Practice Based Commissioning Plan

October 2008 / September 2009

Harrow Wide Practice Based Commissioning Group

FINAL DRAFT

22nd September 2008
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Appendix A
1. Overview

Harrow practices are currently divided into four Practice Based Commissioning (PBC) consortia. As in 2007, the consortia agreed to work together to submit a Harrow Wide plan, via the Harrow Wide Practice Based Commissioning Group (HWPBCG).

### Practice Based Commissioning Consortia Leads

<table>
<thead>
<tr>
<th>Consortium</th>
<th>Lead Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrow Allied</td>
<td>Dr Laurence Hommel</td>
</tr>
<tr>
<td>Harrow Medical Consortium</td>
<td>Dr Kevin Pearce</td>
</tr>
<tr>
<td>Harrow First</td>
<td>Dr Noreen Ryan</td>
</tr>
<tr>
<td>Harrow South</td>
<td>Dr Mike Eddington</td>
</tr>
</tbody>
</table>

All consortia are committed to supporting national and local targets, to reaching financial balance by year end and to continuing to pursue service improvements through their use and development of the Clinical Assessment Service (CAS) and the establishment of an Urgent Care Centre (UCC). As a result the leads, with the support of their constituent practices, agreed unanimously to produce a single commissioning plan for 2008/09.

A united approach to commissioning was felt to be more likely to:

- Achieve the required service changes and subsequent financial savings
- Ensure equity of access to new services
- Support meaningful negotiation with secondary care and other providers

The intentions and initiatives within this commissioning plan are directly in line with the wider NHS Plans and Primary Care Trust (PCT) objectives and HWPBCG are committed to implementation of their plan alongside that of the PCT’s Commissioning Strategy Plan (CSP).

Key challenges seeking to be addressed by both the PCT and the HWPBCG include financial stability, improving appropriateness of referrals and maximisation of demand management systems.

In line with the PCT’s CSP, and building upon work already progressed by the PCT through the Harrow Wide Executive, the HWPBCG has identified the following commissioning priorities to concentrate on in 2008/09.

- Urology
- Ear Nose and Throat
- Gastroenterology
- Reduction in hospital admission for respiratory diseases
- Brief Intervention and Counselling
- End of Life Care
- Review of the Healthcare and Rehabilitation Team (HART)
- Community Nursing
- Stroke/TIA
In addition HWPBCG will continue to support the CAS services currently in place: Dermatology; Cardiology; Neurology (headache); Gynaecology; Ophthalmology and Musculoskeletal, and the proposed further reductions in activity and cost outlined in section 7.

HWPBCG has agreed a number of over-arching principles that underpin its commissioning intentions:

- All practices will work cooperatively, equitably and inclusively, towards improving patient healthcare throughout the community.
- HWPBCG will commission value for money services, assessing and managing health needs using evidence based treatment.
- HWPBCG will value its staff and share effective practice.

In summary this commissioning plan details Practice Based Commissioners’ commitment to:

- Commission services that will result in significant changes in the way services are delivered
- Co-operate and support the delivery of the PCT’s Operating Plan for 2008/09 (and in doing so support the full delivery of local and national targets)
- Through a shared vision with the PCT, deliver World Class Commissioning competencies: better health and well being; better care and better value for money
- Achieve Financial balance, or surplus, against PBC budgets in 2008/09, through the commissioning initiatives in this document and to work in full co-operation with the PCT to develop and implement further savings plans/ schemes in year
- Commission services in line with the wider Commissioning plans of the PCT.
2. Vision

Practice Based Commissioners aspire to ensure the provision of services for patients closer to home, taking into consideration age, ethnicity, and high prevalence health conditions requiring long term care.

The aim of the Group is to achieve financial balance and make savings within the Group’s allocated budget.

The Group is willing to engage with Harrow PCT in the planning of new care pathways and the redesigning of existing care pathways as deemed to be beneficial to patient care.

3. Context

3.1 Harrow PCT’s Strategic Intentions

The PBC Consortia are aware of and, in line with the PBC Governance Agreement, are committed to working in full co-operation with the PCT to deliver:

- The PCT Operating Plan 2008/09 (and financial balance / surplus)
- The Local Delivery Plan

The consortia will also work with the PCT to develop the agreed Commissioning Strategy Plan (CSP) for the next five years.

3.2 PBC Consortia – Harrow Wide PBC Group (HWPBCG)

The HWPBCG consists of the 37 practices that are affiliated to the four Consortia listed on page 3.

3.3 Population Demographics

HWPBCG serves a registered population of 231,600, 215,000 of whom live in the London Borough of Harrow.

While ostensibly an affluent borough (Pinner, Hatch End, Stanmore and Harrow on the Hill) there remain pockets of complex deprivation (notably east and west Kenton and the Rayners Lane and Roxbourne wards) that are comparable with wards in far less prosperous boroughs.

3.3.1 Harrow Profile

In Harrow the proportion of children aged up to 14 years and people aged over 75 years is similar to the England average. Harrow has a higher proportion of people aged 15 to 44 years compared to the England average, but lower than average for London. Projections for 2007 show around 6.5% of Harrow’s population was aged under 5 years, 68.5% were of working age (15 to 64) and 13.6% of Harrow’s population was aged over 65 years.

The age distribution varies within each ward. The percentage of children aged under 5 ranges from under 5% in Headstone North to over 9% in Marlborough. Generally the wards in the south and central corridor of the borough have a greater proportion of the
population aged 5 years and under, whilst the wards in the north of the borough have a higher proportion of residents aged 65 years and over

3.3.2 Ethnicity

In 2001, when the last national Census was performed, Harrow had the fifth most diverse population in the country, with 41% of Harrow’s population being from Black and Minority Ethnic groups, which was much higher than the London average of 29%.

The Greater London Authority produces population projections by ethnic group for each of the boroughs in London. In 2007 projections suggested that around 51% of Harrow’s population was white compared to 67% of London’s population. The biggest Black and Minority Ethnic group in Harrow is Indian accounting for around 26% of Harrow’s population, compared to around 7% of the total population of London. Approximately 11% of Indians living in London live within the borough of Harrow.

3.3.3 Mobility

The population, particularly in the South of the borough, is relatively mobile. As with many London boroughs this has an impact on health improvement work.

3.3.4 Deprivation and income inequality

The Department of Health’s Harrow Health Profile 2007 provides information on variation in the percentage of people on low income (See www.harrowpct.nhs.uk/infoforhealthprof/content.asp?id=61).

Multiple deprivations (a combination of all deprivation indicators – such as health, income, crime and environment) in Harrow is well below the national average, with Harrow ranking 15th out of 19 Outer London boroughs.

A number of areas to the north-west of the borough (around Pinner, Hatch End and Headstone) are among the least deprived in the country, although real deprivation exists in some areas towards the central and southern regions (largely in Marlborough, Greenhill and Roxbourne). The two areas with the highest level of multiple deprivations are in Roxbourne and Pinner.

3.3.5 Projected Population Trend

Population projections as shown below indicate a significant expected increase. Again, this will impact across a range of services from maternity to care for long term conditions.

Table One: Population projections

<table>
<thead>
<tr>
<th>Population segment</th>
<th>Year 0 (Baseline)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
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<tbody>
<tr>
<td>M 0-14</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>21</td>
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<tr>
<td>M 15-59</td>
<td>69</td>
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<td>M 60-74</td>
<td>12</td>
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<td>CHD – Male (15+)</td>
<td>4354</td>
<td>4385</td>
<td>4418</td>
<td>4456</td>
<td>4502</td>
</tr>
<tr>
<td>Male - % total pop</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.1%</td>
<td>5.1%</td>
</tr>
<tr>
<td>CHD – Female (15+)</td>
<td>3147</td>
<td>3151</td>
<td>3159</td>
<td>3171</td>
<td>2959</td>
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<tr>
<td>Female - % total pop</td>
<td>3.4%</td>
<td>3.4%</td>
<td>3.4%</td>
<td>3.3%</td>
<td>3.1%</td>
</tr>
<tr>
<td>COPD – Male (15+)</td>
<td>3296</td>
<td>3316</td>
<td>3328</td>
<td>3361</td>
<td>3387</td>
</tr>
<tr>
<td>Male - % total pop</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>COPD – Female (15+)</td>
<td>2354</td>
<td>2357</td>
<td>2361</td>
<td>2368</td>
<td>2375</td>
</tr>
<tr>
<td>Female - % total pop</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
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<tr>
<td>Diabetes Type 1</td>
<td>770</td>
<td>774</td>
<td>777</td>
<td>780</td>
<td>783</td>
</tr>
<tr>
<td>M &amp; F</td>
<td>12314</td>
<td>12703</td>
<td>13090</td>
<td>13465</td>
<td>13852</td>
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<tr>
<td>Diabetes Type 2</td>
<td>13084</td>
<td>13477</td>
<td>13867</td>
<td>14245</td>
<td>14635</td>
</tr>
<tr>
<td>M &amp; F</td>
<td>6.0%</td>
<td>6.1%</td>
<td>6.3%</td>
<td>6.4%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Hypertension **</td>
<td>25328</td>
<td>25525</td>
<td>25720</td>
<td>25928</td>
<td>26143</td>
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<tr>
<td>Prevalence – Male</td>
<td>29.1%</td>
<td>29.0%</td>
<td>29.2%</td>
<td>29.5%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Prevalence - % total</td>
<td>24666</td>
<td>24770</td>
<td>24894</td>
<td>25049</td>
<td>25216</td>
</tr>
<tr>
<td>Prevalence – Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence - % total</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

3.3.6 Expected incidence growth

These figures are based on published national statistics and assume that no improvement is made in the treatment of these diseases.
**These figures are projections from the Health Survey for England. The number of patients on Harrow practice hypertension registers is significantly less than the figures provided above.

3.4 Population Health Needs

Harrow is a very ethnically diverse borough (over 41% of the population being from minority ethnic groups) and has a higher proportion of over 65s and 5-15 year-olds than London overall. This inevitably provides us with specific challenges as we aim to ensure equal and open access to care for all our communities. Broadly, the key health issues for Harrow include:

- Relatively high levels of low birth weight and infant mortality rate
- High prevalence of diabetes and coronary heart disease
- Relatively high estimated prevalence of obesity
- Relatively high rates of TB
- Relatively low (but increasing) teenage pregnancy rates
- High proportion of over 85s with increasingly complex needs
- Health needs of asylum seekers and refugees

As with all other boroughs in London, the most common causes of death are circulatory disease and cancers. The last borough figures available are for 2005, when a total of 1616 Harrow residents died. The most common causes of death were cancer (26%), coronary heart disease (16%), other diseases of the circulatory system (12%) and stroke (9%).

3.5 Priorities for HWPBCG – 2008/09 and beyond

This commissioning plan has identified some areas of priority where patients experience long waits for treatment or poor access. In addition, reviews are proposed for a range of services that are felt not to be meeting the needs of patients and clinicians in providing effective, holistic care to their patients.

In addition to the initiatives outlined in this plan the PBC Consortia are committed to working in full partnership with the PCT to deliver the PCT Operating plan 2008/09 and CSP initiatives that address wider health issues identified as priorities for the local population e.g. enhanced rates of smoking cessation.

The PBC plans for 2008/09 will more directly address the wider range of health needs by building upon current initiatives and developing new services where necessary.

3.6 Existing targets and national / local priorities

The PCT’s corporate objectives for 2008/09 are based on its operating plan for 2008/09. This in turn reflects national priorities, Local Area Agreements and NHS London-specific targets.

Key areas from the corporate objectives are listed below. HWPBCG is committed to the achievement of the PCT’s operating plan priorities:

- Achieving financial balance and sustainability. Through the use of strong financial monitoring and reporting systems the PBC Group aims to ensure spending represents value for money
Improving the population’s health: cancer mortality, cardiovascular disease, inequalities, life expectancy, mental health, obesity (and related physical activity strategy), sexual health, smoking, screening, child and maternal health (and related breast feeding strategy), MRSA, older people. HWPBCG commits to full co-operation with the PCT in efforts to improve population health and to target areas of health inequalities, working in partnerships with other agencies to deliver health improvement programmes where health and social needs are greatest.

Supporting people with long-term conditions: HWPBCG will make a commitment to work with and build upon delivering PCT measures to implement local and national delivery plans. Health equity audits have targeted coronary heart disease and diabetes as areas of high prevalence in Harrow and HWPBCG will continue to engage with the focus on primary and secondary prevention by targeting areas of greatest need.

Access to services: access – 18 weeks, drug treatment programme. Building upon work undertaken by the PCT and the local secondary care provider, HWPBCG will collaborate with stakeholders to disseminate and implement evidence based care pathways to ensure cost effective use of resources and to ensure every patient completes their care and treatment with the best outcome, on time, with no mistakes and without delay.

Choose and Book; working with the PCT to continue the implementation of the national policy

Improving the patient/user experience. Working with, and building upon, PCT’s local initiatives HWPBCG will aim to identify the components of the patient journey which add value to their care.

3.7 Local challenges and priorities

HWPBCG will support the PCT to achieve the goals set out in the CSP for Harrow:

- Improving health and tackling health inequalities
- Service integration through effective partnerships
- To deliver new models of care in the most appropriate setting
- To ensure effective and efficient use of resources

3.8 Financial situation

The budgets for Practice Based Commissioning will be set in accordance with Department of Health guidance (Practice Based Commissioning – budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance December 2007) and the agreement will be set out within the 2008-09 Governance agreements for each Commissioning Group.

The budget areas included in 2007-08 agreements and to be rolled forward in the agreement for 2008-09 are:

- Accident & Emergency
- PbR Non Elective
- PbR Elective (Inpatient & Day case)
- PbR Outpatients (First and Follow-up)
- Critical Care
- Non Contracted Activities (PbR)
- Direct Access (Pathology & Radiology)
• Prescribing
• Local Community Services
• Mental Health

In addition to the above the following budget areas will be discussed as possible areas to be included in budgets for 2008-09:

• Hospices
• Termination of Pregnancies
• Voluntary Sector Contracts

There are a number of high risk areas within these budget headings outlined above that will require the full delivery of initiatives detailed in this plan (section 7) and ongoing work in partnership with the PCT to identify further savings for 2009/10. Key pressures have been identified as:

**Accident and Emergency**
A&E attendances have continued to rise but the development of an Urgent Care Centre on the Northwick Park Hospital site will support a reduction in cost and inappropriate attendance and admission.

**Non-Elective**
Unplanned admissions are extremely expensive (c £2k per admission). Currently Harrow has limited community based services to support the prevention of admission. PBC Consortia will develop an integrated unscheduled care strategy.

**Critical Care**
Demand for critical care has increased and presents a considerable risk as there is often no alternative treatment available. Careful monitoring of activity to confirm commissioning responsibility and length of stay will ensure the PCT is invoiced accurately in high cost cases.
4. Goals

The strategic commissioning goals of the PCT focus upon improving health outcomes and reducing health inequalities. This will be achieved through the delivery of new care models, enhanced partnership across the local health and social care community and the most effective use of available resources. HWPBCG are committed to implementing these wider PCT commissioning plans (e.g. The Harrow CSP) alongside their own commissioning plans.

HWPBCG plans will adhere to existing, and develop new demand management schemes, support on-going pathway redesign and the achievement of key targets. HWPBCG’s commissioning intentions are aligned with the PCT and share key priorities.

The four key goals outlined by the Harrow CSP are detailed below:

- Improving health and tackling health inequalities
- Service integration through effective partnerships
- To deliver new models of care in the most appropriate setting
- To ensure effective and efficient use of resources

HWPBCG, through this commissioning plan and in partnership with the PCT and other stakeholders shares these overarching goals and will actively seek to achieve them through their commissioning roles.

5 Commissioning Intentions

In order to work towards Local and National challenges and priorities (see section 3.6) HWPBCG will:

- Reduce referrals to secondary care by utilising approved Care Pathways, including CAS
- Support further development of an Urgent Care Centre (UCC) at Northwick Park Hospital to ensure appropriate treatment of primary care patients including integration with out of hour’s services.
- With input from the PCT Prescribing Advisors, continue to monitor prescribing trends to reduce costs in this area
- With the support of the PCT, monitor practices’ performance against existing Service Level Agreements in order to address improve performance year on year
- The consortia will comply with all nationally agreed targets and initiatives
- Support local and national public health initiatives e.g. obesity, smoking

HWPBCG aligns their plans alongside that of the PCT, working to develop a local model which is both pragmatic and mutually supportive.

Consortia have identified commissioning priorities for local development and these are outlined in section 6.

5.1 Patient and Public Involvement

HWPBCG practices are committed to involving patients and the public in decisions on the provision of healthcare. Patient consultation on the current plan for 2007/08 has been very limited given that this is the first year that has required practices to produce a
commissioning plan in Harrow. As a result commissioning intentions and initiatives have been developed following review of local and national feedback upon services.

Engagement will be planned and reviewed for its effectiveness. To ensure engagement is appropriate and meets the needs of all residents’ methods of involvement will be designed with the target group in mind, rather than having a one size fits all approach. The PBCG will be trialling a number of different routes for engagement. At the very least the methods that will be considered will be: direct access to patients; community interest groups and advisory advocates.

For 2008/09 HWPBCG will;

- Arrange an early meeting with representatives from the PPI Forum and local User Groups to enable use of their expertise to plan for patient and public involvement in informing future plans
- Ensure the commissioning plan, including a feedback form, is freely available in all libraries, clinics and other public places for the information and comments of patients
- Target the local community via each practice waiting room, PCT and practice websites and posters in waiting rooms
- With the PCT arrange a series of public meetings to facilitate feedback on the 2008/09 plan and consult on commissioning plans for 2009/10.
- Develop patient participation groups in each practice. Each Practice is committed to publishing the results of such meetings in order for the public/patients to be fully updated and allow feedback

5.2 Stakeholder input

HWPBCG recognises its responsibilities to engage, not only to patients, but also with its wider stakeholders including: secondary care providers, the local authority and voluntary groups. All stakeholders will receive a copy of the plan for 2008/09 and will be invited to comment and will be consulted on proposals for 2009/10.

The Practices are committed to liaising with relevant stakeholders regularly in order to;

- Invite stakeholders to be involved in any discussion and/or changes relating to ongoing patient care
- To ascertain what impact the plan and/or changes will have on stakeholders as well as ongoing patient care
- To share expertise and information which will assist in the implementation of the plan and ensure continuation of patient care at all levels
- To work with stakeholders to ensure maintaining patient care is focused within the community thus avoiding unnecessary hospital admissions.

5.3 Use of Savings

Savings will be distributed at practice level, and will be used in accordance with the governance agreement. The Consortia accepts that any savings should be used to improve care and services to patients.

5.3.1 Use of savings realised from commissioning budget

Savings identified in line with the PBC Governance Agreement for 2008/09 will be deployed in line with that agreement. The use of any savings will be discussed with the PCT to ensure compliance with the guidance.
6. PBC Commissioning Priorities

6.1 Harrow Medical Consortium

Lead: Dr Kevin Pearce

HMC is a collection of 16 practices with an overall list size of 67,618. The practices are fairly evenly distributed throughout the borough and encompass a wide socioeconomic group. This distribution makes it very difficult to assess “local” needs as the consortium is not geographically concise.

The consortium has currently no plans to develop its estate. As a consortium we have asked all practices at Belmont Health Centre to consider the development of a GP Led Health Centre.

The practices have been active in the year with implementing the childhood obesity strategy, numerous audits for example steroid use to non steroidal us and osteoporosis management and many more. Each practice has carried out a needs assessment with the aim of improving the quality of care for patients. It will be used by practices to determine future development.

PBC Cluster Map
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Current provision</th>
<th>Health outcome</th>
<th>Patient involvement</th>
<th>How does it fit with local/national priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respite Care</strong>&lt;br&gt;Harrow Consortium will:</td>
<td>* map current provision of respite care in Harrow&lt;br&gt;* Identify gaps and carry out a needs assessment&lt;br&gt;* Propose service changes through development of a business case</td>
<td>Improve the quality of life for carers and service users&lt;br&gt;Establish a mechanism for provided emergency care when carers are acutely ill</td>
<td>Practices have identified patients who meet the criteria and propose to get their view by using a questionnaire</td>
<td>The government has identified respite care as a priority in ‘Our Health Our Say’ document</td>
</tr>
<tr>
<td><strong>Palliative Care</strong>&lt;br&gt;A small working party will:</td>
<td><em>map current provision&lt;br&gt;</em> Identify gaps&lt;br&gt;* propose service changes to address gaps through the development of a business case</td>
<td>There is some confusion amongst patients and carers resulting from multiple agencies involved in providing care for the terminally ill patients at home</td>
<td>PACT Group</td>
<td>The aims of the NHS EOL programme are to <em>extend the boundaries of palliative care provision</em> …&lt;br&gt;A key element for the future of EOL within Harrow is to ensure <em>patients receive a comprehensive range of palliative care services</em></td>
</tr>
</tbody>
</table>
| **Back Pain** | Direct access to MRI scanning for lumbar spine and cervical spine following an agreed pathway | Patients with lower back pain or sciatica for more 6 weeks are usually referred for physiotherapy but are not routinely scanned | Improve diagnostic accuracy, patient management and shorten the patient pathway | Individual patients have been consulted and have an expectation of a scan | Better access to diagnostics
Patients should be managed in the community wherever possible |
6.2 Harrow First Group

Lead: Dr Noreen Ryan

Harrow First Group is made up of eight practices spread over a wide geographical area in the west of Harrow. Because of their wide geographical spread practices within the cluster draw their patients from wards across the whole range of deprivation within Harrow.

Practices range in size from just over 5000 patients to in excess of 11,000 patients. In terms of registered patients Harrow First is the largest commissioning group in Harrow, with nearly 69,000 registered patients. Within the cluster there are quite significant differences in the age profile of practices’ registered populations; practices in the south west of the borough having a younger population and those in the north having an older practice population.

PBC Cluster Map
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Current provision</th>
<th>Health outcome</th>
<th>Patient Involvement</th>
<th>How does it fit with local/national priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domiciliary Phlebotomy</strong></td>
<td>District nurses currently do blood tests are home for housebound patients</td>
<td>Improve the care of housebound patients with chronic diseases</td>
<td>Discussed within the patient participation groups with Harrow First Group Cluster</td>
<td>Management of long-term conditions</td>
</tr>
<tr>
<td>Provide domiciliary phlebotomy by using phlebotomists rather than district nursing staff</td>
<td>Currently there is a shortage of district nurses for this cluster</td>
<td></td>
<td></td>
<td>Reduction in health inequalities by improving equity of access to these services</td>
</tr>
<tr>
<td><strong>Podiatry and Retinopathy Service</strong></td>
<td>Currently these services are provided at a limited number of Centres, and feedback from patients indicate that access is difficult</td>
<td>Maintenance of foot health and prevention of complications. Monitoring and early detection of changes preventing complications</td>
<td>Discussed within the patient participation groups with Harrow First Group Cluster</td>
<td>This initiative will improve equity of access to these services</td>
</tr>
<tr>
<td>Review current provision and identify additional sites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Increased Provision of Physiotherapy in the community</strong></td>
<td>Limited direct access at practice/clinic level Patients are referred to and have to attend secondary care</td>
<td>A streamlining of the patient pathway so that waiting times are reduced and the patient experience is improved</td>
<td>Discussed within the patient participation groups with Harrow First Group Cluster</td>
<td>This initiative is in line with local and national priorities to re-locate services into the community to enable hospitals to focus on their main role as providers of specialist complex care</td>
</tr>
<tr>
<td><strong>Community Leg Ulcer Clinic</strong></td>
<td>This is a tissue viability nurse-led nurse, however demand is very high and nurse does not have the capacity to see all patients</td>
<td>Improve healing rates by early intervention Reduce unnecessary hospital attendance Provide community based follow up to support early discharge</td>
<td>Discussed within the patient participation groups with Harrow First Group Cluster</td>
<td>This initiative is in line with local and national priorities to re-locate services into the community to enable hospitals to focus on their main role as providers of specialist complex care</td>
</tr>
</tbody>
</table>
6.3 South Harrow Cluster

Lead: Dr Mike Eddington

South Harrow is a collection of 4 practices with an overall list size of 37,362. The practices are fairly evenly distributed and encompass a wide socioeconomic group. The Cluster has a very varied practice population with a high percentage of the population being refugees, which brings its own challenges.

The practices have been active in the year with implementing an obesity pilot, undertaking numerous audits and are considering supporting an HIV pilot.

PBC Cluster Map
### Table of commissioning priorities

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Current provision</th>
<th>Health outcome</th>
<th>Patient involvement</th>
<th>How does it fit with local/national priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phlebotomy and Glucose Tolerance Testing</strong></td>
<td>Some practices provide this service in-house whilst others send their patients to the Wealdstone Centre</td>
<td>Improve chronic disease management</td>
<td>Patient involvement</td>
<td>Improve the quality of primary care services, health outcomes and reduce variation between practices</td>
</tr>
<tr>
<td><strong>Provide additional community based service</strong></td>
<td>Some practices provide this service in-house whilst others send their patients to the Wealdstone Centre</td>
<td>Improve chronic disease management</td>
<td>Patient involvement</td>
<td>Improve the quality of primary care services, health outcomes and reduce variation between practices</td>
</tr>
<tr>
<td><strong>Increased Provision of Physiotherapy in the community</strong></td>
<td>Patients are referred to and most have to attend secondary care</td>
<td>A streamlining of the patient pathway so that waiting times are reduced and the patient experience is improved</td>
<td>Patient involvement</td>
<td>This initiative is in line with local and national priorities to re-locate services into the community to enable hospitals to focus on their main role as providers of specialist complex care</td>
</tr>
<tr>
<td><strong>Palliative Care</strong></td>
<td>There is some confusion amongst patients and carers resulting from multiple agencies involved in providing care for the terminally ill patients at home</td>
<td>Improve access to services by coordination of care for all palliative care patients</td>
<td>PACT Group Patient feedback</td>
<td>The aims of the NHS EOL programme are to ‘extend the boundaries of palliative care provision’ …</td>
</tr>
<tr>
<td></td>
<td>Promote the use of Gold Standard Framework or standards within GP Practices</td>
<td>Reduce unplanned admissions to hospital</td>
<td></td>
<td>A key element for the future of EOL within Harrow is to ensure ‘they receive a comprehensive range of palliative care services’</td>
</tr>
</tbody>
</table>
6.4 Allied Group

Lead: Dr Laurence Hommel

Allied Practice Based Commissioning Group is an association of 8 practices in the Harrow East area, responsible for organising and providing primary health care for a cumulative patient population of just over 51,000 patients.

All the GPs in the Allied Group have a like-minded approach to general practice, concentrating on the maintenance of good health and preventative medicine.

The Group has been active in the past year in assessing the requirements of the Group’s patient population to enable the 2008/09 commissioning plan to priorities these identified needs. The Group will explore the feasibility of increasing the provision of community based physiotherapy, develop a community obesity strategy which will be made available to the total Group practice population and to analyse our cumulative needs in respect of direct access services.

Cluster Map
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Current provision</th>
<th>Health outcome</th>
<th>Patient involvement</th>
<th>How does it fit with local/national priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>Patients are referred to NWLH for treatment</td>
<td>A streamlining of the patient pathway so that waiting times are reduced and the patient experience is improved</td>
<td>Improved care plan for patients following discharge</td>
<td>This initiative is in line with local and national priorities to re-locate services into the community to enable hospitals to focus on their main role as providers of specialist complex care</td>
</tr>
<tr>
<td><strong>Increase provision of Community based Physiotherapy</strong></td>
<td>Current waiting times is 8-9 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Review use of Direct Access Services</strong> (Pathology and radiology) to ensure only necessary and appropriate tests are ordered</td>
<td>NWLH provides this service on a tariff base system</td>
<td>Patients will have only appropriate tests done</td>
<td>Improve access by managing demand</td>
<td>In line with the London-Wide Commissioning Intentions this initiative will ensure a better specification of the standards to which services must be provided</td>
</tr>
<tr>
<td><strong>Management of Obesity</strong></td>
<td>GPs have access to dieticians and drugs but not to psychotherapists</td>
<td>Prevention and reduction of co-morbidity which is often secondary to obesity</td>
<td></td>
<td>A key priority of ‘Choosing Health’ is tackling obesity.</td>
</tr>
<tr>
<td><strong>Develop services to support the management of obesity in the community</strong></td>
<td>Exercise on prescription</td>
<td></td>
<td></td>
<td>NICE guidelines suggests a multi-disciplinary approach to managing obesity.</td>
</tr>
</tbody>
</table>

Table of commissioning priorities
7. Harrow wide Commissioning Initiatives 2008/09

HWPBCG will co-operate with the wider PCT’s efforts to achieve targets and to implement agreed future (SPA) and existing initiatives (e.g. CAS and UCC).

Any planned initiative to develop new service models by HWPBCG will aim to tackle health inequalities, strengthen community partnerships and deliver National agendas whilst endeavouring to make effective and efficient use of resources.

Proposals for service re-design for the following areas are attached below Initiatives 7.1-7.4)

- Urology
- Ear Nose and Throat
- Gastroenterology
- Reduction in hospital admission for Respiratory diseases

HWPBCG also intend to work with the PCT and other stakeholders to review the following services:

- Brief Intervention and Counselling
- End of Life Care
- HART
- Community Nursing
- Stroke/TIA

These are all areas with long waiting lists, or which have been identified as priorities for service re-design. All these services impact to a greater or lesser degree on the management of long term conditions and unscheduled hospital admission. Integration with other community and secondary care provision, both existing and planned, is essential to achieve patient focused, responsive and cost effective services.

7.1 Initiative 1 – Urology Clinical Assessment Service

**Development of Urology Pathways and Clinical Assessment Service**

The avoidance of unnecessary referrals to secondary care has been identified as a key priority within Harrow. The redesign of Urology Pathways will ensure that patients access the most appropriate service for their presenting condition and, through the development of Primary Care team, will facilitate increased numbers being managed and followed up within community settings.

Our proposal is to develop and redesign Urology Care Pathways that achieve the following:

- Appropriate support to GP practices to better manage urological disorders in
• More cost-effective treatment
• A reduction in waiting times
• An increase in the number of follow-ups managed in Primary Care where appropriate
• Increase in numbers of patients being treated closer to home in community settings
• Appropriate use of secondary care where necessary.
• Improvement of the patient care journey taking into account principles of patient choice.

The following areas are proposed for a CAS-style service:
• Management of Lower Urinary Tract symptoms (LUTs)
• Direct access to transrectal ultrasound scan
• Direct access to day case flexible cystoscopy
• Direct access to urodynamics
• Prostate cancer monitoring and treatment
• Integrated continence service

**Initiative Capital Requirements Description**
Modest expenditure on equipment may be required but services could feasibly be provided in existing practice premises and clinics. Some training for GPSIs / specialist nurse may also be required.

**Description of impact on initiative on quality and outcomes**
Good quality care means getting the right care at the right time from the right professional eliminating unnecessary waits and delays for routine care. Refinement of this service will ensure money is not wasted through inappropriate referral, follow up and secondary care management. Offering services within primary care settings will produce quality outcomes at reduced cost. Implementation of such a care pathway will result in a net freeing up of resources, which can subsequently be used for reinvestment in primary care. Appropriate referrals to the right specialist, with the appropriate diagnostics, will also facilitate achievement of the 18 week target.

**Description of impact of initiative on activity levels**
• Reduced numbers of referrals to secondary care compared on a month by month basis with the previous financial year (2007/08)
• Possible reduction in unnecessary admissions to hospital through better management of patients with Long Term Conditions in Primary Care Settings.
• Many more patients will be managed by their own GP or by a GPwSI in a community setting.
• A re-focus on self-care should have a positive impact on both patient care but also on access to care services.

**Description of initiative on commissioning costs**
See section Seven.

Savings are expected to be made through:
• Decreased numbers referred to secondary care
• Reduction in follow-ups in secondary care
• Increased management of urological conditions within primary care settings
Stakeholder engagement commentary
The PCT with PEC clinical support has already discussed the development of a urology service with Northwick Park Hospital Physicians and managers. The consultants are supportive and have agreed to train and mentor the GPSIs and assist in the development of care pathways.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of engagement from GPs</td>
<td>• Effective launch of the service</td>
</tr>
<tr>
<td></td>
<td>• Use of all CAS services by practices is monitored and remedial action taken</td>
</tr>
<tr>
<td></td>
<td>where necessary</td>
</tr>
<tr>
<td></td>
<td>• PBC consortium to ensure clinical adherence within their groups</td>
</tr>
<tr>
<td>Administrative capacity within the</td>
<td>• Additional staff recruited in year.</td>
</tr>
<tr>
<td>Clinical Assessment Service</td>
<td></td>
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</tbody>
</table>

7.2 Initiative 2 – Ear Nose and Throat (ENT) Referral Management and CAS

Ear Nose and Throat (ENT) Referral Management and CAS
ENT services have been identified as an area of high activity. During the financial year 2006/07 there were 2994 new ENT outpatient attendances for Harrow patients at a cost of £345,994. In addition 4317 follow-up appointments occurred during the year. Unfortunately the figures do not provide a breakdown of the type of conditions being seen and treated. The bulk of these consultations occurred at NWLH, but included referrals to Edgware Community, Royal Free, St Mary’s and Hillingdon Hospitals. Surgical data demonstrates that 334 day case procedures were carried out during the same period.

ENT has become a major specialty and encompasses not only ears, nose and throat, but now includes diseases of the head and neck, facial plastic and skull base surgery.

A large number of ENT consultations result in a surgical outcome, however, there are a number of conditions that could be assessed and managed in a primary care setting, for example, non-specific pharyngitis, epistaxis, rhinitis, otitis externa, eczema of the ear canal and ear toileting.

ENT conditions can be managed in the primary care setting. Often, referral to secondary care results because the diagnosis and treatment of many conditions is limited by lack of appropriate equipment and facilities, and many of these conditions could otherwise be managed by primary care practitioners, with additional training. Only one in seven patients attending for secondary ENT care requires surgical intervention, many others attend for confirmation of diagnosis or for the management of chronic conditions, many of which are then ultimately discharged back to primary care for on-going management.

The PBCG believe ENT is an area where substantial gains in the use of resources can be made by providing primary care led services in the community that will allow for triage of
Nurse practitioners may also provide basic support e.g. for management of wax and patient education on management of chronic rhinitis, snoring using appropriate protocols and pathways.

- CAS - GPwSI led service for intermediate/appropriate ENT conditions
- Audiology - Audiologist led hearing assessment / hearing aid provision
- Ear care clinic - Nurse/PwSI led service providing aural toileting for chronic ear conditions such as wax, otitis externa and stable mastoid cavities

**Development of Care Pathways**

The development of care pathways should achieve the following

- Appropriate support to GP practices to better manage ENT disorders in the primary care setting, and so reduce inappropriate referrals to secondary care
- Appropriate referrals for patients to the right specialist or therapist in accordance with the care pathway

Appropriate care pathways may be developed for the following conditions -

- blocked nose
- allergic/perennial/atrophic rhinitis
- epistaxis
- facial pain
- otitis externa
- ear wax
- deafness
- otorrhoea
- otalgia
- dizziness
- tinnitus

**Initiative capital requirements description**

We do not feel that it is necessary for all ENT services to be held in a hospital setting and it is clear that the development of community based services may incur equipment and premises costs.

- operating microscope
- microsuction apparatus
- flexible nasolaryngoscope
- rigid (Hopkin’s rod) endoscopes
- head lights and source
- digital imaging capture devices
- sound-proofed booth
- PC based audiometer
<table>
<thead>
<tr>
<th>Description of impact of initiative on quality and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience and audit of the current services provided through CAS demonstrates reduced waiting times and improved patient satisfaction and access. Development of and adherence to care pathways has resulted in higher quality referrals across all practices and provided opportunities for GPs to enhance their skills.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of impact of initiative on activity levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>The target reduction for first out patient appointments is 20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of impact of initiative on commissioning cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>See section 7.</td>
</tr>
</tbody>
</table>

Savings are expected to be made through:

- Decreased numbers referred to secondary care
- Reduction in follow-ups in secondary care
- Increased management of ENT within primary care settings
- Patients will have access to a local non-hospital alternative to unnecessary secondary care
- Improved access, with a significant reduction in waiting times
- Waiting times for necessary secondary care should consequently reduce
- Pan-Harrow access to the service
- Reduction in utilisation of secondary care
- More cost effective delivery of comparable quality of care in the primary care setting

<table>
<thead>
<tr>
<th>Stakeholder engagement commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>- HWPBCG will engage with key stakeholders including secondary care physicians in the development of the service.</td>
</tr>
<tr>
<td>- Hospital consultants in ENT / Audiological Medicine</td>
</tr>
<tr>
<td>- General Practitioners</td>
</tr>
<tr>
<td>- Audiologists</td>
</tr>
<tr>
<td>- Commissioning managers</td>
</tr>
<tr>
<td>- Prescribing advisors</td>
</tr>
<tr>
<td>- Public and patient involvement at relevant stages</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiative risk</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td></td>
</tr>
<tr>
<td>Lack of engagement from all GPs</td>
<td>• Effective launch of the service</td>
</tr>
<tr>
<td></td>
<td>• Use of all CAS services by practices is monitored and remedial action taken where necessary</td>
</tr>
<tr>
<td></td>
<td>• PBC consortium to ensure clinical adherence within their groups</td>
</tr>
<tr>
<td>Lack of engagement from all consultants</td>
<td>• Development of an ENT GPSI service was originally discussed about two years ago. Consultants will be invited to support the clinic in mentoring sessions and in the development of pathways</td>
</tr>
<tr>
<td>Administrative capacity within the Clinical Assessment Service</td>
<td>• Additional staff recruited in year.</td>
</tr>
</tbody>
</table>
### Gastroenterology Pathways and CAS

**Gastroenterology**

It is evident that there are many patients being inappropriately referred to Secondary Care for management of conditions which could readily be managed within a community setting; either by a GP or a GPwSI. The aim of this plan is to provide a community based gastroenterology service which would benefit patients, by streamlining the patient journey, and avoid unnecessary delays in diagnosis, and management.

The management of two conditions considered most readily accessible for re-design are:

- Dyspepsia
- Irritable Bowel Syndrome

Both conditions are common primary care problems, but are often poorly managed because of conflicting guidelines and lack of clear management pathways. Other conditions are suitable for primary care management. The follow up of patients with Inflammatory Bowel Disease, (Ulcerative colitis and Crohn's) and Coeliac disease could be carried out by GPwSI, or GP, which would enable the patient to see the same doctor for a chronic lifelong condition.

All patients with rectal bleeding, except those referred under the Two Week Suspected Cancer rule, could be managed by a GPwSI. Patients presenting with GI symptoms could be managed by the GP by following CAS guidelines, and referred to the GPwSI if appropriate.

First steps in service re-design:

- Engage with Secondary Care Clinicians
- Primary and Secondary Care joint working to produce clinical pathways for Dyspepsia, Irritable Bowel Syndrome and those Inflammatory Bowel Diseases considered suitable for Primary Care continuing management.
- Engage Gastroenterology GPwSI’s with mentoring and clinical support
- Develop CAS Referral Protocols and commence GPwSI clinics

New Primary Care Management pathways would need to be designed in conjunction with a specialist Gastroenterology team.

The above would achieve the following:

1. Better education for GP Practices, to enable more appropriate management of GI problems and facilitate improvements in the primary assessment and treatment of patients with Dyspepsia and IBS
2. Reduced number of referrals to secondary care, anticipated to be 15%
3) Reduced numbers of referrals to Endoscopy

4) Reduced follow-up appointments in secondary care, particularly for IBS patients.

5) Better continuity of care for patients with Chronic GI conditions

6) Increase in the numbers of patients being treated closer to home in community settings

7) Reduction in the number of patients held up by the “Two week Referral system” which continues to undervalue patients with considerable morbidity, but who do not fulfill the two week criteria.

8) An overall reduction in the patient journey times as a result of improved care management pathways and referral management, but also taking into account patient choice.

9) Reduced demand on secondary care services thus cutting waiting times to assist in achievement of the 18 week RTT targets

10) Reduction in the DNA rate (currently over 14%)

Initiative Capital requirements description

Nil

Description of impact of initiative on quality and outcomes

Through the use of clear pathways an improvement in the primary assessment and treatment of patients with dyspepsia and irritable bowel syndrome the following should occur;

1) A reduction in the number of inappropriate referrals
2) An overall reduction in the number of referrals
3) A reduction in the number of secondary care follow-ups
4) A reduction in the number of referrals for endoscopy
5) Reduced costs of service in the community, not constrained by the inbuilt costs in secondary care
6) Quality outcomes should be equivalent to those achieved in secondary care, provided that strict clinical governance protocols are followed.
7) Improved patient pathways leading to improved management and reduction in numbers of unnecessary invasive diagnostic tests
8) More appropriate referrals should facilitate achievement of the 18 week target.

Description of impact of initiative on activity levels

1) Reduced numbers of referrals to secondary care (15%)
2) Reduced numbers of referrals for endoscopy (15%)
3) Reduced numbers of follow-up appointments in Secondary Care (20%)
4) Increased number of patients managed by their own GP or by a GPwSI in a
### Description of impact of initiative on commissioning costs

Savings would be made as a result of:

1) Decreased numbers of referrals to secondary care
2) Reduced follow up appointments in secondary care
3) Reduced numbers of referrals for Gastroscopy and Colonoscopy
4) Increased and more appropriate management of Dyspepsia and Irritable Bowel Syndrome in Primary Care.

### Stakeholder engagement commentary

Formal discussion with the appropriate secondary care Physicians has not yet taken place, although those with whom communication has been sought have been supportive. Formal support for the provision of this service would need to be obtained, together with agreement on training, mentoring, and availability for advice.

Patient and Public involvement at practice level would take place together with engagement of local Voluntary and Disease Specific groups to inform changes in service provision.

Regular Audit of GPwSI clinics to take place through the use of Patient and Practice Questionnaires.

### Initiative Risk

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Lack of expertise to provide service in Primary Care.</td>
<td>1) Work closely with Secondary Care Consultant Clinicians to start a training programme for interested GPs.</td>
</tr>
<tr>
<td>2) Lack of support for service from Consultants</td>
<td>2) To engage with all interested secondary care parties to approve and help with the service</td>
</tr>
<tr>
<td>3) Lack of engagement from GP’s</td>
<td>3) All GP practices to use the CAS service, using peer groups and Practice Based Commissioning Forums to monitor referral practices</td>
</tr>
<tr>
<td>4) Extra workload may place a strain on administrative capacity within the CAS service.</td>
<td></td>
</tr>
</tbody>
</table>
7.4 Reduction in hospital admissions for Respiratory Diseases

Reduction in hospital admission for Respiratory diseases

Asthma is one of the most common chronic diseases in the developed world in both adults and children and is a major cause of morbidity and healthcare costs. Within the UK the prevalence has been reported to be 10.9%. 5.2M people in the UK are currently receiving treatment for asthma (Asthma UK).

A study by Williams et al (2006) into the cost per patient annual expenditure of scheduled and unscheduled care showed that unscheduled care accounted for 47% of total costs in infants, 45% in children and 56% in adults. Death rate from acute exacerbations is approximately 1500 per year (UK). The diagnosed prevalence in Harrow is 5.5% (QOF).

COPD is the sixth most common cause of death in the UK, killing more than 30,000 per year. The diagnosed prevalence in Harrow is 0.7% (QOF).

The morbidity and economic costs associated with COPD are high. The impact on quality of life is significant. Since the mid-1990’s emergency admission rates have risen significantly, with at least 10% of all emergency admissions being as a consequence of COPD. This proportion is greater during the winter. The impact on primary care is more significant, with 86% of care being provided by General Practice, with each patient visiting their GP 6-7 times per year.

The QOF data for Harrow PCT (2006-2007), shows the average diagnosed Asthma prevalence per practice population ranges from 3.5 - 8.9%. COPD prevalence ranges from 0.2 – 1.5%. This variation in rates raises questions regarding the initial diagnosis and the presentation of respiratory disease within Harrow.

Current Service

At present management of asthma and COPD is the responsibility of General Practitioners / Practice Nurses. Dr Foster data shows admission rates to be 216 for asthma and 300 for COPD during the period April '06-March '07.

Although a Respiratory Specialist Nurse is in post at NWLH, no equivalent role exists within primary care. It is not within the Respiratory Specialist Nurses remit to provide a follow-up service on discharge. The HART Team at present do have two nurses with specialist COPD training who offer support to patients in their role as admission avoidance specialists. No support is offered to those with asthma.

A pilot scheme, to avoid admission with acute exacerbation of COPD began in early 2008. The two nurses mentioned above have identified a number of surgeries that they will work with to instigate a management plan to identify patients that would benefit from active management and support by their specialist service.

This will be done by:
- Initial identification of vulnerable patients by surgery
- Identification of nurse and GP specialist within surgery to facilitate good communication pathways
- Home visit by nurse specialist to discuss care package
- Allocation of Emergency Drug Package and health promotion re when to commence ED treatments.
• Direct contact with specialist nurses for support and management of condition and symptoms
• Access to all specialists within the HART Intermediate Care team
• Community pharmacist involvement
• Direct link to acute respiratory consultant
• Specialist nursing service link to consultant respiratory physiotherapist

The aim of the pilot is to:
• Provide a more cohesive respiratory service for this group of patients using the specialist skills available
• Reduce exacerbation rate
• Prevent / reduce admission into secondary care
• Improve communication links between specialist services and GPs
• Support carer’s / families
• Provide educational support to HCPs as identified
• Gather data regarding the capacity requirements of this service group

This pilot will be fully audited and reported.

Proposed Service

The audit of the pilot service will provide useful data on which to base the commissioning intentions for 2008/09.

However, there are a number of services that Harrow PCT should work towards commissioning in the next financial year in order to manage the needs of these patients.

A theoretical and practical educational need has already been identified and plans are presently underway to offer training to both GPs and Nurses across the PCT.

Pulmonary Rehabilitation

This is defined as ‘a multidisciplinary programme of care for patients with chronic respiratory impairment that is individually tailored and designed to optimise physical and social performance and autonomy’ the ideal programme should consist of:
• Exercise training
• Education / expert patient programme
• Nutritional advice

and would meet the overall aims of treatment which are:
• Reduction of symptoms
• Improve exercise tolerance
• Improve health related quality of life e.g. earlier introduction of long-term 02 therapy
• Prevent exacerbations
• Provide package of care that meets the patients’ needs
• Provide treatment that minimises the risk of adverse effects
• Reduce mortality
• Prevent disease progression.

This would mean the commissioning of services such as:
• District Nursing
• Physiotherapist
• Occupational therapists
• Dietician
• Social services
and
• Close links with OOH Services, UCC
• Local links with the voluntary sector, Harrow Carers

and the appointment of a Respiratory Specialist Nurse.

Pulmonary rehabilitation can significantly improve quality of life for these patients, although there is conflicting data regarding information on the reduction of hospital admission rates.

**Appointment of Community Respiratory Nurse Specialist**

This role would have responsibilities as outlined in the pilot above, developing the service to meet NICE guidelines and the awaited National Service Framework. They will also offer support to practices / patients in the management of asthma, optimizing control and reducing secondary care referral / admissions. They should also have responsibility for providing on-going educational opportunities to HCPs across HPCT.

**Rapid Assessment Centre**

The development of a rapid assessment centre (UCC) which would involve the full assessment of the patient by the multi-disciplinary team would offer an alternative assessment of the patient by the multi-disciplinary team would offer an alternative place of treatment, as recommended by NICE. This assessment centre might also include those patients who have not yet been admitted, with the aim of determining whether an admission can be avoided if appropriate medical and nursing care could be provided within the community. This service would link with the pulmonary rehab team.

**End of Life Care**

Patients with end stage COPD need structured palliative care. This should ideally be delivered by a multidisciplinary team, working in synchrony. Some cases may need referral to a specialist palliative care team with access to hospice beds.

**Costs**

Initial pilot project: - No additional staffing costs as resource identified from current staffing expenditure.

Small additional cost of patient emergency medication packs to individual surgeries (GPs to prescribe) per patient:

- Standard pack £4.52 (Prednisolone & Augmentin)
- Alternative antibiotic pack £7.94 (Prednisolone & Cefuroxine)

If required the cost of referral to Respiratory Consultant - £214 New Patient
£109 Follow up (if needed)
Training:
No additional expense this year for spirometry training as this has already been sourced. However, on-going updates will be needed (funding from L & D most likely).

Respiratory Nurse Specialist

Cost of full time Community Respiratory Nurse Specialist-

Full time equivalent Band 7 nurse; up to £41,371 basic salary
   Plus Outer London weighting allowance
   Plus add on costs
   **Total**: £52,000

It may be preferable to consider two part time specialist nurses.

Leave and sickness to be supported by HART intermediate Care Team (to be negotiated).

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Initiative capital requirements description

Cost of drug packs. Additional spirometers

Description of impact of initiative on quality and outcomes

**Pilot Project:**
This will identify, in each surgery, practitioners with a specialist interest in COPD. They will liaise directly with expert practitioners to ensure optimum management and treatment for patients with this long term condition.

**Training:**
Asthma and COPD is reported via the QOF data-
The training will ensure that each practice is meeting the QOF targets in a standardised way. The training will offer support for practitioners and ensure that all surgeries meet minimum standard requirements.

**Respiratory Nurse Specialist:**
This post holder will act as a resource for the community and bridge the gap between primary and secondary care.
They will act as the case manager for frequent attendees into hospital/A+E and as a resource for difficult to manage cases and End Of Life Care.

**Pulmonary Rehabilitation:**
This would facilitate the optimisation of care within the community offering a coordinated approach to patient care and rehabilitation.

---

Description of impact of initiative on activity levels

Reduce numbers presenting to A+E
These long term conditions have traditionally been difficult to manage / ensure patient concordance, particularly in asthmatics and has resulted in high presentation rates into the A+E department. There are significant effects on both physical and mental ill health.

Respiratory presentation into A+E and calls to the LAS account for the majority of presentations.

Historically data for respiratory presentations into A&E has not been identifiable. However, from April 2007 this is now possible. 514 Harrow patients presented to Northwick Park A&E Department between April and October 2007.

A coordinated service, delivered via a Respiratory Nurse Specialist / Pulmonary Rehabilitation Team would assist in reducing acute exacerbations and subsequent presentations. This would be estimated as > 30%.

**Reduction in admission costs / bed days**

Analysis of Dr Foster data shows the total cost for Asthma and COPD admissions April ’06 – March ’07 was **£708,000** with an average bed cost of **£336 per day** (2105 bed days).

**Reduce numbers referred on for secondary care**

The coordination of services and location of community rehabilitation would ensure that the treatment being received is by an appropriately trained professional with the most appropriate resources at their disposal. With specialist input early on in the disease process, referral to secondary care may not be necessary.

The GP referral rate to Respiratory Medicine 06/07 was 333 (new attendees), and 632 patients were seen at follow-up appointments at a cost of £128,316.

For the first two quarters of 07/08 total attendances amount to 536, with a cost to date of £71,336. It is envisaged that by introducing the services outlined above, these attendances, particularly follow up attendances, can be reduced.

**Reduce numbers attending at GP surgeries**

It has been estimated that a GP will see these patients between 6-7 times a year. A coordinated service, with direct access to specialist nurse input has been shown to reduce these attendances by at least 50%

**Description of impact on commissioning cost**

Savings made via:

- Improved recognition and management of condition
- Decreased presentation in A+E and GP surgeries
- Reduction in number of admissions
- Reduction in the number of referrals / follow up appointments in secondary care
- Increased management of rehabilitation in primary care
- Reduction in the co morbidity costs of other related conditions
- Involvement of community pharmacists in domiciliary visiting to those identified in the pilot project where there pharmacological needs will be assessed.

For the role of Specialist Nurse to be cost effective there will need to be a saving of 148 bed days, which equates to 7% of the ’06 / ’07 total.

**Stakeholder engagement commentary**

The pilot project has already been agreed and has commenced small scale Respiratory
consultant and physiotherapy engagement has been developed via the pilot project.

### Risk and mitigating actions

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non compliance from Primary Care Teams</td>
<td>Effective communication channels with all members of PHCT</td>
</tr>
<tr>
<td>Non compliance from other members identified as being crucial to a Pulmonary Rehabilitation Service</td>
<td>Effective communication with all stakeholders</td>
</tr>
<tr>
<td>Non appointment to post/team</td>
<td>Offer alternative working arrangements</td>
</tr>
</tbody>
</table>

#### 7.5 Initiative 5 – Review of counselling provision for patients

**Project to Improve counselling provision for patients**

There is a wide range of NHS services to provide mental health support. For less-severe issues, counselling and psychological treatment are currently available through Brief Intervention Counselling service (BICS) and via the Graduate Mental Health Worker (GMHW) scheme managed by Harrow MIND. The main concerns with the current services are:

- Unacceptable delay for patients accessing the service (an audit by BICS in 2006 showed 50 or more days)
- Equity of provision – for BICS, some counsellors are based in practices, others at Central sites across Harrow.
- There are 2.2 wte graduate mental health workers for the whole of Harrow and they currently work in seven practices, running a parallel service with BICS and unclear definition of the two services.
- High rate of non-attendance to appointments (29% according to BICS audit in 2006), particularly to hospital appointments and central site provision.
- Lack of integration between BICS and the GMHW service.
- Increasing demand for service without any uplift in funding.

A new care pathway has been designed for the Primary Healthcare Team to enable appropriate signposting of patients. This should be circulated to all practices, along with referral information for BICS (see attached). The BICS service will deliver the services in a range of ways including group programmes for anxiety and depression. The expectation is that the new pathway will be implemented with effect from 1.1.08, with a view to developing an integrated service by 1.4.08.

The new referral pathway will factor in the existing local provision of culturally sensitive psychological services provided by the voluntary sector.

NICE guidelines recommend use of Computerised Cognitive Behaviour Therapy (CBBT) programmes – this will be considered. There is a concern over the return on investment being limited in terms of clinical outcomes, and BICS therefore intend to review licence arrangements with a view to using appropriate materials within the system.

**Initiative Capital Requirements Description**

- **Description of impact on initiative on quality and outcomes**
  - Revised processes should improve waiting time, DNAs and equity of access, hence the service user experience. This will be monitored through audits and satisfaction surveys.
- **Description of initiative on commissioning costs**
  - It is anticipated that the cost of the new referral pathway will be delivered within existing funding.
funds available.

Stakeholder engagement commentary
A sub group has been formed which is accountable to the LIT and mental health partnership Board of Harrow PCT. These Groups have a wide range of stakeholders across the Harrow community. The BICS review has the agreement in principle from the LIT members.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of clinical engagement from GPS</td>
<td>Develop a programme of ongoing education and training to GPs and primary care staff via cluster leads and GP lead for mental health</td>
</tr>
<tr>
<td>Increased demand on the psychological services beyond capacity</td>
<td>BICS to audit the service improvements on service utilisation and outcomes</td>
</tr>
</tbody>
</table>

| 7.6 Initiative 6 – End of Life Care Review and Reform |

Three/Five year project to Improve End of Life Care

Some significant work has already been undertaken on End of Life Care; see Harrow PCT’s End of Life Care Baseline Review and Harrow PCT’s End of Life Care Interim Strategy (Nov 2006). The following problems have been identified with the provision of service in Harrow:

- Inequity of Service
- Inappropriate admission to acute services at end of life
- Lack of co-ordination of services
- Lack of choice of place of care at end of life
- Lack of effective Case Management

However, it is still felt that not enough is known about current provision. A Commissioner Led End of Life Strategy Group will be required; including input from District Nurses, Macmillan Nurses, Palliative Care Consultant, Patient and Carer Representation and other stakeholders. It is envisaged that this group would take a staged approach to these problems over a number of years:

Year 1

- Address issues of data quality and collection; from Practices, District Nursing, Hospices, and Hospitals etc.
- Practice audits: Place of death and Place of Care in last year of life compared with Patient’s stated preference and satisfaction with care.
- Review of staffing levels and skills mix within secondary services, community care and primary care. e.g. Macmillan Nurses, District Nurses, Marie Curie nurses; disease specialists eg COPD nurses, community matrons
- Consider patients’ preferences for spiritual care
- Raise awareness of information already available in Primary Care e.g. Cancer Information Folder and routine completion of preferred priorities for care form for
patients on the palliative care register.

- Seek out National Best Practice in other areas to inform service redesign.
- Encourage more GP practices to sign up to the Gold Standards Framework for Palliative care. (see attached excel sheet of Palliative Care list)
- Work towards implementing the recommendations of the End of Life Care Interim Strategy

**Year 2**

- Implement measured service redesign informed from Year 1 review.
- Consider withdrawing funds from acute trusts to fund GP practice based multi-disciplinary Case Management with more support from specialist nurses.
- All previous reviews have concluded that most people’s preferred place of care at End of Life is home. Through supporting this, a future End of Life Care plan could achieve savings and better patient care.
- Continue Review process and data collection, this would need continued support from all stakeholders
- Encourage more GP practices to sign up to the Gold Standards Framework for Palliative care

**Year 3 and on-going**

- Build on processes and ideas developed in year 2
- Increase provision at St Luke’s Hospice, Michael Sobell House, and Hospice at home

<table>
<thead>
<tr>
<th>Initiative Capital Requirements Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No capital required</td>
</tr>
<tr>
<td><strong>Description of impact on initiative on quality and outcomes</strong></td>
</tr>
<tr>
<td>More patients will be able to choose and achieve their preferred place of Care at End of Life.</td>
</tr>
<tr>
<td><strong>Description of impact of initiative on activity levels</strong></td>
</tr>
<tr>
<td>Because of the high cost of patient care at the end of life, if each practice in Harrow could prevent 1 patient from each practice being admitted to Hospital for End of Life Care a significant saving could be made on acute activity. If each patient spends on average 3 days in hospital at an average cost of £1600 per day (for critical care) with 38 practices in Harrow this modest target would represent a saving of £182,400 a year in acute admission costs.</td>
</tr>
<tr>
<td>There would need to be increased community resources such as increased hospice at home provision and appropriately trained nurses. As this improved we would expect to see further savings which would fund the community provision.</td>
</tr>
<tr>
<td><strong>Description of initiative on commissioning costs</strong></td>
</tr>
<tr>
<td>It is not known what could be achieved until the review is completed but the figures outlined above give some idea of the savings which could be made.</td>
</tr>
<tr>
<td>It is likely that we would need extra nursing provision – possibly 3-4 WTE</td>
</tr>
</tbody>
</table>
**Stakeholder engagement commentary**

We need primary care representation on the Strategy Group for EOL Care

There may be a place for joint pan-London initiatives

It will be challenging to get patient representation owing to the nature of the problem. We need to seek carer involvement.

**Initiative Risk**

<table>
<thead>
<tr>
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<th>Mitigating Actions</th>
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</thead>
<tbody>
<tr>
<td>Lack of engagement by stakeholders</td>
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<tr>
<td>May be difficult to identify savings</td>
<td>Audit data</td>
</tr>
<tr>
<td>May therefore be difficult to justify increased community nursing provision</td>
<td>Review of Best National Practice</td>
</tr>
</tbody>
</table>

**Initiative 7.7 – HART**

**HART and Intermediate Care**

1. **Problem**

1.1. Intermediate Care services are underdeveloped in Harrow. From April 2008 the Care of the Elderly services will be provided by NWLHT and Rowan Weald will be developed to provide inpatient Intermediate Care beds. These will be available for rehabilitation following Acute Admission, and be directly accessible from A&E and from the community.

1.2. Community IC services are not well developed at present.

1.3. HART is jointly funded by Harrow PCT, Brent PCT and NWLHT. There is a lack of clarity about the relative weight given to its various roles and whether the commissioners are getting appropriate services. It is provided on a Geographical basis in Brent and Harrow, not by GP or PCT coverage.

2. **Background**

2.1. At present HART services comprise:

2.1.1. **Protocol led Early Discharge facilitation.** This is led by NWLHT and is strictly protocol based. It enables early discharge following TKR, THR, Breast surgery, Pacemaker insertion, DVTs and COPD admissions. It is delivered by physios, OTs and nurses who are able to remove stitches, mobilise post-op, maintain vacuum pumps etc. It aims to reduce length of stay and so is an advantage to the NWLHT and indirectly the PCT.

2.1.2. **Prevention of unnecessary admission**

- **Community.** Ideally rapid intervention can prevent admissions and HART can supply support and therapy in the community. Patients may be referred by GPs, District Nurses and Social Services but practically this service is used to a variable extent by Harrow practices.

It is limited by most patients needing a period of rapid investigation to get a clear diagnosis before formulating a community based management plan; this at present requires admission but could be improved by using HART to fully
work up a patient in the community, then arrange a short admission to AAU for hospital based investigations if necessary.

At present HART devote little time to this role and commitment of staff varies from 0 to 3 per day.

- **Work in A&E** The HART team are referred patients in A&E who are thought to be suitable for rapid discharge rather than admission into hospital. Referrals to HART are protocol based and many suitable patients get admitted to CDU (Observation) or MAU if they do not fit the protocols.

- **AAU** has only recently been opened. It is not clear how the HART are being utilised by the medical team but there is clearly a role for admission avoidance and early discharge planning.

2.1.3. **Community Rehabilitation**

Further details are needed to map the present service and understand how it can be integrated into a future Intermediate Care Service.

2.1.4. **Falls Service.**

The full list of HART services are listed in Appendix one.

3. **Solution**

3.1. A new Intermediate Care Service (ICS)

It is suggested that the present joint HART service be disbanded into separate Harrow, Brent and in-hospital services.

In Harrow this would be replaced by an Intermediate Care service that would provide all Out of Hospital Care to Harrow PCT patients\(^1\). The same team would also provide in-reach therapies to the ICT beds at Rowan Weald.

The team would comprise the present HART therapies and work closely with

- **Urgent Treatment Centre**

  As the UTC develops it will be able to take on a role coordinating the delivery of community services for patients presenting at the hospital. This can be linked with a single point of access. Patients seen in the UTC OOH may need community follow-up until the GP team are available and the ICS would provide this.

- **Existing Community teams**

  o District Nursing day and night teams, residential home teams.
  o Specialist Nursing – diabetes, cardiac, continence, MS, etc.
  o Health visitors for the elderly
  o Community Matron – in services to patients at risk of frequent admission and those with complex LTC needs.
  o End of Life Team
  o Continuing Care

- **Social Services**. It would continue to work closely with Harrow Council to provide respite admissions for patients and carers.

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\(^1\) There would have to be well defined arrangements for out of borough patients which could be coordinated with the District Nursing cover.
• Community Pharmacy
• Hospital at home schemes which may be run by NWLHT or the PCT and PBC groups.
• Community dietetics, especially for community PEG feeding problems.

It would need to operate on a 24/7 basis and take any patients reasonably referred by the acute and community services.

3.2. ICS scope
The team would provide
• all existing HART services – see appendix.
  o Facilitate early discharge
  o Admission avoidance
  o Community rehabilitation
  o Falls service
• new services such as COPD nurses who can work with community matrons on patients at high risk of admission, with NPH on early discharge, and support pulmonary rehabilitation for patients with severe COPD.
• therapy led care at Rowan Weald. The medical input would be provided by a separate contract with NWHLT to provide Care of the Elderly consultant input with day to day medical care provided as at present.
• Community equipment (?joint with Harrow council).
• The aim would be to provide an appropriate level of service for 24hrs, seven days a week.
• Access to the service could be direct or via the SAP.

3.3. Single Point of Access. (SPA)
This is not strictly a part of the ICS but would aid the uptake of ICS by providing immediate signposting to the full range of community services including ICS. Those using the SPA could be
• GPs seeking advice on admission avoidance, community rehabilitation, and rapid diagnosis service in the UTC and AAU etc.
• social services
• OOH providers similar to GPs but also requesting follow-up by ICS and other Community teams such as district nursing. At present all these requests are channelled through the GP. There may be other occasions at night and at weekends where the OOH doctor may be able to avoid admission by having access to OOH community ICS and DN; in-reach care to residential and nursing homes being an obvious example.
• LAS – similar to OOH providers.
• Patients and carers etc.
• NWLHT. A&E, the AAU and ward teams will all need to access the full range of community services. There is a risk that breaking up the existing HART team will impair the ability of secondary care to discharge patients rapidly into the
community. The SAP should counterbalance this.

The SPA could provide signposting and coordination to all community resources:
- Advice on admission avoidance
- ICS access
- Transport issues where appropriate.
- All other community teams, especially district nursing, week-days and OOH.
- GP follow-up appointments for patients attending UTC, A&E, OOH and LAS. Ideally the SAP would be able to book appointments directly into GP surgeries using the web-accessed appointments.
- GP registration for patients not registered, either with local practice or the PCT PMS unit.
- Coordinate rapid investigation of patients who may not require admission
- Coordinate admission to Rowan Weald Intermediate Care beds where appropriate.

4. Expectation
The combination of fully developed UCC, ICS and community services with coordination provided by the SPA should reduce admissions and length of stay. It should be part of an out of hospital service that is valued by patients, by practices and the acute trust. Eventually the ICS could be commissioned separately rather than PCT provided.

5. Risks
The main risks are around splitting up the existing integrated team.

5.1. The HART service is jointly funded by NWLHT and the PCTs. It is used effectively by NPH for the early discharge protocols and in some other areas such as early discharge of patients admitted with COPD. It the service is split up there may be difficulty (real or perceived) by the acute team in using the ICS services effectively. Discussion with the acute trust should identify the best way to get a seamless service.

5.2. The present HART team naturally sits in A&E. The new ICS team will have to assert its presence in UTC, A&E and AAU to identify patients where alternatives to hospital admission exist. This may be by protocol but will also be by personal presence on the units.

5.3. Some PbR tariffs may need to be unbundled to support the ICS.

5.4. The clinical governance needs to be clearly defined. At present the HART team work under the umbrella of the NPH and PCT Care of the Elderly teams.

5.5. The ICS and community teams must work to reduce admission, reduce length of stay and maintain beds available at Rowan Weald. The service will not be effective if it is allowed to develop queues and clear commissioning standards will need to be set at the outset.

5.6. There is no training analysis in this proposal. Training and workforce
assessment would clearly need to be undertaken.

5.7. Patient benefit with attention to access and diversity issues will need to be addressed. This could include a simple health impact assessment.

5.8. There is a risk that the ICS and the existing community resources will not work together effectively, e.g. the crosses over between the ICS care the community matron care packages. This will need some clear commissioning of roles.

5.9. Evaluation and monitoring of the service change will also need to be established.

Appendix 1 - HART Core Business

Listed below are many of the care packages that the HART team offer. They respond quickly (can be within 2 hours) and often pass care over to other services after the initial treatments

Provide therapy services for Intermediate Care Beds at Denham Unit including discharge planning

- SUPPORT DISCHARGE CARE PACKAGES
- SHORT TERM SUPERVISION OF MEDICATION
- REHAB SOCIAL CARE PACKAGE
- RAPID RESPONSE CARE PACKAGE
- OCCUPATIONAL THERAPY
- EMERGENCY PROVISION OF MINOR EQUIPMENT
- PREVENTION OF ADMISSION A/E
- PALLIATIVE /CONTINUING CARE PACKAGE
- BRIDGING CARE FOR SOCIAL SERVICES PACKAGE

HART Nursing Care Packages:

- Some Protocol led
- IV ANTIBIOTICS
- PACEMAKER
- ER PROTOCOL
- HYPEREMESIS
- BREAST SURGERY
- COPD
- HEALTH PROMOTION
- ANTI-COAGULATION
- PALLIATIVE CARE
- VACUUM ASSISTED WOUND CLOSURE
- TISSUE VIABILITY
- CONTINENCE MANAGEMENT
- MEDICINES MANAGEMENT
- PAIN MANAGEMENT
- NUTRITIONAL ASSESSMENT
- CASE MANAGEMENT
- LOAN OF EQUIPMENT
- ADMINISTRATION OF MEDICINES
- CANNULATION
REMOVAL OF CANNULAE

**PHYSIOTHERAPY:**
Some protocol led
SPECIALIST TKR PACKAGE
SPECIALIST THR PACKAGE
SPECIALIST STAIR PACKAGE
SPECIALIST PARKINSONS DISEASE PACKAGE
SPECIALIST MOBILITY and WALKING AID PACKAGE

**Falls Service:**
FALLS CARE PACKAGES
FALLS PREVENTION PROGRAMME EXERCISE CLASSES
FALLS CLINIC

<table>
<thead>
<tr>
<th>Initiative Capital Requirements Description</th>
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</thead>
<tbody>
<tr>
<td>None identified at this stage</td>
</tr>
</tbody>
</table>

**Description of impact on initiative on quality and outcomes**
A review of HART and intermediate care services will facilitate:

- The development of a more cohesive and supportive service for patients
- The development of care pathways for unscheduled care
- Reduction in the number of acute admissions where alternatives are available

**Description of impact of initiative on activity levels**
To be evaluated.

**Description of initiative on commissioning costs**
To be evaluated

**Stakeholder engagement commentary**
HWPBCG will engage with key stakeholders including social services, secondary care clinicians and patients in the development of any new or revised service.

**Initiative Risk**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating Actions</th>
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</thead>
<tbody>
<tr>
<td>See section 5 above</td>
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</table>

**Initiative  7.8 – Community Nursing Review and Reform**

Three/Five year project to Improve Community Nursing
The following problems have been identified with the provision of service in Harrow:

- Poor communication between GP Practice, Community Nursing and patients
- Lack of co-ordination of services
- Costly staffing system, which might be helped by review of skill mix
- Lack of effective Case Management

The Community Nursing service has been under review and is in a position to suggest some changes, with earmarked funding, to tackle some of the issues.

**Communication**

- Agree referral pathway

  - All patients to have care plans, within the notes held at their home, and a visiting plan giving day and time of next visit. Care plans to be shared with GP within a week of assessment

  - Named Care Manager for each patient, communicated to GP Practice

  - Increased community nurse involvement in practice by attendance at practice meetings.

  - Monthly rota information to be faxed to practice, for linked district nurse, plus information of cover arrangements for leave or sickness.

  - Ensure referral information is clear, concise and sufficient.

  - Ensure practices have name of linked nurse and contact numbers.

**Service provision**

- Skill mix – review skill mix to ensure cover at all levels is appropriate.

- Pilot changes in one area of the borough to ensure that effective and efficient care is being delivered.

- Improve response to GP requests (acknowledgement of receipt with information on day and time of first visit)

- Reduce delays in visiting patients with robust communication between community nursing team and practices.

- Share assessment information via the Single Assessment tool.

### Initiative Capital Requirements Description

No capital required. There are currently vacancies within the community nursing team. Recruitment strategy and team skill mix will be reviewed to ensure recruitment at appropriate grades.

**Description of impact on initiative on quality and outcomes**

Improvements in communication and appropriate skill mix will improve the overall care of patients with community nurse input.

**Description of impact of initiative on activity levels**

Collaborative care, by the most appropriate person, will improve the service within existing resources. Care Managers will triage requests and allocate them to the most
appropriate person for action – for example, HCA for phlebotomy or routine tasks, where no other input is required. Better planning (for example, routine annual tests), both by GP practices and the nursing team, will avoid multiple visits and has the potential to therefore reduce visits and costs.

**Description of initiative on commissioning costs**

It is not known what could be achieved until the review is completed.

**Stakeholder engagement commentary**

Liaison with Head of Provider Services and Head of Primary Care Nursing is essential to agree an Action Plan and support implementation of changes for the benefit of patients.

**Initiative Risk**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating Actions</th>
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</thead>
<tbody>
<tr>
<td>Lack of engagement by stakeholders</td>
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<td>May be difficult to identify savings</td>
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<tr>
<td>May therefore be difficult to justify increased community nursing provision</td>
<td>Review of Best National Practice</td>
</tr>
</tbody>
</table>

**7.9 Initiative 9 – Review of Stroke Services**

**Stroke Services**

The impact of stroke on individuals, their families, the NHS and social care is hugely significant. Figures published by the National Audit Office show that around 110,000 people suffer a stroke each year at an overall cost to the economy of around £7 billion. Stroke is the third biggest killer in the UK and is the biggest cause of adult disability. Evidence from the Harrow Annual Public Health Report data shows that Harrow has the highest prevalence rate for stroke in North West London. The age-standardised rate of premature (under 75 years) mortality from circulatory disease in Harrow was 78.7 per 100,000 which is in fact lower than the rate for England as a whole which was 90.5 per 100,000. A general decrease in mortality from stroke has been seen in Harrow from 54.5 per 100,000 in 1993 to 42.7 per 100,000 in 2005, resulting in an overall decrease of 21.8%. This was not as big as the decrease that has been seen nationally where rates have reduced by 35.9% from 83.5 per 100,000 in 1993 to 53.5 per 100,000 in 2003.

‘Action on Stroke Services: An Evaluation Toolkit for Providers’2006 recommended four specific improvements in stroke care;
- Increasing acute stroke unit capacity
- Rapid access to TIA services
- Rapid scanning to enable thrombolysis
- Early supported discharge arrangements

The 2007/08 Payment by Results tariff offers the ability to unbundle acute stroke care to make it easier to respond flexibly and appropriately to stroke care.

**Current arrangements**

Currently the service provided within NWL does not meet the outcomes listed above and stroke patients are not always being treated on a specialist stroke unit. Although two-thirds of stroke patients are managed on stroke units at some time during their hospital stay only approximately 10% of patients are likely to be admitted to an acute stroke unit.

However there is a new stroke initiative from NWL to provide a Hub and Spoke model of
A redesign of the Stroke Services available to Harrow patients will ensure that patients receive access to the appropriate service for their presenting condition in the shortest possible time.

This initiative seeks to develop and redesign stroke services, in line with National Policy Developments and NICE Guidelines currently in consultation. The redesigned service will aim to achieve the following outcomes:

- FAST (face, arm, speech test) use by referring GP’s
- London Ambulance Service receive appropriate training to enable them to direct appropriately within the treatment window of 3 hours
- Stroke patients are taken immediately to the nearest hospital providing full stroke service (one that is able to provide CT scans and interventional treatment 24 hours per day, 7 days per week)
- Rapid CT scan and reporting within 3 hours of episode to be made available at Northwick Park Hospital 24 hours a day 7 days a week. Currently patients are transferred to Central Middlesex
- Thrombolysis treatment available 24 hours a day, 7 days a week - currently only available 9 - 5
- TIA/Mini Stroke patients should be assessed within 24 hours to establish severity of their condition, if not at high risk all tests should be completed within 7 days of event
- Follow up should be made one month after event
- If appropriate, carotid intervention should be made within 14 days
- Direct admission to identified Stroke Beds and resources (physio, speech therapy etc)
- Appropriate number of trained medical staff available 24 hours a day
- Involve and improve communication between community resources from the start
- Hold workshops, Expert Patient Programmes, events in shopping centres etc.
- Engage vulnerable members of the population – typically with hypertension/obesity
- Address problems within Primary Care involving Practices, Community Pharmacies

In the spring of 2008/09 new guidance will be published advising on the development and provision of Stroke services. The development of this will influence how commissioners will provide a comprehensive Stroke service for the Harrow community. Therefore although there has been considerable work put into the ideal model commissioners would wish to provide it would be prudent to wait for the publication of this further information.

In the interim period a number of changes could be made to improve the current services offered to Stroke patients:

- Ensuring that target QOF levels are met by all practices
- Health promotion advice is available within all surgeries (training as necessary)
- Greater involvement with social care and the voluntary sector to ensure that patients receive optimum information regard healthy living
- Encouragement and facilitation of patients and their families and carers to be informed and empowered to take control of their care.
- TIA/mini stroke patients to be assessed within 24 hours to establish the severity of their condition. If not at high risk all tests should be completed within 7 days of the event.
- Direct admission to identified Stroke beds and access to resources (physiotherapy, speech therapy)
- Agreement of local pathways with rapid access and transfer of suspected patients into an appropriate service.
- Development of a Stroke care network to ensure dialogue between commissioners and service providers.

**Initiative Capital Requirements Description**

Much of what has been suggested in the interim period will have a minimal impact on additional costs. The unbundling of the Stroke Tariff as services begin to move into the community may facilitate a transfer of revenue.

As the health and well-being of the community is optimised there may be cost savings in the presentation and treatment of certain groups as co-morbidity is reduced.

**Description of impact on initiative on quality and outcomes**

The impact of stroke on individuals and their families is significant, and is the third biggest killer in the UK. The development of primary care prevention has reduced the number of presentations but there is still more that can be done to reduce the pre-disposing factors of stroke. Offering services within primary care will make them more accessible to patients and reduce costs. Care pathways will assist in the assurance of a cohesive, standardised and auditable service for patients.

**Description of impact of initiative on activity levels**

- Reduction in presentation
- Improvement in overall community health
- Reduction in presentation to secondary care
- Provision of optimum stroke management
- Improved access to services

**Description of initiative on commissioning costs**

Open access to the TIA service will ensure appropriate and timely management for patients, reducing stroke incidence.

Full costs of implementing a more responsive, timely and focused acute and rehabilitation service must be set against reduction in dependency and improvement in quality of life.

**Stakeholder engagement commentary**

Commissioners will work with patient representatives and other stakeholders to develop service modernization proposals.

**Initiative Risk**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of engagement from Primary/secondary care</td>
<td>PBC consortia support clinical adherence to pathways</td>
</tr>
<tr>
<td></td>
<td>Facilitate primary/secondary care dialogue e.g. through service redesign groups</td>
</tr>
<tr>
<td>Lack of engagement from patient groups and voluntary sector</td>
<td>Early discussions with PPI Forum, and voluntary groups e.g. Age Concern</td>
</tr>
<tr>
<td>Lack of resources</td>
<td>Full cost /benefit evaluation</td>
</tr>
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### 8. Overall Impact

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<tr>
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<tbody>
<tr>
<td><strong>Support for Existing Schemes</strong></td>
<td></td>
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<tr>
<td>Dermatology CAS</td>
<td>OP-5% reduction on 2007/08 out-turn.</td>
<td>CAS / Acute providers</td>
<td>£11k (Based on NWLH Price)</td>
</tr>
<tr>
<td>Cardiology CAS</td>
<td>OP-Maintenance of 2007/08 out-turn</td>
<td>CAS / Acute providers</td>
<td>£0k</td>
</tr>
<tr>
<td>Ophthalmology CAS</td>
<td>OP-Maintenance of 2007/08 out-turn</td>
<td>CAS / Acute providers</td>
<td>£0k</td>
</tr>
<tr>
<td>Neurology CAS</td>
<td>OP-reduction of 5% against 2007/08 out-turn</td>
<td>CAS/Acute providers</td>
<td>£7k (based on NWLH Price)</td>
</tr>
<tr>
<td>Gynaecology CAS</td>
<td>OP-Reduction of 5% against 2007/08 out-turn</td>
<td>CAS / Acute providers</td>
<td>£24k</td>
</tr>
<tr>
<td>MSK CAS</td>
<td>OP - Reduction of 30% against 2007/08 out-turn</td>
<td>CAS/Acute providers</td>
<td>£133k</td>
</tr>
<tr>
<td>Paediatrics CAS</td>
<td>OP- reduction of 25% against 2007/08 out-turn</td>
<td>CAS/Acute providers</td>
<td>£89k</td>
</tr>
<tr>
<td>Minor surgery CAS</td>
<td>OP- Maintain 2007/08 out-turn</td>
<td>CAS/Acute providers</td>
<td>£0k</td>
</tr>
<tr>
<td>Referral Management</td>
<td>Maintain 2007/08 out-turn (non CAS specialities)</td>
<td>Acute providers</td>
<td>£0k</td>
</tr>
<tr>
<td><strong>New schemes</strong></td>
<td></td>
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</tr>
<tr>
<td>Gastroenterology</td>
<td>OP-reduction of 15% against 2007/08 out-turn</td>
<td>Acute providers</td>
<td>£31k</td>
</tr>
<tr>
<td>Ear Nose &amp; Throat CAS</td>
<td>OP-20% reduction on 2007/08 out-turn</td>
<td>Acute providers</td>
<td>£50</td>
</tr>
<tr>
<td>Urology CAS</td>
<td>OP-20% reduction in 2007/08 out-turn</td>
<td>Acute providers</td>
<td>£47k</td>
</tr>
<tr>
<td>Unscheduled Care A&amp;E Attendance incl. Paediatric A&amp;E</td>
<td>Attendances- reduction of 40% on 2007/08 out-turn</td>
<td>Acute providers (NWLHT)</td>
<td>£1,305k</td>
</tr>
<tr>
<td>Unscheduled Care: Non-elective Admission</td>
<td>Admissions- reduction 10% against 2007/08 out-turn</td>
<td>Acute providers (NWLHT only)</td>
<td>£971k</td>
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</tbody>
</table>
Summary action plan for initiative implementation:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Key Action</th>
<th>Key Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Urology Clinical Assessment Service</td>
<td>• Review baseline data to gauge capacity required</td>
<td>April 08</td>
</tr>
<tr>
<td></td>
<td>• Recruit GPSI / Community based secondary care physician</td>
<td>• Data reviewed</td>
</tr>
<tr>
<td></td>
<td>• Recruitment of Nurse Specialist</td>
<td>• GPwSI / Consultant recruitment commenced</td>
</tr>
<tr>
<td></td>
<td>• Purchase of equipment</td>
<td>• Job specification for Nurse Specialist produced</td>
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<tr>
<td></td>
<td>• Ensure sufficient CAS capacity</td>
<td></td>
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<td></td>
<td>• Develop pathways in line with national and local guidelines</td>
<td>August 08</td>
</tr>
<tr>
<td></td>
<td>• Launch Service at GP Forum</td>
<td>• Recruitment completed</td>
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<tr>
<td></td>
<td></td>
<td>• Pathways agreed</td>
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<tr>
<td></td>
<td></td>
<td>• Equipment purchased</td>
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<td>October 08</td>
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<td></td>
<td>• Service begins</td>
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<td></td>
<td>Ongoing</td>
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<tr>
<td></td>
<td></td>
<td>• Training and development of GPwSI's and Nurse Specialist</td>
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<td></td>
<td>• Monitoring of service uptake and outcomes</td>
</tr>
<tr>
<td>2. Ear Nose and Throat (ENT) Referral Management and CAS</td>
<td>• Review baseline data to gauge capacity required</td>
<td>Dec 08</td>
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<tr>
<td></td>
<td>• Recruit GPSI/Community based secondary care physician</td>
<td>• Data reviewed</td>
</tr>
<tr>
<td></td>
<td>• Ensure sufficient CAS capacity</td>
<td>• GPSI/consultant /PwSI recruitment begun</td>
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<tr>
<td></td>
<td>• Develop pathways in line with national guidelines eg NICE</td>
<td>Jan 08</td>
</tr>
<tr>
<td></td>
<td>• Launch service at</td>
<td>• Clinicians appointed</td>
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<td></td>
<td></td>
<td>• Care pathways agreed</td>
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<td></td>
<td>• Service begins</td>
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<td></td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td>3. Gastroenterology Pathways and CAS</td>
<td>4. Reduction in hospital admissions for Respiratory Disease</td>
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<tr>
<td>Review baseline data to gauge capacity required</td>
<td>Implementation of pilot scheme</td>
<td></td>
</tr>
<tr>
<td>Recruit GPSI/Community based secondary care physician</td>
<td>Training programme devised</td>
<td></td>
</tr>
<tr>
<td>Ensure sufficient CAS capacity</td>
<td>Evaluation of pilot informs service development</td>
<td></td>
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<tr>
<td>Develop pathways in line with national guidelines eg NICE</td>
<td>Recruitment of nurse specialists</td>
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<tr>
<td>Launch service at GP Forum</td>
<td>Evaluation and monitoring of new service</td>
<td></td>
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<tr>
<td>Monitor uptake of service</td>
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</tbody>
</table>

**April 08**
- Data reviewed
- GPSI/consultant /PwSI recruitment begun

**Oct 08**
- Clinicians appointed
- Care pathways agreed
- Service begins

**Ongoing**
- Monitoring of service uptake and outcomes

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<tbody>
<tr>
<td><strong>January 2008</strong></td>
<td><strong>September 2008</strong></td>
</tr>
<tr>
<td>Pilot scheme begins</td>
<td>Roll out of service begins</td>
</tr>
<tr>
<td>Training programme publicised and implemented</td>
<td>Recruitment of specialist nurses</td>
</tr>
<tr>
<td>Pilot scheme evaluated</td>
<td>Review of service to include integration with unscheduled care and community services review</td>
</tr>
</tbody>
</table>
10. Consortia / Practice Clinical and Corporate Governance

10.11 Clinical Governance

Clinical governance will quality assure practice based commissioning for HWG.

10.12 Values and principles

Clinical governance will work through the following principles:-

- The primacy of patient safety
- An ethos of supporting practitioners rather than blame
- The participation of all clinicians in the practices.
- Maximal rather than nominal lay involvement
- Involving all stakeholders such as Hospital Trusts, Harrow Wide Executive and the PCT
- Promoting evidence-based, effective and efficient referral pathways for patients
- An educational approach using the principles of adult learning as the key to improvement
- The identification and management of poor performance
- Be properly resourced
- Looking critically at its own function

10.13 Structure

A clinical governance lead for HWG will be identified and will work through a clinical governance group with a lead clinician for each participating practice with management and administration support. Patients, PCT and other stakeholders will also be represented.

10.14 Processes

Agreed Care Pathways, based on best evidence and / or developed by HWG, will be disseminated. Clinicians will be informed and discussions will take place at practice or commissioning group level to ensure that they are understood and integrated into practice clinical computer systems. Their use will be systematically audited with feedback to the individual practices and clinicians together with the clinicians’ overall use of secondary care. In addition significant events and complaints about referrals will be discussed at both a practice and group level and the learning from them integrated into the referral protocols and systems within HWG. All of these will form part of the data that clinicians will use for their annual appraisal that will inform their professional development plan (PDP). Where an individual clinician or practice's use of secondary care is seen to be
outside the pattern of the norm this will be discussed with the individual to determine the cause and a plan of action determined if appropriate.

The clinical governance group will monitor the effectiveness of these processes and modify them in the light of experiences.

10.15 Outcomes

The clinical governance lead will report regularly to the executive of HWG so that the learning feeds into the commissioning group’s strategy.

### 10.2 Corporate Governance

**10.21 Harrow Wide Practice Based Commissioning Group**

Harrow wide PBC Group has been formed on an informal basis to produce a commissioning plan for 2008/09. However the four consortia are responsible for:

- Monitoring adherence to the principles outlined in this document
- Delivering the plan to agreed timescales
- Proposing remedial action where necessary

Where one or more practice does not comply with the agreed strategy, the PCTs Medical Director may be asked to provide additional support.

**10.22 PBC Governance Agreement**

All practices in HWPBCG are signatories to the Practice Based Commissioning Governance Agreement for 2008/09 with the PCT. The PBC Governance Agreement sets out the roles and responsibilities of the PCT and consortia/practices. Practices endorsing this commissioning plan in section 10 and appendix A are stating their commitment to support the contents of this document and reinforcing their commitment to the provisions in the PBC Governance Agreement.

**10.23 Monitoring**

In line with the PBC Governance Agreement for 2007/08 the monitoring and implementation of this plan will primarily be the responsibility of the Harrow Wide Executive. Within that Agreement the PCT will actively monitor all aspects of this plan, providing regular review and where appropriate requesting remedial action.
11. Signatures

11.1 Consortia Leads

Harrow Wide Practice Based Commissioning Group Plan for 2008/09

The consortia lead signatories below confirm their endorsement of this commissioning plan. (ALL practices must sign appendix A)

Consortium: Date:
Harrow First ………………………………………………..  …………………………….
……………………………………………………..  …………………………….
Harrow Consortium ………………………………………………..  …………………………….
……………………………………………………..  …………………………….
Allied Group ...……………………………………………..  …………………………….
……………………………………………………..  …………………………….
Harrow South ………………………………………………..  …………………………….
……………………………………………………..  …………………………….

12.2 Harrow PCT PBC Governance Committee Chair

Chair: Date:
……………………………………………..  …………………………….
……………………………………………..  …………………………….
Appendix A

Harrow Wide Practice Based Commissioning Group Plan for 2008/09

The practice lead signatories below confirm their commitment to full implementation of this commissioning plan.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Practice</th>
<th>Date</th>
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