



Delivering the Harrow Vision: Right Care, right place, right time

Harrow summit – workshop notes

9th November 2011

Introduction

On 9th November 2011, the Harrow Clinical Commissioning Board hosted a stakeholder event to discuss the vision for Out of Hospital Care. The aims of the workshop were to:

- communicate the health context in which Harrow will operate over the coming years,
- convey the financial challenges ahead,
- explore and refine the out of hospital vision for Harrow,
- test the application of this vision to patient pathway scenarios and understand the key changes to be made across the health system, and
- create a shared understanding of the next steps for making the out of hospital strategy real.

The event brought together over a hundred people to hear presentations from the Harrow Clinical Commissioning Board, followed by a series of exercises. Participants included patients, GPs from all practices in Harrow, secondary and community clinicians, commissioners, and other key stakeholders from organisations across Harrow including:



Workshop context and structure

The workshop was structured in two parts – the first part featured presentations to set the context for the session and the second part comprised of exercises centred on real patient journeys described by Harrow's GPs. The event was facilitated by NHS NWL's Delivery Support Unit.

NWL CONTEXT

NWL is facing **urgent clinical and financial challenges**

Our **Out of Hospital Strategy** is critical to our success in meeting these challenges

Five NWL boroughs are holding workshops to involve the healthcare community in shaping the local Out of Hospital Strategy

PRESENTATIONS

Welcome Dr Kaushik Karia Harrow CCG	Background Rob Larkman Brent/Harrow sub-cluster	Clinical context Dr Genevieve Small Harrow CCG	Financial context Dr Kanesh Rajani Harrow CCG	Harrow Vision Dr Amol Kelshiker Harrow CCG	Acute Perspective Prof Rory Shaw NWLHT
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HARROW CCB PANEL QUESTIONS AND ANSWERS

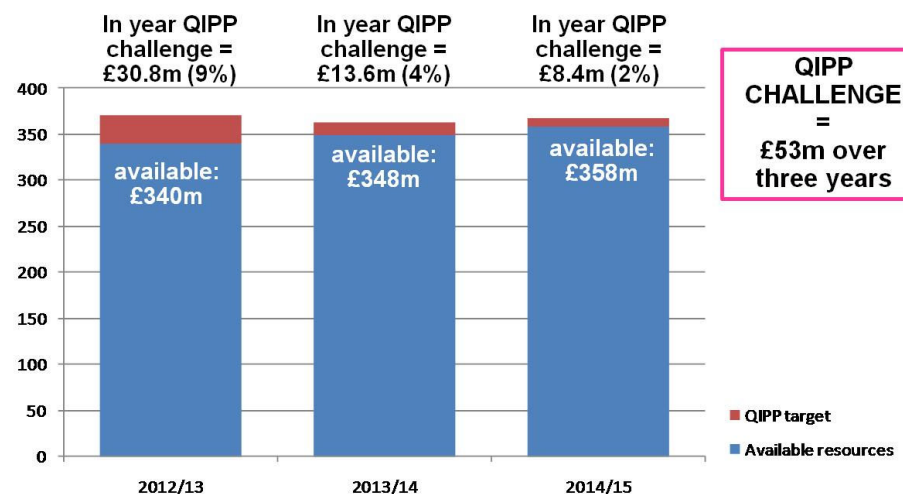
WORKSHOP TOPICS AND CLINICAL FACILITATORS

Cardiology Dr Masood Farooqi	Epilepsy Dr Larry Gould	Falls Dr Chris Jenner	Mental Health Dr Genevieve Small	Paediatrics Dr Amol Kelshiker	Urology Dr Dilip Patel
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Musculo-skeletal Dr Kanesh Rajani	End of Life Dr David Lloyd	Frequent admissions Dr Imtiaz Gulamali	Gynaecology Dr Kaushik Karia	Chronic Kidney Disease Dr Will Maramis
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Summary of context for Harrow

- The **scale of the financial challenge** for NWL is large: 4% for most other boroughs in 2012/13 alone
- Benchmarking shows that Harrow is doing fairly well – and we know that there is good practice that we can demonstrate but **Harrow's financial challenge is larger: 9% in 2012/13**
- Traditional approaches of 'salami slicing' to make improvements won't make big enough changes to services to achieve financial sustainability AND maintain high quality clinical services.
- Our only option is to **redesign the whole system** – this is our Out of Hospital Strategy
- We need to do it now while we have the **momentum of the changes** that are already underway (mergers, QIPP, etc)
- We will need to re-invest savings in the right places to make this happen.



Source: CSP financial model October 2011

The vision for Out of Hospital Care in Harrow

To deliver modern, high quality, cost-effective services which provide:

the **right care**

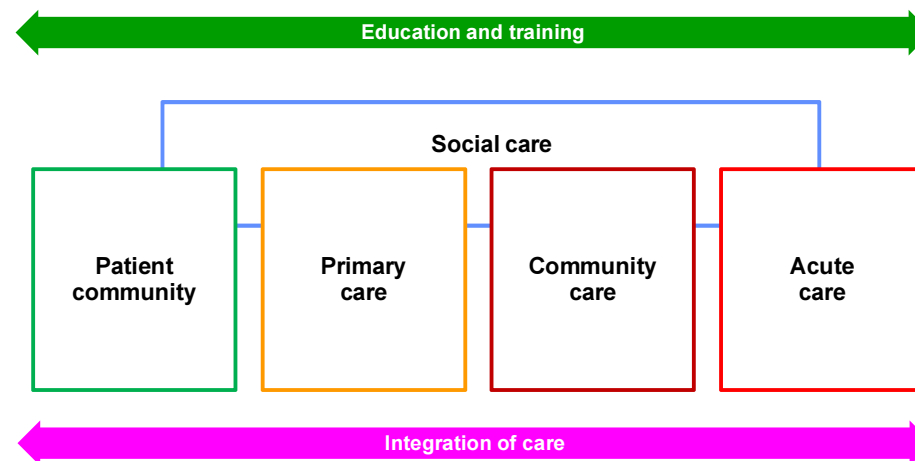
in the **right setting**

by the **right person**

- Improve quality
- Reduce dependence on acute care
- Appropriately skilled clinician
- Integrated
- Change behaviours and practice in primary care, secondary care and the community

Underpinned by the following strategic aims:

- Improve health and wellbeing in partnership with patients and wider community.
- Ensure service provision is needs-led, sustainable and fair.
- Build on evidence and good practice.
- Create the environment for learning that empowers patients, carers and clinicians.



Exercises

Exercise 1: Making it better

Discuss a patient story
How could it be improved?

Pathways discussed:


- Cardiology
- Falls
- MSK
- End of Life
- Gynaecology
- Urology
- Epilepsy
- Mental Health
- Paediatrics
- Frequent Admissions
- Chronic Kidney Disease

Exercise 2: Making it real

What are changes are needed in the health system to enable the improvements?

Falls

Patient community	Primary Care practices and networks	Primary Care hubs	Community care settings (including care at home)	Acute care settings	Other
<p>Patient has been unsteady for 1 year with falls at home</p> <p>Serious fall at home</p>	<p>GP appointment, patient denies unsteadiness</p>		<p>Community nursing visits</p>	<p>A&E attendance</p> <p>A&E attendance</p> <p>A&E attendan</p> <p>Emerger admissi</p> <p>Surgery fractured</p> <p>T&O out follow up</p>	
<p>David is an 80 year old widower who has been generally healthy throughout his life. His daughter has become worried over the last year that David has become unsteady as he has had several falls at home for which he has gone to A&E, but been discharged home.</p> <p>He denies having any problems other than getting older, and reluctantly visits his GP. When examined, he has a low frequency tremor, a shuffling gait and there may be some increased tone with possible cog-wheeling. He does eventually admit to his GP that he has been feeling slightly more unsteady recently but doesn't want any further help.</p> <p>A week later, David experiences a more serious fall at home which requires him to be taken to hospital by ambulance. In A&E, he is found to have fractured his hip and is admitted as an emergency for surgery which he has two days later. Once recovered from his operation, he is seen regularly by the Trauma and Orthopaedics team at the hospital, often by a junior doctor who says that he should come back in six months for further review. He is visited by the Community Nursing team in the week after his surgery.</p> <p>David does not see his GP again as he has no appointments for other minor problems as they arise.</p>					



Worksheet 1: New pathways Table 8

Patient community	Primary Care	Community Care	Acute Care
PATIENT UNSTEADY + FALLS	LETTER TO GP RE: FALLS		A&E
FAMILY CONCERNS	INFORM GP	SOCIAL CARE ASSESSMENT	FALL CLIN
HOME	Follow up	Com. nursing/Therapist follow up	PR
EXERCISE REFERRAL			SEEN PH

Worksheet 2: Key changes Table 8

Patient community	Primary Care	Community Care	Acute Care
Ability to raise concern by patient or carer/family	Empower professionals	Identify vulnerable patients → Flag ↔	A&E Triage → rapid response discharge chain → Falls Service
Build trust by having continuity of care	Establish telephone contact point once discharged from Com nursing etc.	Information sharing across services.	A&E discharge letters accurate and timely
Routine questionnaire to older patients to facilitate case finding (at risk - before they fall)	Education of 10/Com / Social care prof re falls risks.	Follow up in community by rapid response + then other services.	Anyone falling seen by Fracture Liaison Service.
Education of patients			Stop T&O follow up → replace by physician follow up.
(Home assessments) For equipment/Grab bars. ? Done now.			
Info in different languages to meet the changing demographic of the elderly people in Harrow.			

Example of group exercises

Common themes

Across all of the workgroups, there were several recurring themes fed back as the key priorities :

Group	Integration/ multi-disciplinary working	improved communications between services	patient & carer education	joined up IT/ shared care records	Single point of access	Extended hours of service	Risk assessment/ stratification	Clinician up- skilling/ rotations
Cardiology	✓	✓	✓	✓	✓			✓
Frequent Admissions	✓	✓	✓	✓		✓	✓	✓
Mental Health	✓	✓	✓	✓	✓			
Epilepsy	✓	✓	✓					✓
Musculo-skeletal	✓	✓	✓	✓				
Chronic Kidney Disease	✓	✓	✓	✓			✓	✓
Urology	✓	✓	✓		✓			
Falls	✓	✓	✓	✓	✓		✓	
Paediatrics	✓	✓	✓	✓				
End of Life Care	✓	✓	✓	✓		✓	✓	
Gynaecology	✓	✓	✓	✓	✓			

Top priorities fed back

Workgroup suggestions

Top priorities and next steps

Top priorities based on the group exercises across all pathways:

- More integration of care across secondary, community and primary settings
- Improved communication between services
- More patient education and ownership of care, included through use of technology
- More flexible workforce arrangements and information sharing

Next steps *(to be reviewed by CCB)*

- To consolidate the information provided in the exercises, identify common themes and work these into the development of strategy.
- To reflect the pathways back to individual workshop groups for further iteration so that pathway redesign can actively commence.
- To continue to build on the successful engagement to work across organisational boundaries and start making the radical changes needed.