Appendix 3

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Harrow Council
Clinical Commissioning Groups	NHS Harrow CCG
Boundary Differences	Same organisational boundaries
Date agreed at Health and Well-Being Board:	19/03/2014
Date submitted:	
Minimum required value of ITF pooled budget: 2014/15	£4,445m
2015/16	£14,373m inc. capital
Total agreed value of pooled budget: 2014/15	£4,445m
2015/16	£14,373m inc. capital

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Harrow CCG	
By	Dr Amol Kelshiker	Rob Larkman
Position	CCG Chair	Accountable Officer
Date		

Signed on behalf of the Council	Harrow Council
By	Paul Najsarek
Position	Interim Head of Paid Service and Corporate Director Community, Health & Wellbeing
Date	

Signed on behalf of the Health and Wellbeing Board	Harrow Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Susan Hall
Date	

Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

To date a service provider stakeholder engagement event took place on the 10th December 2013. The detailed write up of the service provider stakeholder engagement can be found in the related documentation section. The following organisations attended:

- North West London Hospital Trust
- Central and North West London Mental Health Trust
- Ealing Integrated Care Organisation
- Harrow Integrated Care Pilot
- Harrow Healthwatch
- Harrow Mencap
- Harrow Age UK
- Harrow Public Health
- Harrow Council
- NHS Harrow CCG

The aim of the engagement event was to:

- Develop a common understanding of the BCF with Harrow's key stakeholders
- Jointly form a vision of the 2 year plan with Harrow's key stakeholders
- Understand from Harrow's key stakeholders the opportunities in how to locally achieve the national plan conditions

c) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Harrow Council and Harrow CCG regularly engage with and seek views from local residents, service users and carers to test out potential ideas for service redesign, scope alternative plans where proposed ideas do not meet the requirements of engagement groups. This engagement aims to support continous improvement to service quality and safety, and inform the development of annual commissioning intentions (do we? CCG colleagues – can you evidence this? As discussed in officer group one of your areas of weakness is around patient engagement and co-production so we should be clear about how we can evidence this). In developing the BCF plans, both organisations have used this approach to inform the strategic direction.

On Monday 27th January 2014 Harrow Council held a Health and Social Care Integration Summit. The conference was attended by over 80 people representing users, carers and voluntary sector together with NHS and social care staff.

The purpose of the summit was:

- To inform stakeholders about current developments in Health and Social Care

joint working.
- To give stakeholders an opportunity to feed into the Health and Social Care Integration plan.
- To provide stakeholders with an opportunity to learn about and discuss key health and wellbeing projects and contribute to this work.

The summit included:

- A market place for stakeholders to visit the health information provided by our partners.
- Presentations from the Leader of the council, Head of Paid Service, Portfolio Holder for Public Health and Chair of the Clinical Commissioning Group.
- A workshop session led by facilitators on the Health and Social Care Integration Plans and questions on joint assessment and 7 day working.

There was some very constructive feedback from people who came along, which will go a long way towards helping us to shape our services in the future.

Both Harrow Council and harrow CCG are working together to improve communications between our organisations to share service developments to understand the impacts which in turn are used used to inform communications to patients, service users and Harrow residents .

d) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
BCF - write up of service provider stakeholder engagement event 10 December 2013	Stakeholder engagement event write up  Stakeholder Event Dec 2013
HSCI - write up of service provider stakeholder engagement event 27 January 2014	HSCI service user and public event write up  HSCI Stakeholder Event Jan 2014.doc
Harrow Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment (JSNA) is the means by which Harrow and its partners will describe the current and future health, care and wellbeing needs of our population and the strategic direction of service delivery to meet those needs.
Harrow Joint Health & Wellbeing Strategy	The Joint Health and Wellbeing strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out for the period 2013 to 2016

Harrow CCG Out of Hospital Strategy	The Harrow CCG Out of Hospital strategy sets out local priorities for improving access; experience of care; and the provision of care closer to home for Harrow residents and service users. The BCF and development of Harrow CCG Out of Hospital Hubs are aligned to the care of frail older people.How?
Harrow CCG 3 year Recovery and Finance plan (2014/15 – 2016/17)	CCG Governing Body agreed priority areas to provide a sustainable health care system over the 3 year period, outlining the financial plan and joint working opportunities with partner commissioning organisations (Harrow Council) and local service providers. This focused on working as a whole system to reduce growth into highest risk needs from lower and medium risk groups through an integrated system of early detection and support. The transfer of CCG funding into the BCF has created pressure of £3m across the health & social care economy. In order to agree the BCF plan a number of efficiencies, led by the CCG but supported by the Council are proposed to deliver full year savings by 1st April 2015. A 50/50 benefits and risk share has been agreed in the event that benefits are delivered in 14/15 and that the full year savings cannot be delivered by 1st April 2015.
Harrow WSIC Early Adopter Bid	Provisionally there is a Harrow wide high level plan to support the delivery of whole systems integrated care through the transformation of out of hospital provision through the networking of Harrow primary care services with health and social care providers to support the top 25% of patients classed as vulnerable and at risk of increased hospital attendances and admissions. Currently social care are working through the detail of this to better understand the potential impacts.

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

North West London's Whole System Integrated Care (WSIC) aim is to improve the **quality of health and social care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community. Harrow mirrors this aim to support the delivery of the Better Care Fund (BCF).

Harrow is a committed partner of WSIC and this Better Care Fund Plan provides one of the components to move towards our overall aim.

- Better co-ordination around the individual
- Better sharing of information across teams to reduce delays for the individual
- Improved experience of care
- Improved outcomes, reducing reliance of intensive services and maximise independence

Harrow is not starting from a baseline of zero activity related to integrated care and joint pathways between health and social care. Our existing schemes supporting the integration agenda are:

- Participant in the Shaping a Healthier Future programme
- Participant in the NWL Whole Systems Integrated Care development through an early adopter application
- Integrated Care Pilot
- Nursing homes support scheme
- STARRS Intermediate Care Service
- Social care reablement and reablement plus services (underpinning the In Case of Emergency (ICE) project)
- Health and Social care Hospital Discharge teams
- Expansion of community bed capacity to support a reduction in delayed transfers of care
- Primary care development of Peer Grouping to support the development of local

pathways to support out of hospital shifts

- Development of In case of Emergency vulnerable adults programme
- 2013/14 Winter Warmer project (targetted communications to reduce A&E admissions over peak period)
- Implementation of Co-ordinate My Care end of life care plan
- Upgrading of GP IT systems to support safe information governance friendly systems to align practices to GP Networks and sharing of activity as part of the out of hospital strategy

These existing schemes have been commissioned to provide positive outcomes for local residents and services users, whilst supporting the delivery of Harrow's key strategies (e.g. JSNA, commissioning intentions and finance/recovery plans. Our vision aligns to our local population needs analysis and joint strategic needs analysis, which in turn is reflected in Harrow's Health and Wellbeing Board Strategy.

The development of our local Harrow plan is based on a stepped approach model. By this we mean that we will phase the implementation of this plan across a number of years. Initially this plan will look to detail the following phases:

- **Phase 1 (2014/15)** – developing a year of pilots (including exploring the use of the West London procurement frameworks to support the financial pressure on the CCG across the health & social care economy to deliver the BCF within the minimum financial envelope, embedding existing services in line with commissioning plans for 2014/15 and scoping further joint health and social care service improvement initiatives which will develop financial mechanisms to incentivise desired outcomes including benefit and risk sharing.
- **Phase 2 (2015/16)** – further alignment of services to benefit the service user, improve pathways, enhance 7 day working and review the progress of role of Health & Social Care Co-ordinators established within year one as part of the ICP programme
- **Phase 3 (2015/16 – 16/17)** – reviewing the opportunity to move towards a whole person approach (including how the total budget allocated for an individual's care can be used to greater effect across the health & social care economy)
- **Phase 4 (2016/17)** – system wide evaluation and sustainability review

The jointly agreed overarching agreed principles for this plan are :

- Development of genuine partnership across all organisations including a commitment to quarterly reviews of progress/delivery of BCF outcomes and realigning plans in line with agreed market shaping / development strategies and in dialogue with providers. This will include a look ahead to 2015/16 to support the early development of on-going plans and manage developing risks/issues

- Joint transfer of learning and commissioning pathways across organisations to support commissioning alignment and potential efficiencies i.e., shared procurement processes across the established social care West London Alliance and to explore the use of social care's My Community e-Purse across health pathways

- The plan needs to reference the current challenging financial position of both organisations and seek to identify any financial pressures which may arise as a result and jointly consider how these can be addressed.

- To alleviate the financial pressures within the health & social care economy, it has been necessary to agree an efficiency programme which reduces expenditure within CCG budgets and enable the BCF to be contained within the financial envelope and mean that Harrow CCG can deliver its financial targets

- Local agreement has been reached on a ***Benefits and Risk Share [50:50] and*** attaches a number of conditions, which will be reflected in a legal agreement between the CCG and the Council. If these conditions are not met the BCF will no longer be agreed and will need to be escalated to NHSE
    - That all historic matters which the CCG has referred to as being open to it to pursue through litigation, such as the existing s47 disputed cases, are no longer pursued by the CCG. This will not include matters which arise after the date of the BCF agreement
    - That the 50:50 split applies to the BCF funding only and does not create a precedent for any other joint ventures or arrangements
    - That the ICE arrangement funding is limited to a one-off saving in 2015/16
    - That the CCG must dedicate appropriate resources and take a proactive lead to realise the identified savings and that both the CCG and the Council must take all reasonably practicable and commercially reasonably steps to realise any savings that either of them enables the other party to make under the arrangements.
    - That any savings delivered in 2014/15 (ahead of the requirement for full year effect savings to be delivered in 2015/16) will be split on a 50:50 basis in line with the agreement

- Focus on adult population initially (including Continuing Care, Mental Health and Learning Disability services), recognising that once established the programme

can consider development to cover paediatrics pathways.

- Focus on the high risk health and social care populations, whilst maintaining a degree of support towards lower level needs to ensure the sustainability across the wider health and social care economy. The cohort definition will be informed by the Whole Systems Integrated Care Populations Outcomes Workstream. This will build on the existing populations targeted through current schemes i.e. Integrated Care Pilot and social care vulnerable client lists

- The funding will initially support existing services which in time may be redesigned in response to wider integration plans and projects funded by the transformation element within the BCF.

- Across the local health and social care economy significant improvement in performance has already been made with the resulting financial benefits taken to support existing health and social care pressures. As a result, national (and any locally defined) performance metrics will be set based on the current performance of the local health and social care economy to support sustaining the economy over the longer term.

  Throughout both of these years, Harrow will continue to develop the wider plan as part of the North West London WSIC programme as developments occur and Pioneer pilot site schemes are implemented, evaluated and outcomes shared.

What changes will have been delivered in the pattern and configuration of services over the next five years?

The model of care Harrow will move to delivering will provide the following changes

- Aligned health and social care systems to support the proactive management of vulnerable adults as existing commissioned services are expanded and service models evolve (e.g. ICP, STARRS and ICE programmes)

- Where required services will move to a 7 day provision to support patient flow from acute settings to community services and maintain positive outcomes of care so patient recovery times are not impacted through reduced service provision at weekends

- Through the development of GP networks we will encompass services to support primary care in managing demand without the need for acute intervention. This will be achieved by aligning a new model of integrated district nursing to map to emerging GP networks / Peer Groups, use of Peer Group based health and social care co-ordinators and consultants in the community to support the delivery of MDT developed care plans

- Services will focus on the patient rather that the constraints of the service provider. The model of care will move to a care co-ordinated approach with services where clinically safe are provider in community settings that are accessible to patients/service users and have co-located supporting services on site to reduce delays in continuity of care

- We will develop joint pathways across health and social care to reduce delays and the need for reassessments

- We will align information sharing of patient records across health and social care services through the development of an integrated IT system. This will be achieved by upgrading GP practices to web based programmes, implementing within acute and community providers the capacity to transfer information to GP systems and developing social care systems to include the NHS number as the lead identifier to support the linking of care plans

- An outcomes based approach that supports the wider personalisation agenda, which will link GP's care plans with social care outcomes, supported by a joined up assessment and case management to support Harrow residents

- Improve outcomes by reducing premature mortality and reducing morbidity

What difference will this make to patient and service outcomes?

The difference our Better care Fund will provide for the Harrow residents and service users: Residents will be able to say:

- All of my treatment/support plans are accessible to all who require to see it

- Through better aligned services I was able to take control of my own health and social care provision

- It doesn't matter what day of the week it is – as I get the support appropriate to my health and social care needs

- Social care and health services help me to be proactive. Services supporting me anticipate my needs before I do and help me to prevent things getting too so bad I don't need to go to hospital unnecessarily

- If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay

- I only have to tell my story once and they pass my details on to others with an appropriate role in my care

- Systems are sustainable and what might once have been spent on hospital care for me is now spent to support me at home in my community

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

What are the aims and objectives of your integrated system?
Harrow is a committed partner of WSIC and this Better Care Fund Plan provides one of the components to move towards our overall aim.
The Harrow BCF is will achieve this aim through:

- Better co-ordination around the individual
- Better sharing of information across teams to reduce delays for the individual
- Improved experience of care
- Improved outcomes, reducing reliance of intensive services and maximise independence

We have agreed the following aims and objectives:

- Care is coordinated around the service user, his or her social network and duplication of services are avoided

-Care is seen as proactive rather that reactive based on a whole systems and MDT approach

-The service user is empowered to manage their own care and when required have the knowledge of who their key care co-ordinator is and how to contact them

-The experience of health and social care is seen as seamless

-Care plans are individually tailored

-Care plans are shared across service boundaries with seamless information governance arrangements

-Key services are accessible 7 days a week

-We aim to reduce health inequalities for Harrow

Measuring success – including appropriate health gain

These are set out in detail in the BCF application template excel sheet. The principal measures of success will be to maintain all current performance as benchmarked at the end of 13/14

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Interventions under the Better Care Fund

The short descriptions below set out the schemes we plan over the first two years of the Better Care Fund. However it is expected that these services will continue post year two of the Better Care Fund. The success and impact of each element will be monitored through the quarterly reviews.

Details of key schemes / changes and how we aim to implement them

The section above provided an overview of the schemes and changes within the health and care system. In this section we will provide details of key schemes and how we plan to implement them across health, social care and the wider system.

Scheme one: Maintaining Social Care Eligibility Criteria:

Through the continuation of funding as part of the NHS Funding Section 256 Transfer, this will support Harrow Council maintaining the current social care eligibility criteria, alongside the additional funding made by the council for new placements in response to the ageing population and increasing pressures of young people with complex needs coming through transition.

Protecting social care services within Harrow Council means that those identified as being in need of social care support continue to receive the care they require.

The proposals within this plan protect adult social care services through managing the demographic pressures, which may otherwise result in a change to the Fair Access to Care eligibility criteria threshold

As part of the quarterly review system discussions will continue to provide measures to enable discussion and consideration on how the condition of maintaining social care services can be achieved.

Scheme two: Maintaining Discharge Performance

We have identified opportunities to maintain and more to an enhanced system for acute discharges. This will be achieved in the following ways across the health & social care economy:

- a dedicated intermediate care social worker to work with community intermediate care bedded units (Denham, Cedar & short-term winter beds)
- an additional Social Worker in the social care Continuing Care Team. This would enable faster joint assessments and reduce delays for clients with complex needs (fixed term post)
- an additional acute based social care discharge coordinator based at NWLHT
- an enhanced reablement & assessment service with the ability for direct referral from primary care. This will support the maintenance of discharges patients remaining in the community
- agree a discharge protocol and process that starts on the day of admission of an older person to hospital
- Draw up appropriate risk protocols shared between hospital clinicians, community clinicians and social care with proactive case finding within the wards
- Ensure that services in the community facilitate discharge out of hospital in a safe and effective way

Scheme three: STARRS intermediate care service

Harrow currently commissions an intermediate care service provided by NWLHT. This service provides admission avoidance, early supported discharge, community domiciliary physical and neurological rehabilitation and an overarching single point of access. This service will be scaled up across the initial two years of the Better Care Fund to deliver the following benefits:

- Baseline service (2013/14) capacity to avoid 1700 non elective admissions and 1000 A&E attendances
- 2014/15 capacity enhancement to avoid 3315 non elective admissions and 1837 A&E attendances
- 2015/16 capacity enhancement to avoid 3839 non elective admissions and 2127 A&E attendances to support demographic growth
  CCG to describe benefits

As part of the development of the intermediate care pathway the STARRS model will develop further by:

- Embedding seven day working across all the contributors to STARRS
- Enhancing the use of the third sector in supporting residents to be transported back home and in providing support for the few hours until mainstream services commence.
- Further aligning the service with the liaison psychiatry support services currently operating within NWLHT (provided by CNWL)
- Further alignment to London ambulance service pathways to provide direct referral via the community avoiding the need for unnecessary acute attendance and

ambulance conveyances

- Further alignment to Urgent Care Centre pathways avoiding the need for A&E attendances, pressurising A&E
- Where patients do attend A&E a revised pathway will be implemented to manage their flow through A&E to e Enhancing the use of the third sector in supporting residents to be transported back home and in providing support for the few hours until mainstream services commence.

- ensure that joint assessments are completed with the A&E clinician to maintain the A&E 4 hour target
- Further aligning pathways to support rapid access to social care where required i.e. restarting packages or assessing for new packages of care

Scheme four: Reablement

The Harrow Council reablement service provides planned, short term, intensive help. The service is designed to help a person:

- restore their independence
- do as much as they can for themselves, rather than someone doing things for them.

Reablement workers spend anything between one and six weeks supporting each individual to re-learn lost skills following:

- a period of illness
- disability
- a time when a person may have lost some confidence.
- returning home after spending some time in hospital
- have a physical disability
- feeling frail and need support to remain in your own home
- want to regain skills and confidence to live independently

By adding this service to the Better Care Fund this will support the condition of maintaining social care eligibility criteria in addition to supporting demand management schemes to reduce acute flow and supporting acute discharges in a timely fashion to support the management of delayed transfers of care. All of these elements for part of protecting social care services.

Scheme five: carers services [need to distinguish between this and that via social care reform adequately]

The carers service is a jointly commissioned set of pathways supporting carers to manage in the community. Through the Better Care Fund we aim to prevent the breakdown of carer support networks for services users and patients to increase the

impact of self-management in the community. Overall we intend for this to be part of the emerging GP Networks and community hub development as part of Harrow's out of hospital strategy. The impact of this will be a reduced requirement for unplanned respite and hospital admissions.

We will aim to support to carers and caring families including the provision of respite care, with an absolute focus on optimising the independence of the person and development of self-care plans in collaboration with service users and carers

Scheme six: Intermediate Care

Our Better care Fund will develop intermediate care services wider than the STARRS and Reablement programmes. We will include into the Better Care Fund the following budget lines:

- Health Intermediate Care Spot Placements
- Health Intermediate Care Elderly Mentally Ill Community Rehabilitation Beds
- Social Care Hospital Discharge Team
- Social Care Intermediate Care Bridging Care Fund

The use of these budgets jointly will support the rapid flow of patients when medically fit for acute discharge into appropriate community settings. We have highlighted the need to further develop community physical rehab beds to increase the throughput of activity by addressing skill mix shortages. This will be achieved by uplifting community budgets to allow providers to recruit substantively to additional therapy posts. The expected benefit will be an increase from 30 admissions per week to 40 admissions per week onto community physical rehabilitation beds.

The use of Social Care Intermediate Care Bridging Care Funds will support the management of patients in the community that are medically fit for acute discharge but where packages of social care are delayed due to care providers capacity to respond where demand is high. This will be integrated into the STARRS services to support seamless services as the STARRS service provides early supported discharge for Harrow residents.

The use of a ring-fenced intermediate care spot budget will support the ability for commissioners to proactively purchase additional bedded resources at times of increased capacity which will have a positive impact on acute services and support the management of acute activity. This will integrate with the existing STARRS service by utilising the community rehabilitation element to provide additional therapy within bedded locations if required to further support patient recovery times. These services will be operational 7 days a week.

Scheme seven: Social Care Reform

The costs of social care reform relating to carer issues such as putting carers on a par with users for assessment; implementing statutory Safeguarding Adults Boards; and setting national eligibility will be funded from the BCF in line with Government expectations. In Harrow this could see a significant increase in the support provided to carers from the existing 2,400 to in the region of 24,000. Costs associated with early assessment & reviews, transition to the capped model and deferred payments are

assumed at this stage to be funded by the new burdens grant. This level of funding will need to be reviewed as the position becomes more clear following legislative changes as this progresses through parliament

Scheme eight: Integrated Care Pilot / transformation initiatives

We will build on the existing ICP programme in Harrow. We will invest further to maximise the delivery potential across a number of ways, in particular those which enable a shift in resources from acute provision to community based services to ensure that the national condition of protecting social care services can be achieved.

Risk stratification: We have developed and implemented a risk stratification tool that identifies people with complex health issues and those who are at risk of their condition deteriorating or being admitted to hospital. We know that for older people social risks play a crucial role in defining the outcomes.

As part of a natural progression towards an integrated system, we will:

- Enhance the risk profiling to include social care determinants and factors. This will allow us to identify not just people with health risks but also those with social predictive factors; for example, where changes in social factors such as care requirement, status of partner, social isolation make a difference to outcomes for our population.

- We will also increase the reach of the risk stratification tool to identify people in the lower segments of the risk pyramid (medium risk) i.e. people who are at risk of their health and/or social care needs becoming more complex. This will allow us to proactively manage them much earlier in a fashion that allows them to retain their independence and improve their overall health and wellbeing.

As part of implementation, we will develop joint health/care assessment approach and incorporate it in the risk stratification tool. In order to do that, we are exploring ways of incorporating key datasets within a common database.

Development of robust, shared, MDT led and care plans. We successfully implemented robust care plans for a proportion of identified patients with diabetes and frail elderly people with complex needs as identified through risk stratification and other means. The care plans are developed by a multidisciplinary group (MDG) of health and care professionals and signed-off by the service user or patient.

We will extend this further to: scale it to all people with complex health and care needs; and include people with medium risk who will benefit from care planning and introduction of self-care pathways.

Key aspects of this scheme are:

- The care plans will be delivered around the MDGs at the level of (or aligned to) emerging GP networks

- The plans will be personalised and centred around the person and agreed with the

service user

- They will be developed by integrated and virtual provider networks representing health, social care and third sector.
- An absolute focus on optimising the independence of the person and development of self-care plans in collaboration with service users and carers
- Shared accountability and governance
- Involvement of the third sector especially in provision of health trainers (lifestyle coach or behaviour change agents) to support people, one to one or in groups
- Sharing and the active management of care plans are crucial enablers. We will explore the use of a shared record system can be part of the solution.

Employment of 6 care co-ordinators and community consultants. This will provide the ability for care plans to be followed up and patients/carers proactively managed in a planned way to avoid the risk of exacerbations of their conditions or existing care plans falling apart. The consultant will act as a senior support role leading the MDT, providing clinical guidance to the GP as the accountable medical officer and manage virtual wards in the community. These roles will integrated with the STARRS service to reduce the risk of patients requiring short term acute intervention that could be managed in the community. This enhanced team will liaise with acute providers to further integrate the ICP model of care across acute and community setting

Scheme nine: Whole System Integrated Care Initiatives

A main component of Harrow's Better Care Fund will be the development of the WSIC programme which will act as the overarching system to support better care for service users. This system will incorporate all of the schemes highlighted as part of this document through either alignment of existing services, direct provision or providing system enablers to support an integrated health and social care system and will enable a shift in resources from acute provision to community based services to ensure that the national condition of protecting social care services can be achieved.

The system will have many components. These are described as:

- **Primary Care Networks** – we will develop a single Harrow wide primary care led provider model. This will focus on the top 20% population (high risk population) which will require collaboration and a governance relationship between acute, mental health, community including the voluntary sector and social care settings. We intend to build and expand on those developed through the ICP programme. Consideration to the use of existing models of MDGs and IMGs is underway which will look to integrate with the existing ICP case management programme and support the 7 day working agenda. This will align to existing key services such as Intermediate Care (HARROW STARRS), UCC, Walk in Centers, social care reablement, existing ICP pathways

- **Out of Hospital Hub development** – Harrow plans to implement its out of

hospital strategy by making better use of existing hubs in the west of the borough and developing an additional hub in the east of the borough. This will support the shift of planned activity into the community resulting in services provided closer to the patient and provide more timely access to referrers.

- **Integrated District Nursing** – as part of the GP Network development, harrow will jointly redesign within 2014/15 the district nursing services with the existing service provider. This will realign existing core services to GP networks whilst ensuring that efficient services are achieved. Harrow intends to review the existing investments within core district nursing services and expand where required. The intention is to ensure that core and specialist nursing is aligned to primary care and has the capacity to be responsive over a 7 day 24 hour service

- **Integrated Unscheduled Care services and out of hours primary care** – our intention is to review existing elements of the service and align to GP Networks and community consultant support to allow the rapid assessment of ambulatory care high risk patient who would usually result in an acute admission if services in the community were not available. Early options are developing regarding a Primary Care led front end to A&E which is integrated to the existing UCC, but provides a more integrated services with core primary care by having the ability to redirect effectively

- **Integrated End of Life services** – We will realign and better integrate the services we provide to people towards the end of their life. Our processes will be more seamless and enable health and social care staff alongside the third sector to provide support to patients and their families and carers around end of life care.

- **Integrated IT services** – This is an important aspect of the delivery of integrated care for Harrow.

  We also aim to enhance the interoperability of IT systems across health and social care organisations. As part of information sharing and governance (as part of the ICP), Hillingdon is working towards the creation of a single client centred identifier and shared information across different providers. Further work is required to ensure that care plans are accessible to social care and other parts of the system

- **7 day services** – we will build on the existing early adopter initiative established. NWLHT have completed a staff consultation with their therapies departments and have implemented 7 day therapies, which aligns to their medical and nursing rota. This aligns to the existing seven day services within intermediate care, district nursing and UCC based at Northwick Park Hospital.

  We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Harrow system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

  In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide a holistic service seven days a week.

- **Telehealth pilot** – we will continue the development of telehealth pathways with the use of private provides aligned to our existing pathways i.e. STARRS. For 2014/15 we will expand the remit of the telehealth service to also include heart failure in addition to the existing COPD pathway. This will increase the impact of the services for patients at risk of exacerbations of these two clinical conditions.

Scheme ten: Access to LA Efficiency Resource

Detailed below are the schemes which have been identified to enable efficiencies of £3m to be realised across wider CCG budgets which in turn enable schemes to be funded within the BCF financial envelope and mean that Harrow CCG can deliver its financial targets.

- **In-case of Emergency programme** – we will look to continue the implementation of this social care led service which proactively manages blocks of 25 high risk vulnerable patients at a time and supports them to remain independent in the community, thereby avoiding hospital admissions. This is established (and funded by) in parallel with the ICP programme and further development towards the streamlining of these two services will be developed within 2014/15 for further impact in 2015/16. A cohort of 25 service users has evidenced savings of £250k during 2013/14 for the CCG. This evidence would suggest that it is possible to scale up and to potentially deliver savings of up to £1m in 2015/16 as a one off basis, funded by ICP. This would result in a programme of 4 cohorts of 25 service users.

- **West London Alliance Framework** – health will learn from the established social care commissioning and brokerage systems used to purchase home care and bedded service provision across a range of services. The intention will be to create efficiencies within existing heath expenditure across continuing care, mental health, dementia, learning disabilities budgets. Any efficiencies above the £3m in 2015/16 and savings delivered in 2014/15 will be shared in accordance with the *Benefits and Risk Share Agreement* (see principles of Harrow Better Care Fund). Consideration may be given to directing such benefits to further protecting social care services.

- Integrated Care Pilot [ICP] – it is considered reasonable to expect benefits in the region of £500k in 2015/16 in relation to wider integration schemes

Scheme eleven: Capital Funding

There is an intention to utilise the capital funding allocation to support the following developments:

- Adapting IT systems to accommodate use of NHS number as unique identifier and interact with health IT systems
- Providing the relevant adaptations to homes to reduce the need for specialist placements and enable residents to be cared for in their own homes. This will be

managed through the disabled facility grant process

- We will develop initiatives with the West London Alliance support the development of additional bedded capacity across London by investing in the development of new estates programmes and provide access to preferential facilities rates for service providers
- Additional grants will be applied for in year which will support health to upgrade primary care IT systems to manage the requirements of an integrated IT platform

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Shaping a Healthier Future, and our Out of Hospital Strategy set out how we plan to reconfigure acute services to focus on the needs of our patients. These documents include analysis of the financial savings that will be delivered through improved out of hospital services reducing acute activity and a set of implementation plans up to 2018. We have evaluated our proposed changes (together with other NWL boroughs) on the Value for Money criterion. This covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes.

The anticipated impact on NHS service delivery targets as a result of these changes will:

- reduce mortality through better access to senior doctors
- improve access to GPs and other services so patients can be seen more quickly and at a time convenient to them
- reduce complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community
- ensure less time is spent in hospital by providing services in a broader range of settings

Consequently, the impact on NHS service delivery targets in the scenario that we do not deliver activity reductions through improved out of hospital care, we expect most NWL sites to move into deficit, with no overall net surplus. In the downside scenario there would be an overall deficit of £89m, with all bar one acute site in deficit. Therefore the changes planned in NWL are critical to the future sustainability of this health and care economy.

Achieving this will require significant investment in primary and community care and reduced acute activity, as described in our Out of Hospital Strategy. In Shaping a Healthier Future, we set out major changes in how services will be configured in our health economy over the next 3-5 years, including:

- Central Middlesex becoming a local hospital and elective hospital
- Charing Cross becoming a local hospital
- Ealing becoming a local hospital
- Hammersmith becoming a specialist hospital with obstetric-led maternity unit and a local hospital
- St Mary's – a local hospital, a major hospital, a Hyper Acute Stroke Unit (moved from Charing Cross Hospital) and a specialist ophthalmology hospital (moving the Western Eye Hospital onto the site)

e) Governance

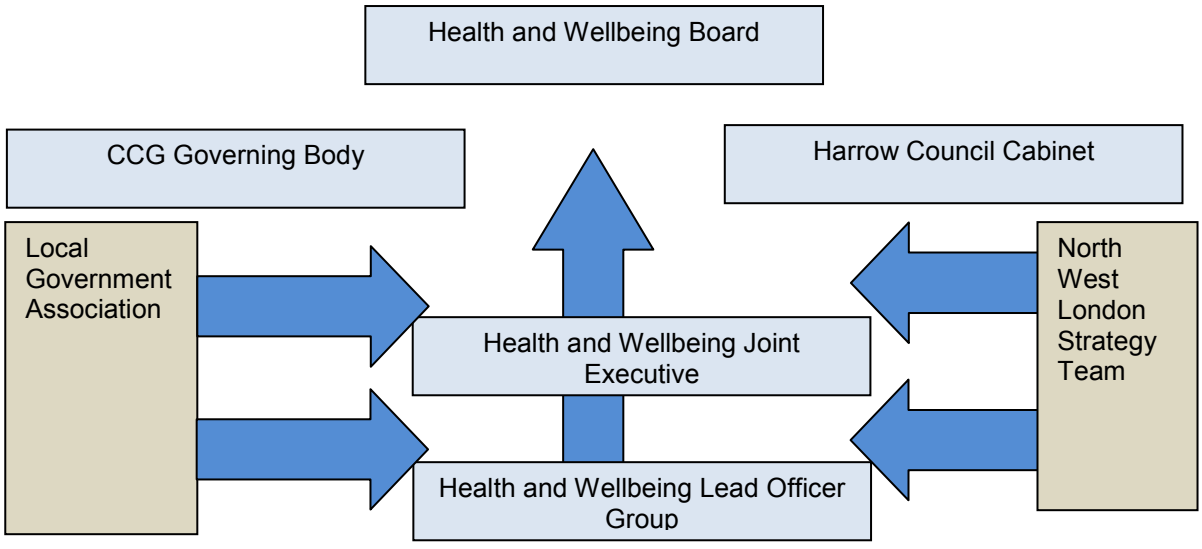
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

There are well-established channels of governance to build on in Harrow. Our Better Care Fund governance arrangements will mirror those we have in place for the management of funds under Section 75 National Health Services Act 2006.

The Harrow Health and Wellbeing Board takes full strategic oversight for health and care systems in the Borough and has been involved from the outset in the planning for Better Care Fund. The Board has established a sub-committee specifically to take forward its work on integration in Harrow.

Finally, our local Healthwatch has taken a key role in engagement with service users, carers and patients, who are also a key member of our Health and Wellbeing Board

The following governance model if in place to support this plan:



The individual components are described below:

- CCG Governing Body / Harrow Council Cabinet – formal final sign off authority for each organisation. The Health and Wellbeing Board actions are reported to these two formal sign off authorities.

- Health and Wellbeing Board – joint health and social care board to oversee the completion of the Better Care Fund plan and ensure alignment to Harrow Health and Wellbeing Strategy

- Health and Wellbeing Joint Executive - senior accountable officer group responsible for the development of the Better Care Fund plan and providing a senior steer to the lead officer group

- Health and Wellbeing Lead Officer Group - task and finish group to develop key details of the Better Care Fund plan which reports to the Health and Wellbeing Joint Executive

- North West London Strategy Team - strategic group provide support and guidance to CCGs and Councils regarding the Whole System Integrated Care agenda

March 2014 final document sign off process
The following sign off process has been suggested to support the final version sign off of the Better Care Fund plan ahead of the 4 April 2014 submission date to NHSE:

- 11 March 2014 - Review/sign off at Harrow CCG Seminar
- 12 March 2014 - Review at Health and Wellbeing Joint Executive
- 13 March 2014 – Approval by Harrow Council Cabinet
- 18 March 2014 - Review/sign off at Harrow CCG Executive
- 19 March 2014 - Sign off at Harrow Health and Wellbeing Board
- 25 March 2014 – sign off at Harrow CCG Governing Body

NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

Eligibility for adult social care is currently set by each local authority on the basis of resources and in response to nationally defined categories, with councils not required to meet need that is met by other means including that met by informal carers or other agencies. In Harrow eligibility is set at Critical and Substantial and this would be expected to be maintained through the period of funding though the BCF [CARE – 15/16 proposals not yet agreed and given size of challenge may include a change in the criteria?].

Locally, protecting adult social care services is expected to :-
- Ensure the ability to respond to demography/increasing social care needs of younger adults with disabilities and older people.
- Fund the costs of Care Bill implementation
- Maintain essential social care services

Please explain how local social care services will be protected within your plans.

The NHS transfer monies have been allocated to schemes which support social care and have health benefits.

The continuation of existing Section 256 NHS funding transfers will reduce the need for the council to adjust social care eligibility criteria in the short term, although given the increasing complexity and rising demographics the challenge will be to maintain this level of support within the relevant financial envelope.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Harrow system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

Both organisation have signed up to the North West London WSIC programme which includes working towards 7 day services. Elements of this are currently being developed through the 2014/15 contracting rounds with Harrow's acute and community providers through a 7 days services CQUIN and will be further enhanced through the development of Harrow's early adopter pioneer bid.

NWLHT have recently (December 2013) implemented 7 day therapies rota to mirror medicine and nursing

Health intermediate care services (STARRS) operate across 7 days

Primary care offers extended service across both walk in centres and urgent care centres. There is an intention to increase the utilisation of primary care networks as part of the WSIC early adopter application

7 day working is a core component of Harrow's Out of Hospital and Mental Health strategies

Developing integrated services under the banner of WSIC will also provide increased

access to 7 day working i.e. integrated nursing and out of hours primary care provision

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.

We are developing as part of the WSIC programme an integrated IT project will support all health providers to input directly onto GP web based systems

Social care are signed up to the use of the NHS number as the single identifier and are committed to ensuring that this occurs by April 2015

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The local authority is committed to moving towards the use of the NHS number as the unique reference and the existing social care system can record the NHS number. There are plans are in place to populate this as part of social care processes.

Our present social care systems already allow the entry of the NHS number. We can adopt this number as a common identifier by 2015 which will allow time for service processes to be amended to ensure the routine capture of the NHS ID is completed.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Through our PSN connection we already conform to the secure email standards

We are committed to adopting systems based upon Open APIs and Open Standards. The majority of our practices will be using EMIS Web, a tool that allows primary, secondary and community healthcare practitioners to view and contribute to a service user's cradle to grave healthcare record.

To enable cross-boundary working, we will improve interfaces between systems. Further, we are creating a data warehouse that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and analyses to take place across multiple, separate systems. Also, it will improve data quality by identifying gaps or inconsistent records.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott2.

Yes, there is a commitment to ensure that all data sharing processes will be supported by the appropriate level of IG controls

Harrow Council has adopted version 2 in relation to Caldicott.

Harrow CCG maintains existing Caldicott processes adopted from Harrow PCT

All of this will take place within the Information Governance framework, and we are committed to maintaining five rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:
Confidential information about service users or patients should be treated confidentially and respectfully

Members of a care team should share confidential information when it is needed for the safe and effective care of an individual

Information that is shared for the benefit of the community should be anonymised

An individual's right to object to the sharing of confidential information about them should be respected

Organisations should put policies, procedures

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

NWL has implemented an Integrated Care Programme (ICP) across local CCG areas which involves risk stratification of practice populations with care plans developed for these patients. Early implementation in Harrow has focused only on 4 key clinical pathways identified at risk.

In 2014/15 this programme will:

- Extend the processes for identification – further risk stratification and more referrals from other agencies
- Ensure a comprehensive and holistic multidisciplinary care plan, with GPs as the accountable professional for the patients care
- Facilitate the use of EMIS Web to ensure electronica access across providers to the care plan for input and update
- Commission multidisciplinary groups focused around the emerging GP network to develop wider provider networks making clear recommendations

- Require the GP network to provide self-management and prevention support/education
- Facilitate care planning coordination and case management around the emerging GP network, supported by a health and social care coordinator and/or lead professional depending on complexity and need
- Ensure patient involvement in developing the care plan so that they are empowered to self-direct their care
- Regular reviews to ensure care plan interventions are being delivered and recovery goals are being achieved
- Improve out of hours coordination through special flags for patients that are accessible to 111 and other out of hours providers
- This is anticipated to increase the number of patients receiving this anticipatory integrated care model.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	**Risk rating**	**Mitigating Actions**
1. Financial stability for both organisations, particularly in the context of significant reductions in LA funding over the next four years	High	£3m efficiency programme identified to alleviate pressures within the health & social care economy 50:50 risk share with attached conditions Expected future savings from integration to ensure social care services protected
2. Continued demographic pressures	High	Demographic pressures will grow. We will approach mitigation in a number of ways, including: Allocating resources appropriately to target groups with complex health and care needs with the aim to stop increasing the risk profile. Develop detailed activity

		modelling across health & social care to better understand the impact of demographic pressures and how combined resources can be effectively deployed,.
3. Potential exposure of financial risks if BCF outcomes are not delivered	High?	A strong focus on benefits realisation through detailed planning
4.The pace and scale of change implemented locally may not align to NHS England's expectations as a result of the existing economic pressures	High	To be defined as part of the on-going planning discussions
5. Inability to shift resources from acute into community	High	Need some words around the financial challenges of NWLHT Link to monitoring of schemes once clear of those which have shift from acute – may link more to QUIPP than BCF?
6. Organisational cultural risk – the ability for organisation change management to occur within the desired time frames	High	To be defined as part of the on-going planning discussions
7. User expectation cultural risk – Harrow residents and service users may not initially agree/understand the model of care and effectively use the commissioned services	High	Development of an engagement and communications plan