



Better care, closer to home

Harrow Strategic Partnership Board

June, 2012

PCT Key Data 2012/13

	Notified Allocation	Allocation per head	Planned Surplus		QIPP Target	
	£'000	£	£,000	%	£,000	%
NHS Brent	569,828	2,175	15,428	2.8	11,491	2.1
NHS Harrow	358,496	1,651	-	-	14,100	4.2
NHS Ealing	623,631	1,852	-	-	19,612	3.3
NHS Hillingdon	430,321	1,665	-	-	15,097	3.7
NHS Hounslow	416,174	1,722	-	-	14,518	3.7
NHS Hammersmith & Fulham	371,698	2,237	7,084	2	14,168	4
NHS Kensington & Chelsea	378,838	1,953	7,332	2	14,846	4
NHS Westminster	507,518	1,909	9,672	2	16,926	3.5
	3,656,503	1,883	39,516	1.1	120,759	3.5

Opportunity to be inventive: Towards a Health and Wellbeing Strategy

The health needs of the people of North West London are changing;

New standards in Hospital care :

- 24/7 A&E must access to 24/7 General surgery**
- Acute paediatrics must be 24/7**
- All diagnostics must be available 24/7**
- Midwife led units co-located with Obstetric units**
- Not enough staff**

Community and Primary Care:

- as people live longer and live with more chronic and lifestyle diseases pressure on social and community care**
- New technology in medicine and diagnostics –**
- Allows more near patient testing**
- Tele-health and tele-monitoring**

Reconfiguration is based on three overarching principles

Three overarching principles underpin our vision for care

1

Localising routine medical services means better access closer to home and improved patient experience

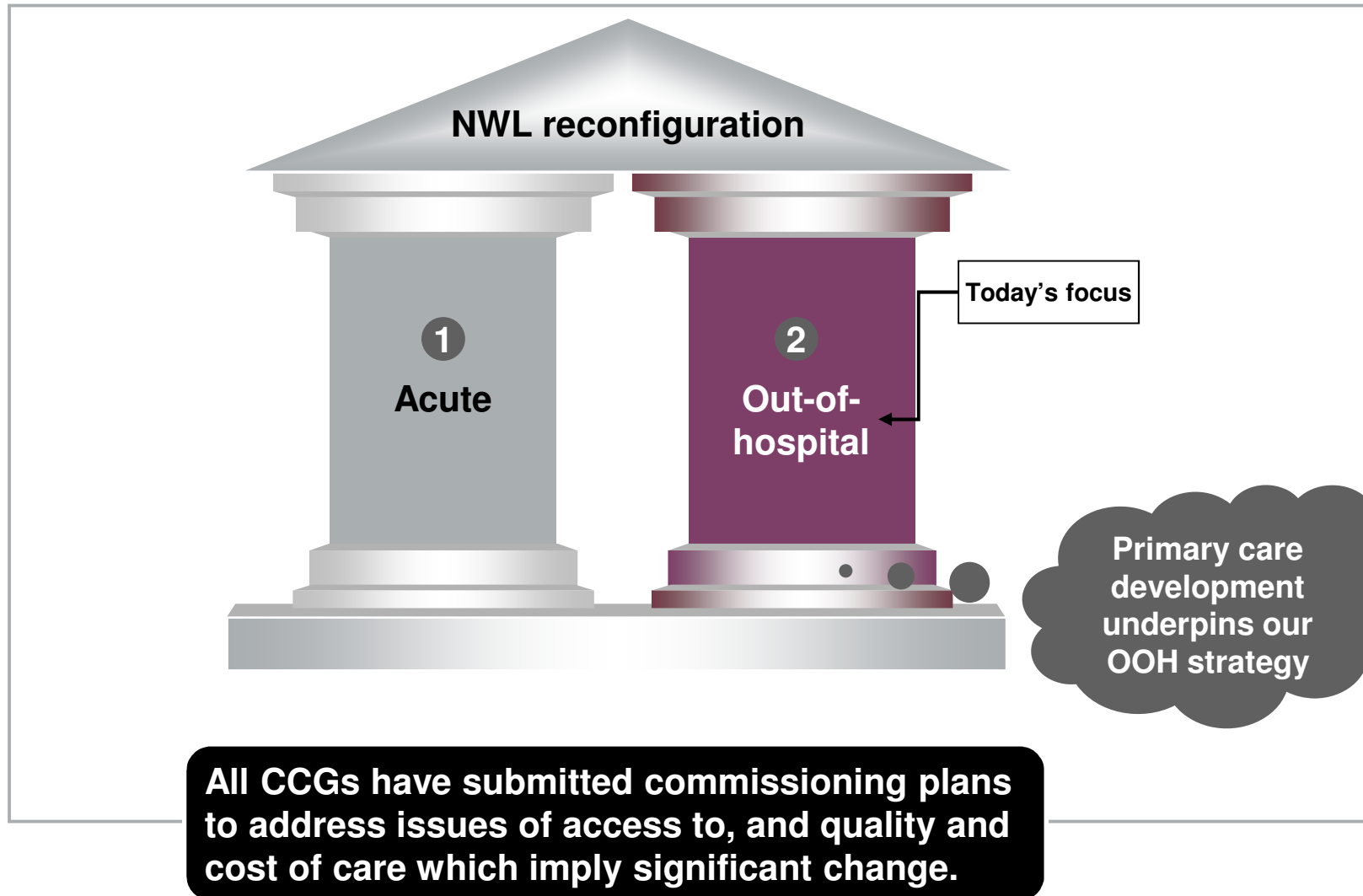
2

Centralising most specialist services means better clinical outcomes and safer services for patients

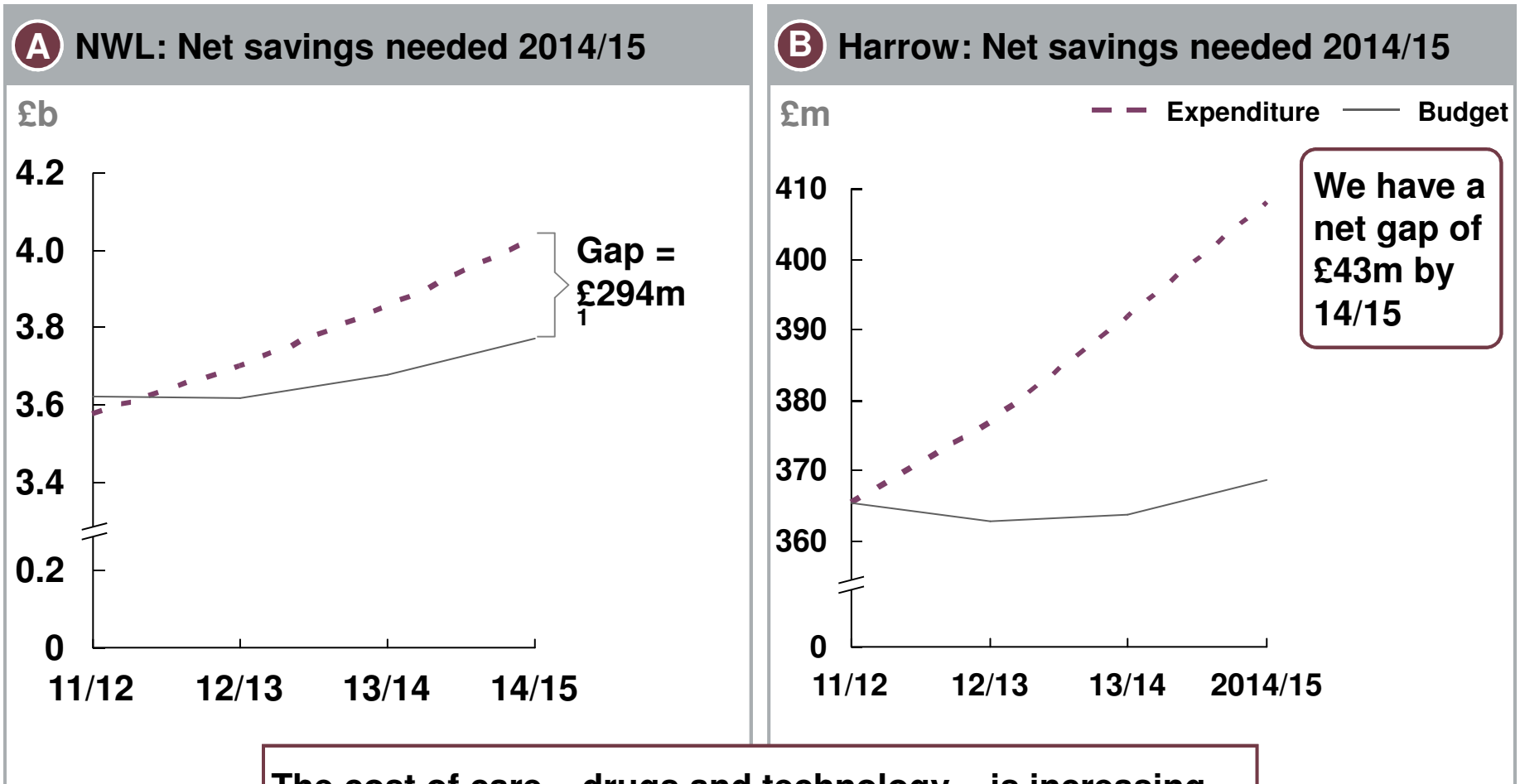
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Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure seamless patient care

There are two pillars to the reconfiguration



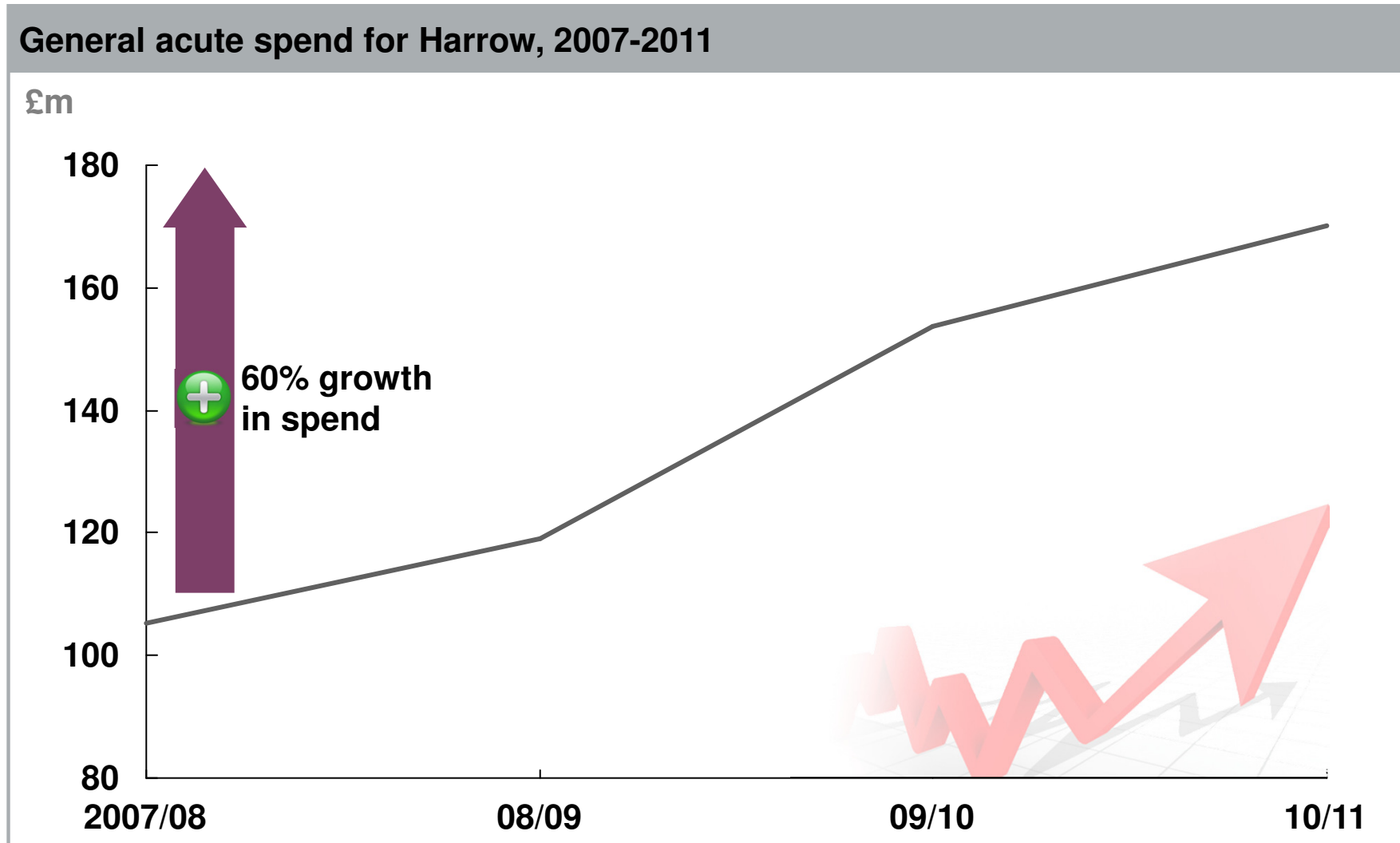
1 Under our current model of care we can't afford to meet future demand



The cost of care – drugs and technology – is increasing, while money for the NHS is static resulting in a funding shortfall

SOURCE: Department of Health Annual Reports, Operating Framework 2009/10 and 2010/11, NWL Commissioning Service Plan, 1 Dec 2011

② We face a growing burden in acute spending



SOURCE: PCT general acute spend 2007-2011

We have a clear vision for how OOH care will look in the future

Harrow CCG is committed to improving primary and community care in its locality by providing the right care in the right place, at the right time

By offering a much wider range of high-quality services over extended hours to the community, we will reduce the need for patients to attend hospitals and help reduce demand on acute services

We will achieve our vision by improving patient care in 5 areas



- **Easy access to high quality, responsive primary care** to make out of hospital care first point of call for people



- **Clearly understood planned care pathways** that ensure out of hospital care is not delivered in a hospital setting



- **Rapid response to urgent needs** so that fewer patients need to access hospital emergency care



- **Providers (social and health) working together**, with the patient at the centre to proactively manage **LTCs**, the **elderly** and **end of life care** out-of hospital



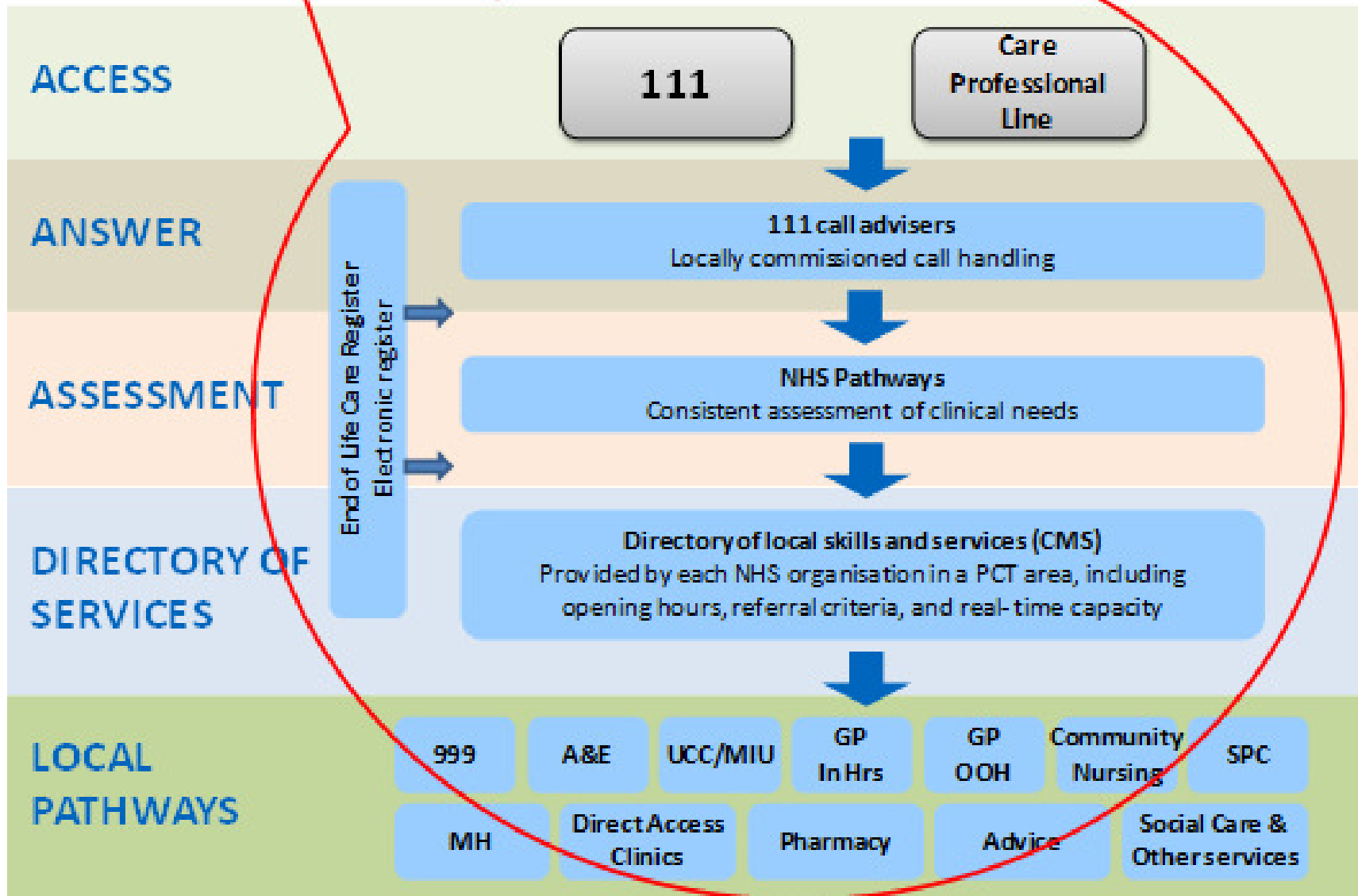
- **Appropriate time in hospital** when admitted, with **early supported discharge** into well organised community care

Specifically, this means

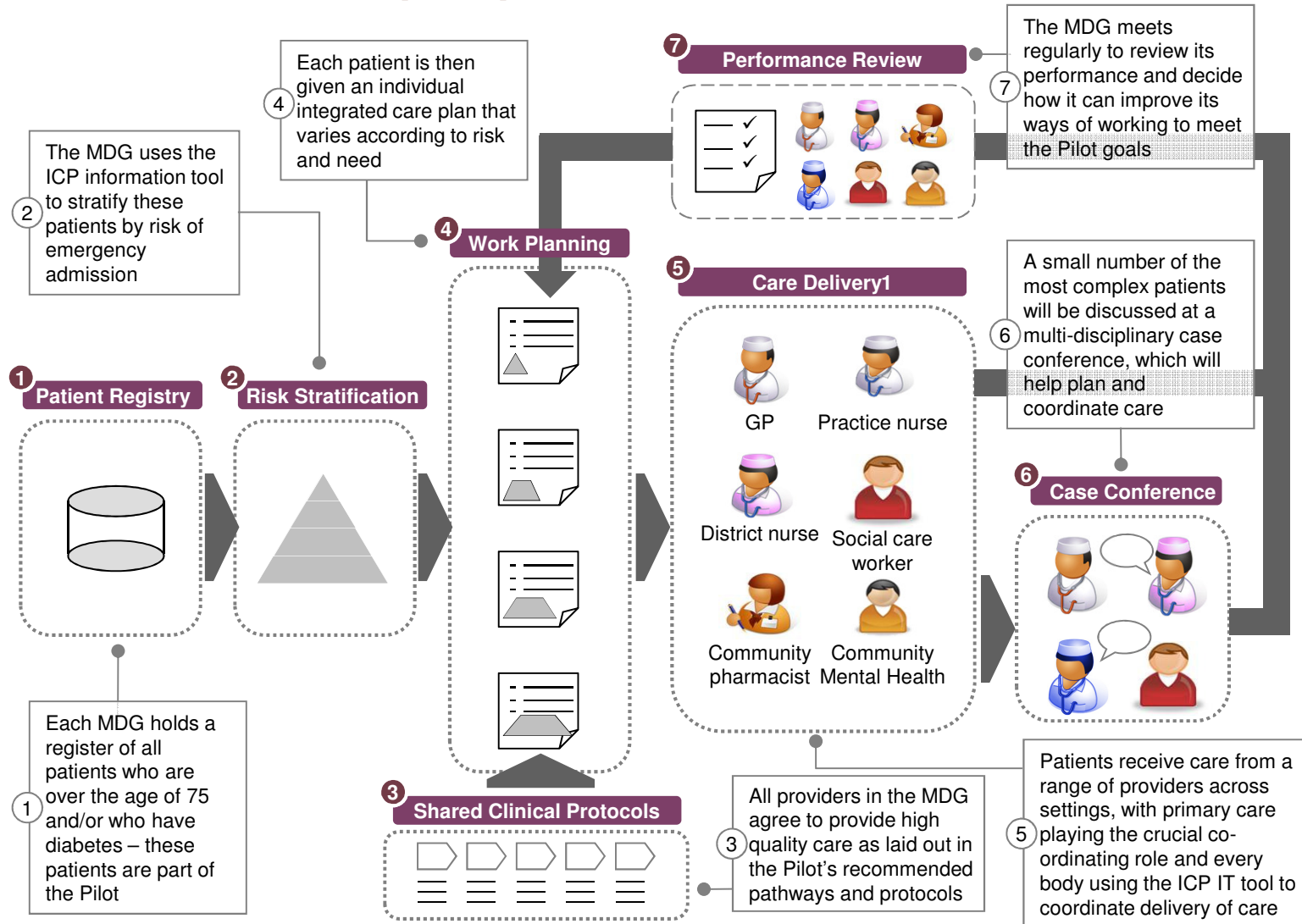
- GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care, **111**
- Whenever possible, patients will have access to services closer to home
- If a patient has an urgent need, a clinical response will be provided within 2 hours- STARRS -
- ICP- Patients will have a named coordinator who will make sure they have all the services they need. If a patient's condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home
- Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care- STARRS



COMMISSIONING INTELLIGENCE AND CONTROL

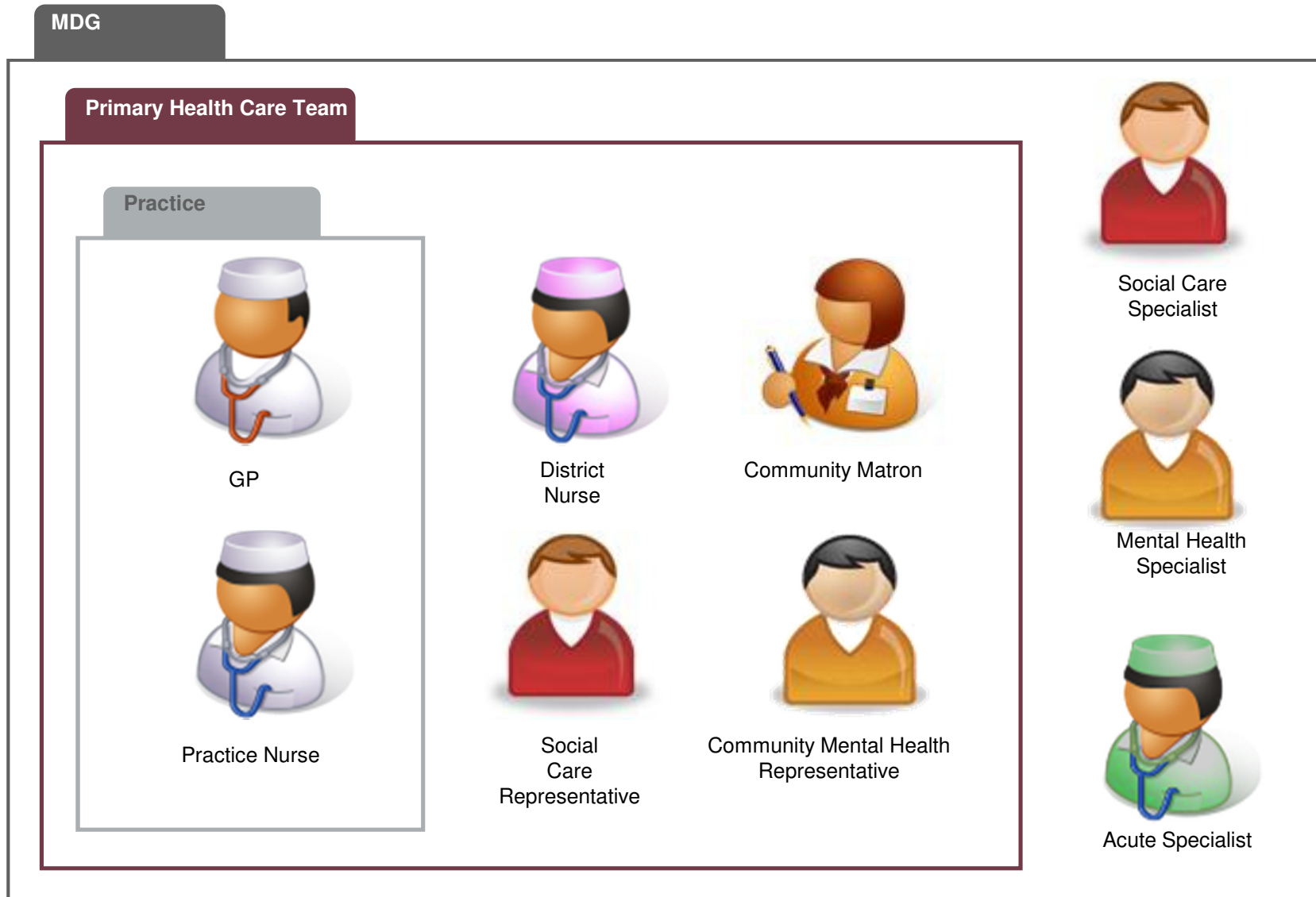


Integrated Care Pilot will promote a proactive, integrated approach to care for our most complex patients ...



1 Icons are illustrative only: any number of other professionals may be involved in a patient's care, a case conference or performance review

Integrated care is about forming Multi-Disciplinary Groups (MDGs)...



Rapid response and short term service (STARRS)

Description

- STARRS involves short-term, intensive interventions which enable patients to reach their rehab potential before moving on to their ultimate care destination
- This includes both time-bound rehabilitation (health therapy care) and reablement (social care, with therapy management)
- There are two key entry points for individuals:
 - Those at **risk of acute hospital admission**
 - Those who are **medically fit for discharge** from acute care (and have a reablement / rehabilitation need)
- The key operational elements are:
 - The **Rapid Response** team (i.e. urgent assessment and intervention to stabilise a patient for a maximum of 72 hours, as an alternative to A&E attendance)
 - The **Short-Term Service**, comprising of one, or a combination of
 - Temporary beds (health step-up and step-down beds and social care beds)
 - Time-bound Reablement service (i.e. social home care, with therapy management)
 - Time-bound Rehabilitation service e.g. therapy
 - Acute home care
 - Access to both is co-ordinated by a **Single point of access** (referral and triage)

What will be different for patients?

- Patients will not have to go to hospital to receive assessment and medical support but will receive this promptly in their own home
- Patients who are medically fit for discharge but require continued support will be able to receive this in their own home, avoiding unnecessarily lengthy hospital stays

What we will invest in to make this happen

- We will invest in rapid response teams, and a bedded service to make this happen





Who will do it

- The service will be delivered by a multi-disciplinary team of nurses, therapists and social care home workers who are able to perform rapid assessment and intervention at the home/ normal place of residence

Where it will happen

- Care will happen at a patient's home/ normal place of residence, or as part of a bedded service

We're increasing investment in out-of-hospital care across NW London

		Estimated new investment	Estimated additional workforce*	Estimated additional space
At Home		£18-20m	320 - 350	
At your GP (or care network)		£35-40m	180 - 210	<ul style="list-style-type: none"> ● 3,400-3,500m² ● ~45 consulting rooms
Health Centre		£26-28m	250 - 300	<ul style="list-style-type: none"> ● 8,300-8,400m² ● ~40 consulting rooms ● ~130-140 beds
Urgent care centre		£1-2m	10 - 20	<ul style="list-style-type: none"> ● 100-200m² ● ~5 consulting rooms

Plus £25-30m other investments

*Whole Time Equivalents

Total £105-130m

These changes will mean we will be able to offer more care in the right place for patients and rely less on hospitals

For an average practice in Harrow (~6300 list size)¹ this translates to...



274 patients per month who will not have to travel to hospital for outpatients but will be able to have them provided by a specialist GP or consultant in a local community health centre



37 patients per month who will not have to wait in A&E to see a doctor in an emergency because of better access to high quality primary care



10 patients per month whose emergency admissions per month will be prevented through improved and timely primary care



5 patients per month who will not face long waiting lists for minor procedures carried out in hospital but will be able to have their minor procedure provided by a specialist GP or in a local community health centre

¹ Average activity reduction for Harrows 37 practices translating to an average population size of 6300

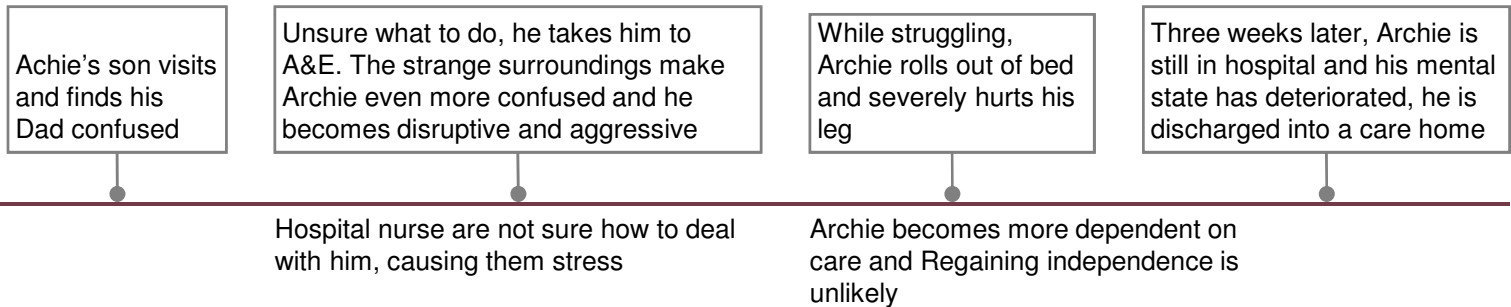


Rapid response to urgent needs so that fewer patients need to access hospital emergency care

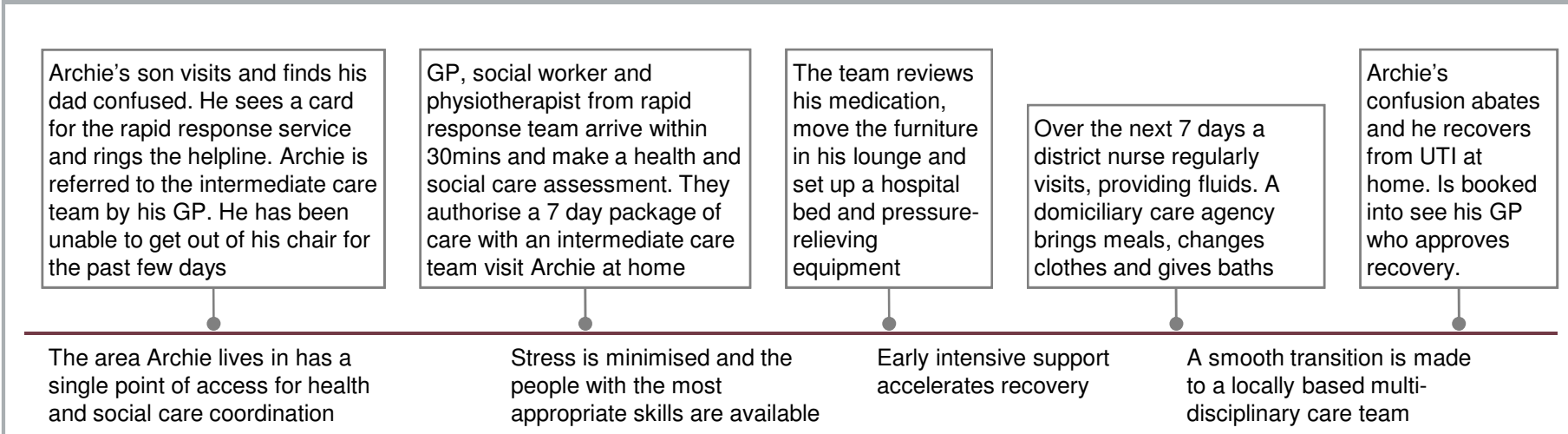
Archie is 80. He lives alone and struggles to look after for himself. He has COPD, and arthritis with restricted mobility. He has been admitted to A&E 7 times in the last 12 months and has usually been admitted. Recently he has developed an urinary tract infection which has led to him becoming confused.



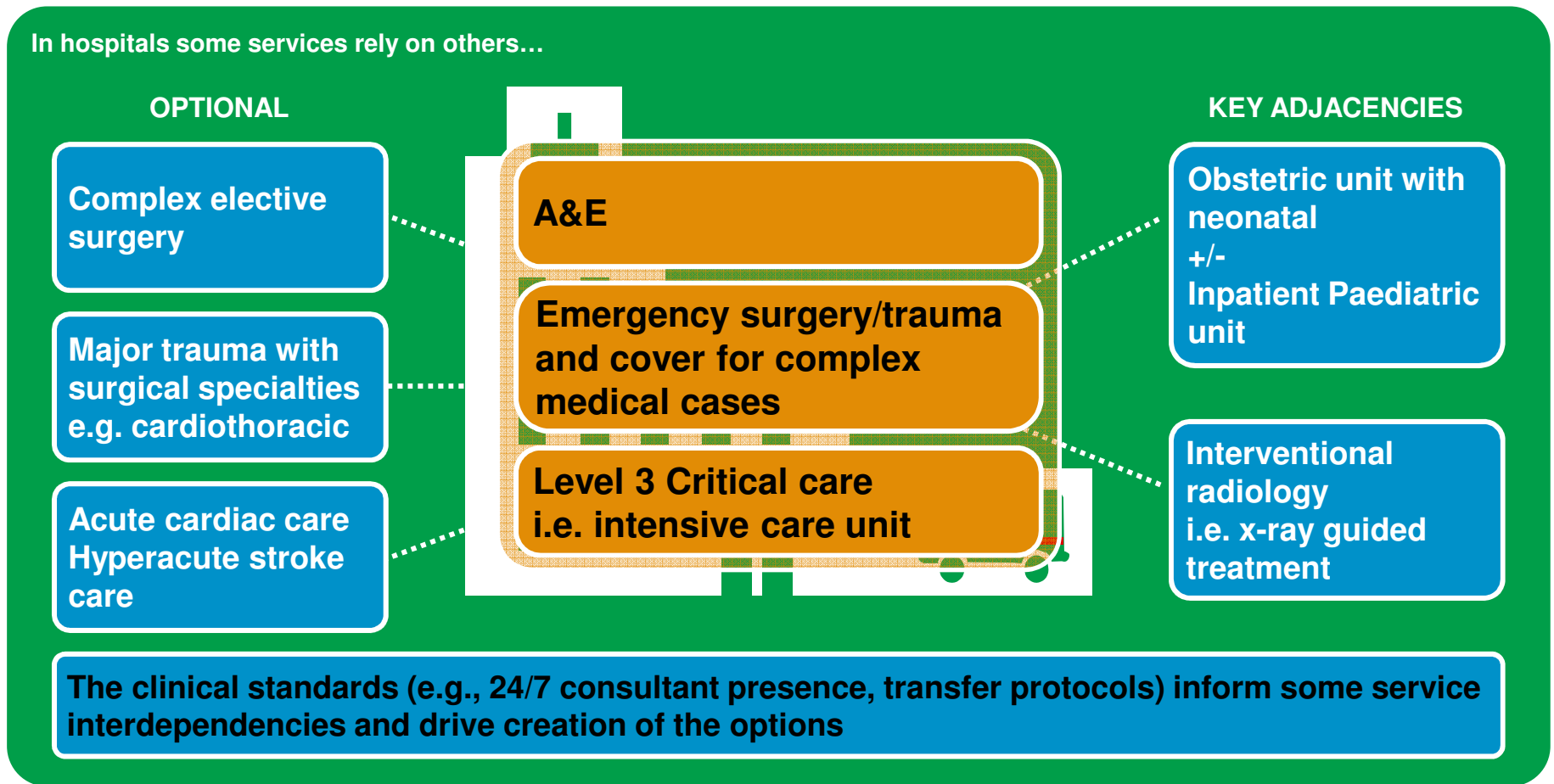
Urgent care has been stressful when patients need support ...



In future, we will meet patients' needs at home ...



Clinicians have been thinking about how we can best achieve our standards

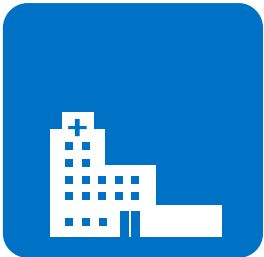


■ Driver of service model

■ Adjacent services requiring access to emergency surgery and/or ICU, level 3

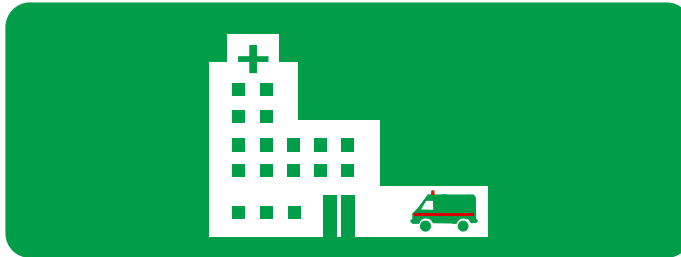
The range of services offered at each type of care centre is different

Local Hospital



24/7 Urgent Care Centre
Outpatients & Diagnostics
General Practice
Out of hours
Rehabilitation
Minor trauma
Minor procedures
Midwifery unit
GP beds

Major Hospital



24/7 A&E	Complex surgery
24/7 Urgent Care Centre	Major Trauma Centre
Outpatients & diagnostics	Inpatient paediatric
Urgent surgery	Obstetrics & Midwifery unit
Urgent/complex medicine	HASU
ICU, level 3	Acute Cardiac Services
Psychiatric Liaison Service	NICU level 2/3
Trauma unit	
Interventional radiology	

Elective Hospital



Elective surgery (including day case)
Elective medicine
Outpatients & diagnostics
Rehabilitation
ITU/HDU
UCC

Specialist Hospital



Examples:
 Cardiothoracic
 Cancer
 Orthopaedics

■ Essential service □ Optional service

Most activity will remain as it is now

But by applying the proposed models to our current sites and using criteria developed by local clinicians, patients and the public, our clinical leaders have recommended that:



Out-of-hospital services will be expanded and improved in all areas



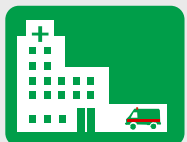
All Specialist Hospitals will stay as they are, including Hammersmith which would retain its specialist hospital services if not designated as a Major Hospital



Elective Hospitals can be located with, or independent of, Major Hospitals

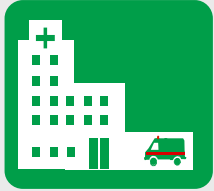


All 9 current hospital sites with an A&E will continue to provide Local Hospital services with a local A&E service such as an Urgent Care Centre – so patients will continue to go there for around 75% of the services they currently access there (outpatients, diagnostics and urgent care centre)



In order to meet the quality standards, NW London should have 5 Major Hospitals with 24/7 A&E, consultant-led obstetric units, inpatient paediatrics and associated complex care

For individual hospital sites, it is proposed:



Hillingdon Hospital and Northwick Park Hospital are proposed to be Major Hospitals, due mainly to their location and the related effect on patient numbers and travel times



Central Middlesex Hospital is proposed to be developed as an Elective Hospital, as well as providing Local Hospital services including a local A&E service such as an Urgent Care Centre



For the six other current hospital sites with an A&E:

It is proposed three should be Major Hospitals and three Local Hospitals (with a local A&E service such as an Urgent Care Centre). There are existing relationships between pairs of these hospitals due to the way they are used by patients and their accessibility, as follows:



Chelsea & Westminster, and Charing Cross



West Middlesex, and Ealing

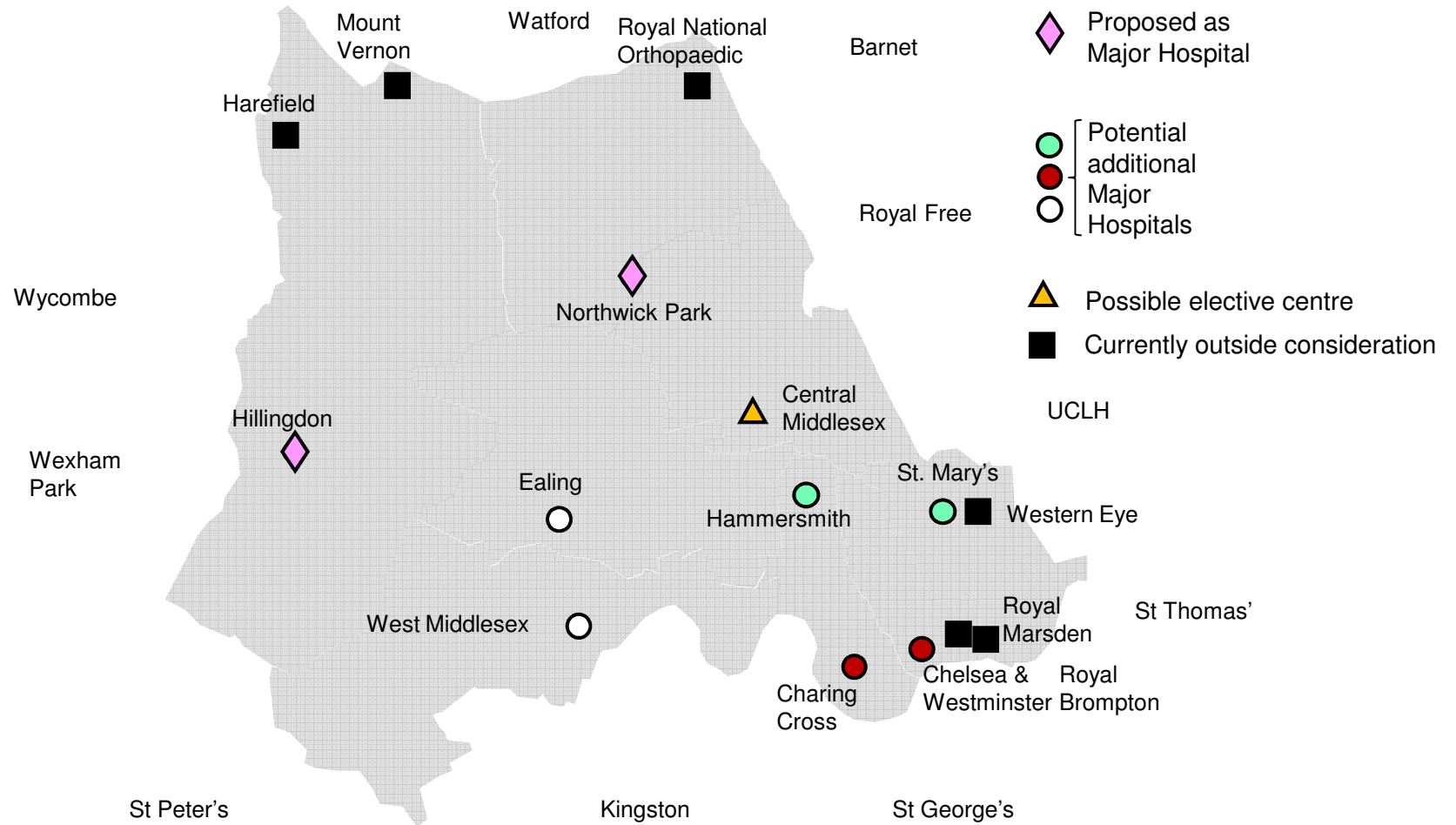


St Mary's, and Hammersmith (which will remain a Specialist Hospital)

Local GPs, hospital doctors, other clinicians and commissioners are developing options for public consultation based on these 'pairs' of hospitals



So we now have a list of Eight options



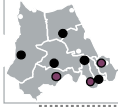
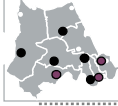
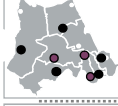
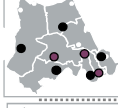
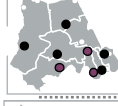
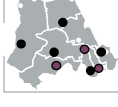


Informed by patients and clinicians and these events, the evaluation criteria we have used are:

	Criteria	Sub-criteria
1	Quality of care	<ul style="list-style-type: none">▪ Clinical quality▪ Patient experience
2	Access to care	<ul style="list-style-type: none">▪ Distance and time to access services▪ Patient choice
3	Affordability and Value for Money	<ul style="list-style-type: none">▪ Recurrent cost to the system▪ Capital cost to the system▪ Financially sustainable Trusts▪ Transition costs▪ Value for money
4	Deliverability	<ul style="list-style-type: none">▪ Workforce▪ Expected time to deliver▪ Co-dependencies with other strategies
5	Research and Education	<ul style="list-style-type: none">▪ Education and research

Summary of evaluation

++ High evaluation
-- Low evaluation

	Quality of Care		Access		Value for Money					Deliverability			Research & Education		Total count	
	Clinical quality	Patient experience	Distance and time to access services	Patient choice	Capital cost to the system	Transition costs	Site viability	Surplus for acute sector	Net Present Value	Count for VfM	Workforce	Expected time to deliver	Co-dependencies with other strategies	Disruption		Support current and developing research & education delivery
 <ul style="list-style-type: none"> West Middlesex Hammersmith Chelsea & Westminster Northwick Park & St. Mark's Hillingdon 	++	++	-	+	--	--	+	+	-	-3	+	-	-	-	-	-2
 <ul style="list-style-type: none"> West Middlesex Hammersmith Charing Cross Northwick Park & St. Mark's Hillingdon 	++	+	-	-	--	--	+	+	-	-3	-	-	-	-	-	-7
 <ul style="list-style-type: none"> Ealing Hammersmith Chelsea & Westminster Northwick Park & St. Mark's Hillingdon 	++	+	-	+	--	--	--	-	--	-9	+	--	--	-	-	-11
 <ul style="list-style-type: none"> Ealing Hammersmith Charing Cross Northwick Park & St. Mark's Hillingdon 	++	-	-	-	--	--	--	--	--	-10	+	--	--	-	-	-16
 <ul style="list-style-type: none"> West Middlesex St Mary's Chelsea & Westminster Northwick Park & St. Mark's Hillingdon 	++	++	-	++	+	-	+	+	++	4	+	+	+	+	+	14
 <ul style="list-style-type: none"> West Middlesex St Mary's Charing Cross Northwick Park & St. Mark's Hillingdon 	++	+	-	+	+	-	+	-	+	1	-	+	+	+	+	7
 <ul style="list-style-type: none"> Ealing St Mary's Chelsea & Westminster Northwick Park & St. Mark's Hillingdon 	++	+	-	++	+	-	--	-	+	-2	+	--	-	+	+	2
 <ul style="list-style-type: none"> Ealing St Mary's Charing Cross Northwick Park & St. Mark's Hillingdon 	++	-	-	+	+	-	--	--	-	-5	+	--	-	+	+	-4