier LIFTCo or another provider if acceptable terms or opportunities could not be agreed with LIFTCo. Whilst it is recognised that redevelopment costs would be high, our initial discussions with the incumbent GP's at Belmont Health Centre have centred around a proposal from them to buy the building from the local authority and completely redevelop the site. This would leave the discretion of the suppliers to the GP's. In line with the CSP, NHS Harrow will consult with Primary Care partners and work with them utilising their estate where this supports delivery of the Outline Business Case objectives. Within the Full Business Case a detailed analysis and appraisal of the various funding options will be carried out to ensure the best value option has been selected. This cannot be completed until the site specific plans are worked up by the PCT and all potential partners. The PCT has experience from the development of Alexandra Avenue (LiftCo) and Pinn Medical Centre (GP owned) premises to benchmark the value of alternative partners compared to funding with public capital.

NHS Harrow has developed options for working with a partner to develop and assist in funding any additional major Estate requirements. NHS Harrow has had introductory meetings with LIFTCo to discuss the East Harrow project and they have expressed a keen interest to work together with NHS Harrow to establish all potential options for developing a poly-system. All options will be considered to maximise the return of the NHS Harrow budget, from enhancing existing sites to the consideration of the potential of disposal of sites to fund new site development. No additional infrastructure costs have been included in the modelling at this stage.

From the analysis of options for development of the Polysystem Hub we anticipate that for both revenue and capital the costs are affordable when taking into account the level of savings anticipated from the East Harrow model.

5.14 Summary

From the scenario analysis completed it is clear that the policy of shifting services into a Primary Care setting is vital to securing financial stability and future investment in healthcare within Harrow. NHS Harrow believes that the East Harrow Polysystem and the development of Belmont Health centre into a Hub are essential in the realization of the full benefit of these savings.

6. NEXT STEPS AND ENGAGEMENT

6.1 Stakeholder Engagement

The key objectives of our communications and stakeholder engagement plan will be to raise awareness of the Poly-system for the East Harrow area, its aims and objectives particularly with reference to benefits for patients and the impact it will have on their health and wellbeing. The Project Board will:

- Ensure effective engagement takes place with all stakeholders to gain their understanding and commitment to the project. NHS Harrow will work with its partners to realise opportunities for joint working to achieve common goals and will ensure that the

development of plans are not to the detriment of partnership priority and that they do not inappropriately de-stabilise existing provision.
- Ensure that communications around the key messages for stakeholders are consistent, timely and disseminated effectively.
- Ensure that all stakeholders are listened to and that they are able to feedback their views, ideas and concerns using appropriate channels.
- Ensure that there are appropriate mechanisms in place to monitor and evaluate outcomes.
- Build upon what we know about patient experience and promote active involvement of all local stakeholder groups.
- Ensure awareness, understanding and engagement in the development of out of hospital care and patient centred services.

6.2 Pre-engagement exercises

We have consulted and taken on board views and opinions from the following groups as part of our pre-engagement activities:

- A department of health commissioned 'Gateway Review' provided critical analysis of our plans and engaged relevant Harrow stakeholders to draw its conclusions and feedback
- Overview and Scrutiny committee have provided valuable feedback and continue to help us shape our plans
- NHS Harrow have discussed our plans with East Harrow GP's
- The relevant Practice Based Commissioning (PBC) cluster leads have been consulted
- NHS Harrow works in partnership with the North West London Hospital Trust and regularly communicate our plans and progress. They support our demand management plans where possible and a number of them are provided with direct clinical support or supervision.
- Our Public and Patient Involvement committee are a critical friend and help us shape and test our plans for public understanding
- NHS Harrow remains in regular contact with the Local Authority; directors of social care services, Place Shaping and the planning team have commented on our plans at various stages
- This document has been circulated to a range of healthcare providers in draft format and comments have been taken on board where possible.

6.3 Public Consultation

NHS Harrow will undertake a full Section 244 consultation upon the development of a Poly-System for East Harrow. The specific questions to be addressed within that consultation are given in the recommendations section at the end of this document. Considerable consultation was undertaken in 2008/09, as set out in the CSP, in determining priorities and strategies for service change. In the case of the Primary and Community Care Strategy these included a commitment to consult upon a new model of care for the identified priority areas. Consultation will be supported by a consultation plan and a clear set of documentation approved by the Board. Following an update to the Overview and Scrutiny Committee in September 2009, a three month period of consultation is expected to begin on 9th December 2009 for 14 weeks.

It is recognised that there will be discrete and particular needs for each stakeholder group and that a one size fits all approach cannot be adopted, therefore the methods of consultation and engagement will be tailored to meet individual needs. A Local Implementation Plan will be developed for engagement with all stakeholders.

NHS Harrow has a large and diverse stakeholder group, therefore for the purposes of this consultation they have been grouped into the categories below:

Patients and the public

Existing patients/carers will be consulted together with local people suffering with long-term health conditions and older, frail people or people with dementia. There is a very active patient's group in the East Harrow area, local GP Patient Participation Groups, and the wider population will be engaged through a variety of media. The purpose will be to seek views on the proposals, focusing on the benefits for patients and the impact that health service improvements can make to the local health economy.

This will be carried out by arranging presentations to local groups, e.g. BME refugee and voluntary and community groups, leaflet campaign, visits to key forum groups, NHS Harrow website, Media releases, Harrow People Magazine, E-mail shots. Community and voluntary communication distribution methods, e.g., HAVS newsletter.

Local Authority

NHS Harrow will engage and involve the Local Authority who will be encouraged to raise awareness amongst their constituents and residents and to have the opportunity to become involved and have a clear mechanism for feeding their views into consultation planning. We will also raise awareness amongst Overview and Scrutiny Committees, MPs and Local councillors on the strategic role of these proposals in improving the quality of local care. This will be achieved by holding Community events, Area committee meetings, Ward Newsletters, MP briefings, attending the Overview and Scrutiny Committee, Harrow Strategic Partnership meetings, Use of both the Local Authority and NHS Harrow website.

Clinicians and staff

NHS Harrow will ensure that staff and clinicians have the opportunity to become involved and have a clear mechanism for feeding their views into consultation planning. Objectives will be to develop NHS staff as potential ambassadors and drivers for change, to ensure awareness of the aims of the consultation and ask target audiences their view on the proposals we are presenting as solutions for improving quality of and access to health services in East Harrow and to listen to and incorporate staff views in shaping plans.

Providers and potential providers

NHS Harrow will ensure that existing providers and potential providers have the opportunity to become involved and have a clear mechanism for feeding their views into consultation planning.

Plans for partnership working with Local Involvement Networks (LINks)

Close working relationships are being developed with the LINks organisation that are relatively new in Harrow. A member of the LINKs executive team is involved in the project team and board and as the consultation develops LINKs will be involved and informed. It is envisaged that the LINKs will be a key part in the consultation and engagement process. This will be achieved by LINks being involved in the project team and board, in being kept informed and briefed and by regular one-to-one meetings. The objectives of involvement will be ensure that LINks are able to provide informed feedback into the planning process and to assist with encouraging informed debate with the wider community.

6.4 Governance

The NHS Harrow Board has approved the establishment of a Project Board to lead the development of the Poly-system development in East Harrow. That group will continue to lead this work making regular reports to the NHS Harrow Board via the Senior Responsible Officer (SRO) for this work (the NHS Harrow Director of Development and System Management). The SRO will also update the NHS Harrow Executive Committee on a more frequent basis. NHS Harrow will continue to keep the Overview & Scrutiny Committee appraised on progress against the key milestones below.

The outcomes of work-stream activity will then be considered alongside the outcomes of Public consultation in order that a Full Business Case can be produced according to the timescales below.

6.5 Implementation

Following approval of the Outline Business Case the Project Board will progress the following actions:

Table 21

Key Milestone	Timescale
Approve outline business case and consultation document	November 2009
Launch Public Consultation	9th December 2009
Planned service commencement – Mollison Way GP-led Health centre	11th January 2009
Complete Public Consultation	17th March 2010
Feedback consultation results via NHS Harrow website	April 2010
Report Outcomes of Consultation / NHS Harrow response	May 2010
Full Business Case completed	June 2010
Commence procurement and building activities	July 2010
Service commencement - Community Health Centre 'hub'	Approx. April 2012

The consultation document will be available online on our website using an online-based survey tool and also distributed as a hard-copy. The results will be collated and will inform whether to proceed with the development of the Belmont Health Centre.

6.6 Risks and Mitigation

Table 22

RISK	CORRECTIVE PRECAUTIONS
System Change There are a number of factors causing the health system to change and modernise; these changes will take time and commitment to realise their full potential.	• We are working in partnership with primary care providers and local hospitals to stimulate modernisation, improvements and growth in the system • The poly-system model has been carefully considered and communicated through Healthcare for London • The NHS Harrow plans will receive public scrutiny from all stakeholders • Resulting service improvements will be well communicated within the Harrow community • A clear direction of travel was indicated early through the NHS Harrow Primary and Community Care Strategy • NHS Harrow is working with secondary care providers to ensure services traditionally delivered in hospital can be released into the community without destabilising local hospitals.
Finance NHS Harrow's plans are based on the management of demand for healthcare moving closer to home. Establishing community provision that provides quality and is well governed has taken longer than planned in some areas. Services being delayed or unused may create financial pressures.	• Work with all stakeholders will clarify and promote our new community pathways • The introduction of a Total Referral Management Service will triage appropriate patients into community healthcare provision • Sensitivity Analysis (Appendix D) models scenarios where differing levels of financial savings are achieved. The analysis shows that only with a reduction in savings, based on the Base scenario, of over 30% will the development become unviable. • The plans set out in this document are a fundamental part of achieving financial balance. Should savings not be delivered in line with this plan, a reduction in other areas of care delivery will be considered. • There are likely to be a number of longer term health benefits from the introduction of a poly-system model of care

RISK	CORRECTIVE PRECAUTIONS
Potential destabilisation of Practices Whilst NHS Harrow is not proposing a specific reduction in the number of GP's; there will need to be improvements to some of our existing Primary Care estate to increase productivity. Patients or GP's may choose to access new facilities as a result. This could potentially migrate patients away from practices not offering similar standards of access.	• GP's are being consulted about the plans at each stage in the process • NHS Harrow recognises that patients appreciate a good relationship with their GP and NHS Harrow hopes to maintain this continuity of care • Working in close liaison with the LMC • Maintaining a principle that this strategy is about improving the services on offer and access to them, as opposed to replacing current provision.
Potential destabilisation of other NHS providers Establishing improved or new facilities in the community, with the intention to explore service delivery that has traditionally been delivered in hospital could potentially destabilise other NHS providers	• The actions NHS Harrow takes will be set within the wider context of an acute services review • New community based activity is designed to stimulate the provider market, increasing choice within the health system • NHS Harrow will maintain a partnership approach to any resulting service redesign, to ensure the health system is not destabilised.
Public Consultation Full public consultation is required and therefore carries the risk of failure through limited public understanding or interest.	• NHS Harrow will use a range of methods to increase the level of engagement • Consultation information will be available in various formats to increase understanding • A consultation infrastructure exists and the network has been used for similar exercises • NHS Harrow will work in partnership with Local Involvement Networks (LINks) to encourage involvement • Work will be undertaken to access hard to reach groups opinions.
Procurement NHS Harrow or its partners may need to procure redevelopment building works and potentially service partners to occupy new facilities. To establish a successful procurement, a legal process must be followed and a healthy provider market must exist.	• The procurement exercise will be well communicated to all stakeholders • Options development will remain in open communication with providers for as long as possible • Legal advice will be taken throughout the process • Opportunities for engaging providers will be used to stimulate interest in the plans.

7. KEY RECOMMENDATIONS

7.1 Key Recommendations

The health system in Harrow needs to change to ensure value for money and financial sustainability. To achieve this aim we are recommending investment in primary care services to deliver more cost effective and higher quality 'out of hospital' care.

There is no doubt we need to prepare for a period of financial challenge within the NHS. To address this, we intend to invest in community healthcare provision that delivers more care closer to home and reduces demand on hospital services. This is a fundamental part of our plans to improve healthcare in Harrow, manage demand and ensure financial balance.

Having appraised the health needs, our estate and financial position, we feel that the poly-system model would be the most appropriate model of primary and community care in East Harrow. This model consists of a community health centre hub, operating GP services for registered and unregistered patients, with extended opening hours 8am to 8pm, seven days a week and incorporates other services such as pharmacy and diagnostics normally only found in hospitals. The hub seeks to incorporate a range of services under one roof to shorten waiting times and improve the patient pathway. The hub would be linked 'or spoked' to the other GP practices in East Harrow and most notably to the new GP led health centre on Mollison Way, which would also operate the same extended opening hours as the hub.

Having considered a range of options and having had extensive discussions with stakeholders; we recommend that the most suitable way to deliver the Community Health Centre hub would be to redevelop the current Belmont Health Centre site. It is recommended that a full 14 week public consultation is launched with the option to say yes or no to the proposed redevelopment. In addition, the public views on service provision should be sought.

Appendix A: East Harrow GP Practices and Clinics Sites Overview

		Investment Opportunity to expand and upgrade premises for East Harrow												
IW Ref No	Facility	Extension Potential	Suitable for Investment	Access DDA	Patient List Size (08/08)	Consulting Room	Nurses Room	Treatment Room	Meeting Room	Access	Age	Property Type	Expansion
3	Kenton Clinic	YES	YES	YES	2,540	2	1	1	1	Level	1970's	Purpose Built	Expand in loft
7	Kenton Bridge Medical Centre	YES	YES	YES	3,162	2.5		1	0.5	DDA	1990's	Purpose Built	Convert store/ waiting area/back office area
18	Kenton Bridge Medical Centre	YES	YES	YES	3,563	2.5		1	0.5	DDA	1990's	Purpose Built	Convert store/ waiting area/back office area
9	Stanmore Med Cent (Williams Dr)	LIMITED	YES	YES	5,338	6		2		DDA with lift	2006	Purpose Built	Within premises (patient list size, garden STPP)
9	Stanmore Med Cent (85 Crowshot Ave)	LIMITED	YES	YES	5,338	6		2	1	DDA	1980's	House Conversion	
31	82 Chandos Crescent	LIMITED	NO	NO	1,601					Non compliant	1930's	House Conversion	Only if able to acquire neighbouring premises
15	Charlton Medical Centre	LIMITED	REDEVELOP	PARTIAL	3,992	3		1	1	No DDA WC	1930's	House Conversion	
17	Zain Medical Centre	LIMITED	LIMITED	PARTIAL	2,045	1		1		No DDA WC	1930's	House Conversion	Convert Loft
21	Streatfield Road Surgery	NO	NO	YES	6,889	4	1	1	1	DDA	1930's	House Conversion	
22	Honeypot Medical Centre	LIMITED	LIMITED	YES	6,306	5		1	1	DDA	1930's	House Conversion	
24	11 Bacon Lane	YES	YES	YES	9,429	N/A	N/A	N/A	N/A	N/A	1930's	House Conversion	Adjoining premises/loft
34	The Stanmore Surgery	LIMITED	LIMITED	LIMITED	1,632	1	1	1			1930's	House Conversion	
35	The Medical Centre	LIMITED	NO	YES	2,250	2	2	1			1930's	House Conversion	Acquire adjoining house, use capacity
38	Belmont Health Centre	YES BUT COMPLEX	REMODEL	YES	22,000					DDA	1980's	Purpose Built	Potential to remodel/ extend through new build
B	Honeypot Clinic	YES	YES	YES		8			1		1960s	Purpose Built	Relocate users, extend, redevelop
C	Kenmore Clinic	YES BUT COMPLEX	REDEVELOP	REBUILD		3		1	1		Site	Demolished	Redevelopment Potential

Appendix B: Savings achieved through community provision – Base Case

Savings from Acute Services using Base Scenario for the East Harrow Polysystem for 2009-10 to 2016-17

Savings Generated from Withdrawal of Acute Activity

		2010-11		2011-12		2012-13		2013-14		2014-15		2015-16		2016-17	
	HfL Growth/Tariff Assumptions	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
Elective Medicine	- Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Medicine	- Non Complex	10	11,720	21	23,441	31	35,161	51	58,602	54	60,641	56	62,751	58	64,935
Elective Medicine	- Long Term Conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Medicine	- Under 17	0	606	1	1,213	1	1,819	2	3,032	2	3,138	2	3,247	2	3,360
Subtotal Elective Medicine		11	12,327	21	24,654	32	36,981	54	61,634	56	63,779	58	65,999	60	68,295
Non Elective Medicine	- Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Medicine	- Non Complex	4	7,373	7	14,746	11	22,119	18	36,865	18	38,148	19	39,475	20	40,849
Non Elective Medicine	- Long Term Conditions	1	2,304	2	4,608	4	6,911	6	11,519	6	11,920	7	12,334	7	12,764
Non Elective Medicine	- Under 17	0	344	1	688	1	1,031	1	1,719	1	1,779	1	1,841	1	1,905
Subtotal Non Elective Medicine		5	10,020	10	20,041	15	30,061	25	50,102	26	51,846	27	53,650	28	55,517
Elective Surgery	- Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Surgery	- High Throughput	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Surgery	- Minor Procedures	3	3,558	6	7,116	9	10,675	16	17,791	16	18,410	17	19,051	18	19,714
Elective Surgery	- Under 17	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal Elective Surgery		3	3,558	6	7,116	9	10,675	16	17,791	16	18,410	17	19,051	18	19,714
Non Elective Surgery	- Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Surgery	- Non Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Surgery	- Minor Procedures	1	1,112	1	2,224	2	3,336	4	5,559	4	5,753	4	5,953	4	6,160
Non Elective Surgery	- Under 17	0	1,032	0	2,064	1	3,096	1	5,159	1	5,339	1	5,525	1	5,717
Subtotal Non Elective Surgery		1	2,144	2	4,288	3	6,431	5	10,719	5	11,092	5	11,478	5	11,877
Paediatrics	- Elective	1	609	1	1,219	2	1,828	3	3,046	3	3,152	3	3,262	3	3,375
Paediatrics	- Non Elective	0	311	0	622	1	933	1	1,555	1	1,609	1	1,665	1	1,723
Paediatrics	- Neonatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal Non Elective Surgery		1	920	1	1,841	2	2,761	4	4,601	4	4,762	4	4,927	4	5,099
Obstetrics		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Regular Attendances		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Outpatients	PbR & Non PbR	5,419	656,695	10,838	1,313,391	16,257	1,970,086	27,095	3,283,477	28,179	3,397,742	29,306	3,515,983	30,479	3,638,340
A&E		2,009	192,059	4,018	384,119	6,026	576,178	10,044	960,297	10,446	993,715	10,864	1,028,296	11,298	1,064,081
Community Care		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary Care		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal Other		7,428	848,755	14,856	1,697,509	22,284	2,546,264	37,139	4,243,774	38,625	4,391,457	40,170	4,544,280	41,777	4,702,421
Total Movement from Acute to Polyclinic		**7,448**	**877,724**	**14,897**	**1,755,449**	**22,345**	**2,633,173**	**37,242**	**4,388,622**	**38,732**	**4,541,346**	**40,281**	**4,699,385**	**41,892**	**4,862,923**
Home Care		0	19	0	39	0	58	0	97	0	100	0	103	0	107
Decommissioned Services	- IP & OP	3,115	375,840	6,230	751,679	9,346	1,127,519	15,576	1,879,198	15,576	1,879,198	16,847	2,012,266	17,521	2,082,293
	- Direct Access	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	- Unbundled OP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Other Healthcare Settings		**3,115**	**375,859**	**6,230**	**751,718**	**9,346**	**1,127,577**	**15,576**	**1,879,294**	**15,576**	**1,879,298**	**16,847**	**2,012,369**	**17,521**	**2,082,400**
Total Savings from Acute		**10,564**	**1,253,583**	**21,127**	**2,507,166**	**31,691**	**3,760,750**	**52,818**	**6,267,916**	**54,308**	**6,420,644**	**57,128**	**6,711,754**	**59,413**	**6,945,323**

Appendix C: Savings achieved through community provision – Aggressive Case

Savings from Acute Services using Aggressive Scenario for the East Harrow Polysystem for 2009-10 to 2016-17

Savings Generated from Withdrawal of Acute Activity

		2010-11		2011-12		2012-13		2013-14		2014-15		2015-16		2016-17	
	HfL Growth/Tariff Assumptions	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
Elective Medicine	- Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Medicine	- Non Complex	10	11,720	28	32,008	46	52,011	74	84,081	77	87,007	80	90,035	83	93,168
Elective Medicine	- Long Term Conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Medicine	- Under 17	0	606	1	1,154	1	1,876	2	3,032	2	3,138	2	3,247	2	3,360
Subtotal Elective Medicine		11	12,327	29	33,162	47	53,887	76	87,113	79	90,145	82	93,282	86	96,528
Non Elective Medicine	- Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Medicine	- Non Complex	4	7,373	7	14,034	11	22,804	18	36,865	18	38,148	19	39,475	20	40,849
Non Elective Medicine	- Long Term Conditions	1	2,304	2	4,385	4	7,125	6	11,519	6	11,920	7	12,334	7	12,764
Non Elective Medicine	- Under 17	0	344	0	654	1	1,063	1	1,719	1	1,779	1	1,841	1	1,905
Subtotal Non Elective Medicine		5	10,020	9	19,073	15	30,992	25	50,102	26	51,846	27	53,650	28	55,517
Elective Surgery	- Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Surgery	- High Throughput	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Surgery	- Minor Procedures	3	3,558	6	6,773	10	11,005	16	17,791	16	18,410	17	19,051	18	19,714
Elective Surgery	- Under 17	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal Elective Surgery		3	3,558	6	6,773	10	11,005	16	17,791	16	18,410	17	19,051	18	19,714
Non Elective Surgery	- Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Surgery	- Non Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Surgery	- Minor Procedures	1	1,112	1	2,116	2	3,439	4	5,559	4	5,753	4	5,953	4	6,160
Non Elective Surgery	- Under 17	0	1,032	0	1,964	1	3,191	1	5,159	1	5,339	1	5,525	1	5,717
Subtotal Non Elective Surgery		1	2,144	2	4,080	3	6,630	5	10,719	5	11,092	5	11,478	5	11,877
Paediatrics	- Elective	1	609	1	1,160	2	1,884	3	3,046	3	3,152	3	3,262	3	3,375
Paediatrics	- Non Elective	0	311	0	592	1	962	1	1,555	1	1,609	1	1,665	1	1,723
Paediatrics	- Neonatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal Non Elective Surgery		1	920	1	1,752	2	2,846	4	4,601	4	4,762	4	4,927	4	5,099
Obstetrics		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Regular Attendances		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Outpatients	PbR and Non PbR	5,419	656,695	14,183	1,718,688	23,046	2,792,756	37,256	4,514,781	38,746	4,671,895	40,296	4,834,477	41,908	5,002,717
A&E		2,009	192,059	4,588	438,679	7,456	712,825	12,053	1,152,356	12,535	1,192,458	13,036	1,233,956	13,558	1,276,897
Community Care		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary Care		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal Other		7,428	848,755	18,771	2,157,367	30,502	3,505,581	49,309	5,667,137	51,281	5,864,353	53,333	6,068,433	55,466	6,279,614
Total Movement from Acute to Polyclinic		**7,448**	**877,724**	**18,819**	**2,222,207**	**30,579**	**3,610,942**	**49,434**	**5,837,464**	**51,411**	**6,040,608**	**53,468**	**6,250,821**	**55,607**	**6,468,349**
Home Care		0	19	0	37	0	60	0	97	0	100	0	103	0	107
Decommissioned Services	- IP & OP	3,115	375,840	8,532	1,080,416	13,864	1,755,605	22,413	2,838,118	23,310	2,936,885	24,242	3,039,088	25,212	3,144,849
	- Direct Access	0	0	0	514,703	0	836,359	0	1,352,062	0	1,406,144	0	1,462,390	0	1,520,886
	- Unbundled OP	0	0	0	58,639	0	95,285	0	154,039	0	160,200	0	166,608	0	173,273
Total Other Healthcare Settings		**3,115**	**375,859**	**8,532**	**1,653,795**	**13,865**	**2,687,309**	**22,414**	**4,344,315**	**23,310**	**4,503,329**	**24,242**	**4,668,190**	**25,212**	**4,839,114**
Total Savings from Acute		**10,564**	**1,253,583**	**27,351**	**3,876,003**	**44,444**	**6,298,251**	**71,848**	**10,181,779**	**74,721**	**10,543,937**	**77,710**	**10,919,011**	**80,819**	**11,307,463**

Appendix D: Sensitivity Analysis of Net Saving Achieved for Both Aggressive and Base Scenarios

Sensitivety Analysis of Savings for East Harrow Polysystem

Aggressive Model

	2010-11 £	2011-12 £	2012-13 £	2013-14 £	2014-15 £	2015-16 £	2016-17 £
Forecast Savings	1,253,583	3,876,003	6,298,251	10,181,779	10,543,937	10,919,011	11,307,463
Total Costs	954,773	2,511,499	3,703,236	5,885,374	5,226,602	5,394,279	5,568,663
Net Savings	298,810	1,364,504	2,595,015	4,296,405	5,317,335	5,524,732	5,738,801

Sensitivity Analysis

10.00% Savings not Achieved	173,452	976,904	1,965,190	3,278,227	4,262,941	4,432,831	4,608,054
20.00% Savings not Achieved	48,093	589,303	1,335,365	2,260,049	3,208,548	3,340,930	3,477,308
23.00% Savings not Achieved	10,486	473,023	1,146,417	1,954,596	2,892,230	3,013,360	3,138,084
24.83% Savings not Achieved	81	440,852	1,094,142	1,870,087	2,804,715	2,922,732	3,044,232
30.00% Savings not Achieved	-77,265	201,703	705,540	1,241,872	2,154,154	2,249,029	2,346,562

Base Model

	2010-11 £	2011-12 £	2012-13 £	2013-14 £	2014-15 £	2015-16 £	2016-17 £
Forecast Savings	1,253,583	2,507,166	3,760,750	6,267,916	6,420,644	6,711,754	6,945,323
Total Costs	954,773	1,909,546	2,864,319	5,037,255	4,344,558	4,476,953	4,614,644
Net Savings	298,810	597,620	896,430	1,230,661	2,076,085	2,234,800	2,330,678

Sensitivity Analysis

5.00% Savings not Achieved	236,131	472,262	708,393	917,265	1,755,053	1,899,213	1,983,412
10.00% Savings not Achieved	173,452	346,903	520,355	603,869	1,434,021	1,563,625	1,636,146
15.00% Savings not Achieved	110,773	221,545	332,318	290,474	1,112,989	1,228,037	1,288,880
18.80% Savings not Achieved	63,136	126,273	189,409	52,293	869,004	972,991	1,024,958
20.00% Savings not Achieved	48,093	96,187	144,280	-22,922	791,957	892,450	941,614

Appendix E: Brining care closer to home – an example of our demand management initiatives

Current CAS Services Profile

Specialty	Location of service	Clinicians	Diagnostics	Triage Arrangement	No of sessions per week
Cardiology	Alexandra Ave H&S Care Centre The Pinn Medical Centre Roxbourne Medical Centre Bacon Lane Surgery	4 – GPwSI 2 – consultants 1 – PwSI	ECHO Resting ECG 24-hour tape	Triage is done by the GPwSI's on a rotational basis	PER MONTH 7 GPSWI clinics 4 consultant clinics 5 ECHO clinics
Dermatology	Elliot Hall Medical Centre Hatch End Medical C Bacon Lane Surgery The Pinn Medical Centre	4 – GPwSI 1- consultant		Triage is done by the GPwSI's on a rotational basis	5-6 week Plus Joint mentoring Clinic every 2 weeks
Gynaecology	Alexandra Ave H&S Care Centre Kenton Bridge Medical Centre The Pinn Medical Centre	3- GPwSI 3 consultants from 1st January 2010	Dependent on the pathway eg US, bloods)	Triage is done by the GPwSI's on a rotational basis	GPwSI 2-3 on rota Consulatant Gynaecologist x1 week from January 2010
Minor Surgery	Alexandra Ave H&S Care Centre The Pinn Medical Centre	3- GPwSI		Triage is done by the GPwSI's on a rotational basis	3x week
Neurology (Headache)	Stanmore Park Medical Centre	1- GPwSI Supported by consultant	CT Scan		1 week
Ophthalmology	Northwick Surgery Vision Care -Wealdstone High Road The Wealdstone Centre Alexandra Avenue H&S Care Centre	2- AWP Contracts held with Harrow Health Ltd and The Practice		Consultant triages under AWP contract	5 clinics per week
Musculo-skeletal (MSK)	The Pinn Medical Centre Stanmore Park Medical Centre	1- AWP Harrow Health Ltd	MRI X-Ray	GPwSI and Consultant triage under AWP contract	6 per week including physiotherapy
Urology	Alexandra Avenue H&S Care Centre	1 – GPwSI Consultants in community from Jan 2010	Bladder U/S Flow rates done in clinic	GPwSI triage	1x week GPwSI Consultant clinics x 2 MONTH initially from January 2010

Specialty	Location of service	Clinicians	Diagnostics	Triage Arrangement	No of sessions per week
Diabetes	The Pinn Medical Centre (proposed) Alexandra Avenue H&S Care Centre	1- GPwSI 1- Consultant 1- DSN		Multi-disciplinary team triage	1 x week
Gastroentorology	Alexandra Avenue H&S Care Centre	2- GPwSI Consultants in community from Jan2010	Dependent on the pathway	Triage is done by the GPwSI's on a rotational basis	2 x week GPwSIs Consultants x 2 month from January 2010