REPORT TO HARROW HEALTH AND WELLBEING BOARD: UPDATE ON HARROW INTEGRATED CARE PROGRAMME

April 2014

1. Purpose

The Health and Wellbeing Board has requested an update report on the progress of the ICP in Harrow. This report will cover progress over the course of 2014/15 and the Business Plan for 2014/15.

2. Introduction

The Integrated Care Pilot in Harrowwas set up in July 2012, with the intention of improving care for people with diabetes or over the age of 75 years.

In setting up a pro-active and structured care planning approach, together with expert multi-disciplinary groups, the stated objectives of integrated care were to allow people to stay healthier for longer, improving the management of their condition and in doing so reducing unnecessary utilisation of acute services.

Since its inception, the ICP has been funded from the 70% Non-Elective Fund, which is a fund that NHS England retains from Trusts where non-elective admissions rise above the marginal rate threshold.

3. Achievements in 2013/14

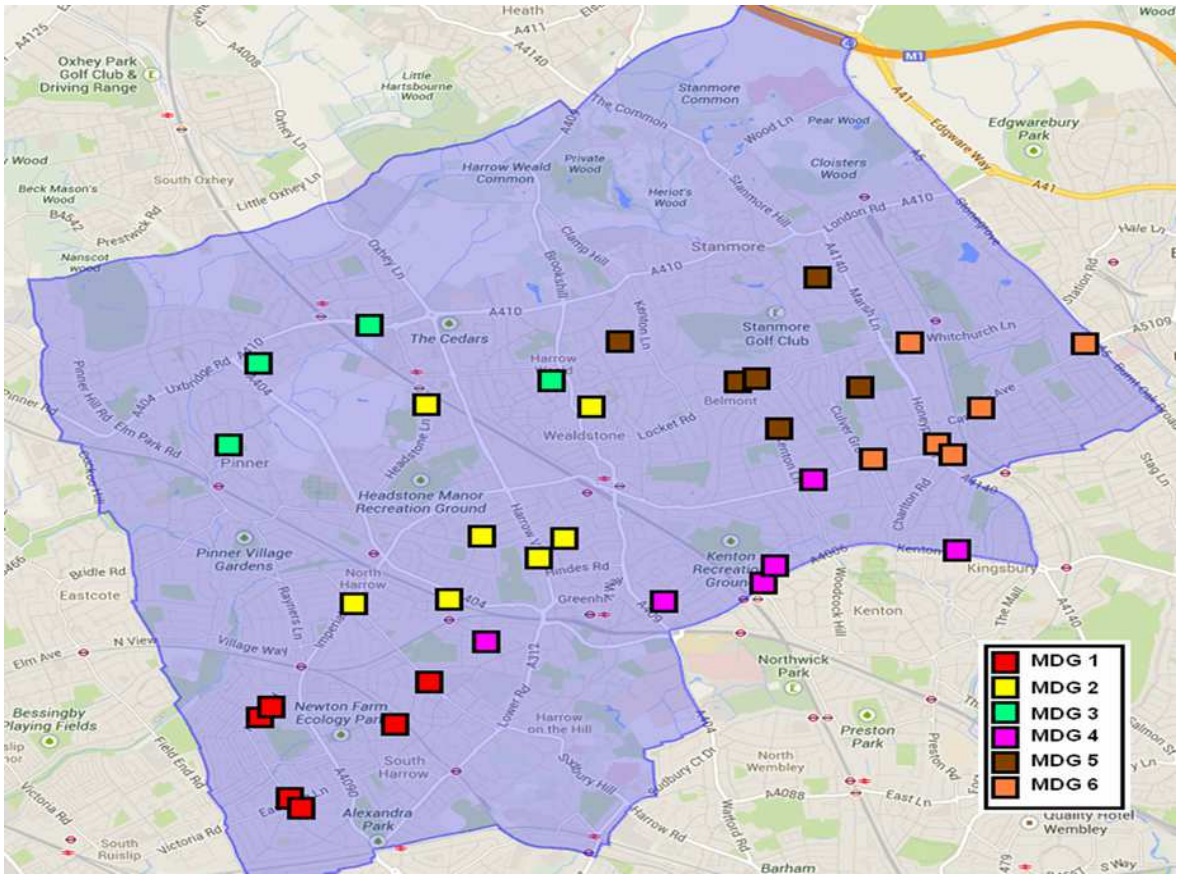
The Outer North West London Integrated Care Pilot Business Plan for 2013/14 covered the four participating boroughs of Brent, Ealing, Harrow and Hillingdon. The Business Plan recognised that 2013/14 would be a period of both consolidation and transition, maximising the potential of Integrated Care. As the ICP has transitioned over the year the focus has become more borough focused. The underpinning achievement for the Harrow Integrated Care Programme in 2013/14 is that the Harrow ICP has become **the strong platform for health and social care integration and the foundation on which whole system integration can be built**, and as such provides the best platform from which to move forward to whole systems integration in 2014/15. This has been achieved through progression of the key deliverables set out in the 13/14 plan.

3.1. Population Coverage

Participation in the ICP has always been very strong in Harrow, with 100% of the population of GP practices signed up to the ICP from its commencement. This has remained strong over 2013/14, which means that Harrow has a population coverage of 15% of the registered population, which is made up of 14,600 people with diabetes, 16,475 people who are aged 75 years or over, 2,090 people with COPD and 1,356 people with Heart Failure. This population-based approach remains a cornerstone both for the Harrow ICP and also for the configuration of services around the identified GP registered populations, including the

alignment of community nursing services. It also remains the foundation upon which local clinical relationships are built, extending into wider integration and care delivery arrangements. This will be of particular importance moving forward in 2014/15.

MAP OF CURRENT MDG CONFIGURATION IN HARROW



3.2. Key Operational Achievements

For the year to date (to M12) of 2013/14, Harrow had care planned 5,891 since April 2013. Together with care plans completed in 2012/13, this means that a total of 8,739have received a care plan since the inception of ICP and that 25% of all people with a long-term condition in Harrow have received a care plan. In terms of the entire Harrow population, this amounts to over 3%. It should be acknowledged that this is a shortfall against the challenging target initially set (54% of target) and that clinicians have struggled to undertake the target number of care planning sessions, primarily because of capacity.

Nonetheless, this is still a significant achievement. There is a growing understanding and consensus from the ICP's senior clinicians, however, that focussing on care planning large numbers of patients may not be the most productive way of maximising the ICP's benefits.

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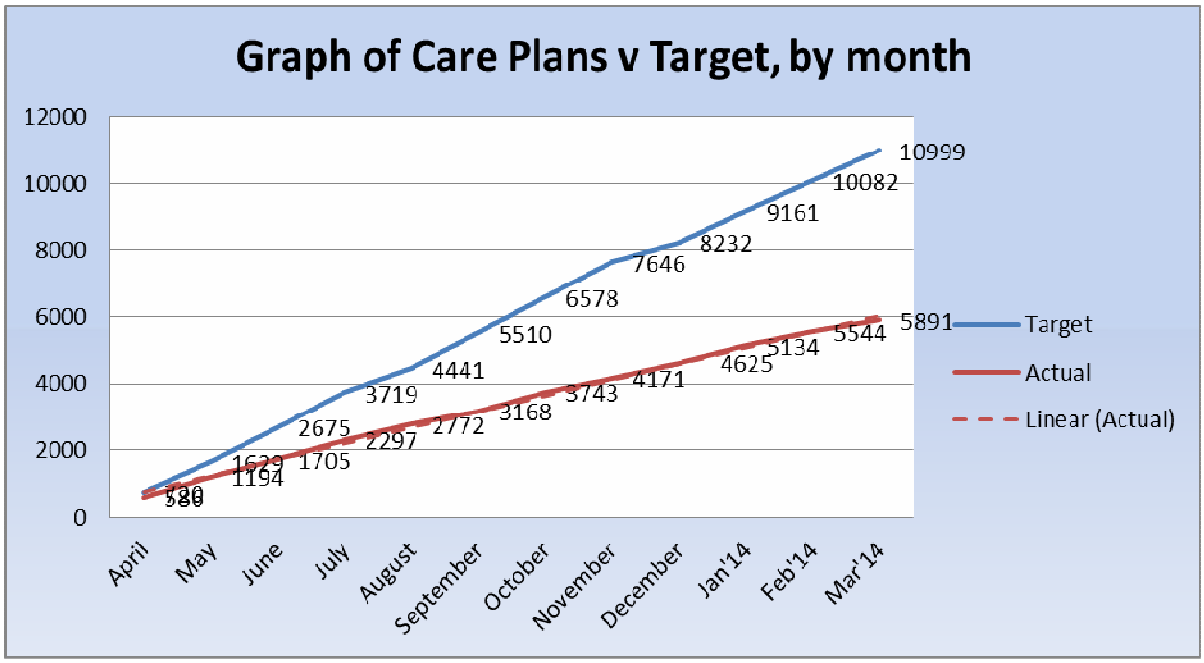


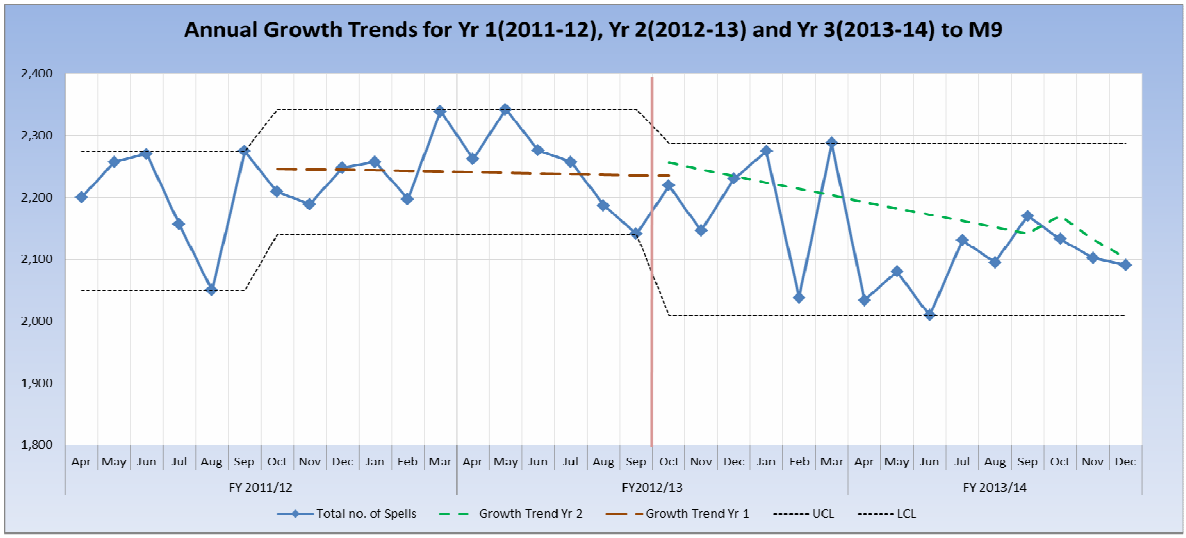
62 case conferences have taken place since between April 2013 and March 2014 (M12), and 336 patients have been discussed. Attendance by GPs at case conferences has been stable, with an average of 76% of practices attending each case conference.

Attendance by the other ICP partners has also been universally strong, with acute partners attending 100% of the time, mental health 95% of the times, social care 81% of the time and community nursing 84% of the time.

3.3. Unplanned Care Service Utilisation Rates

An analysis at M9 was undertaken on emergency admission rates for the ICP populations.

The analysis compared these rates for diabetic and 75+ patients for the first 15 months of ICP with the previous 15 months before ICP started. The red vertical line in the chart below shows the time when ICP care planning started. **Comparing the first 15 months of ICP with the following 15 months, there were 1,407 fewer admissions related to diabetes and 75+. This equates to a reduction of 5%.**



Although this step change cannot be attributed solely to the ICP, it is an encouraging sign that non-elective admissions have held stable against a recent national and local trend of increasing quantities of non-elective admissions. The data suggests that the ICP working in combination with other CCG QIPP schemes is helping to cap the rise in non-elective admissions.

3.4. Patient Experience of Integrated Care

The ICP team developed a bespoke patient survey to understand how integrated care is working for people in Brent, Ealing, Harrow and Hillingdon.

Practices were provided with a supply of pre-printed questionnaires and pre-paid envelopes. Patients were asked to complete the survey following the care planning session, which could be carried out in the GP practice itself, or at home at a later date. Across the 4 boroughs, 497 surveys have been received.

The response to the patient survey has been overwhelmingly positive. For example**, 90% of patients agreed or strongly agreed with the statement "I know what to do if my condition deteriorates"**, which suggests that anticipatory care planning is empowering patients.

89% of patients agreed or strongly agreed with the statement that "the practice team supported me to understand my care and choices available". Additionally**, 88% of patients thought they were "involved in discussions and decisions as much as they want to be".**

3.5.Innovation Fund Schemes

A key element of the ICP has been the opportunity to plan new and innovative schemes using non-recurrent funding to try out projects that support the ICP's core purpose in keeping people healthier for longer, and in doing so reducing unnecessary hospital admissions.

A rigorous selection process was put in place to select these projects against ICP-specific criteria, with applicant organisations completing bid submission forms and project initiation documents. Each IMG then voted to select and refine the successful schemes.

3 key schemes have been launched as part of the ICP. These include:

- Telehealth – managed as part of ICP, this provides remote monitoring for patients with COPD and heart failure;
- Care Home Support Team – provides training and case management of patients in Harrow care homes with high admission rates;
- Home Not Hospital – this project consists of falls support, home support and a night sitting service.

4. CCG Strategic Vision

Over the last year the integration agenda has strengthened and expanded at a national as well as a North West London level. Nationally, there is a recognition that improved health and care integration, both between the commissioners of care and the providers of care, will make the significant improvement to people's quality of life, experience and outcomes as well as reduce fragmentation and duplication and thereby reduce costs. This is reflected in the principles behind the Better Care Fund.

Prior to the announcement of the Better Care Fund, all partners in North West London decided to work together in relation to integration. This partnership is built upon a shared vision to improve the quality of care for local populations by fundamentally changing how systems enable integrated care.

The ICP supports the strategic development of the Better Care Fund schemes and Whole Systems Integrated care, promoting the development at local level to the future alignment of GP networks and fostering peer learning and education.

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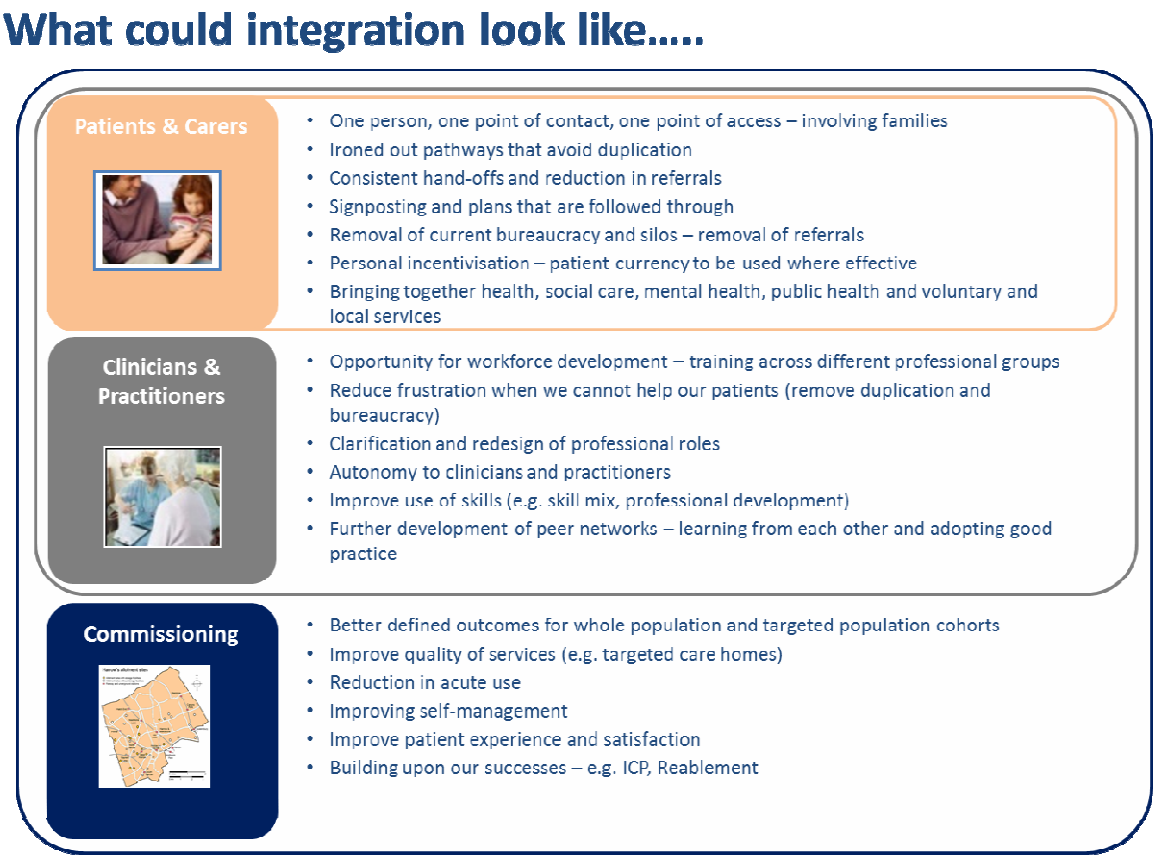


5. Business Plan for 2014/15: Changing the Operational Model

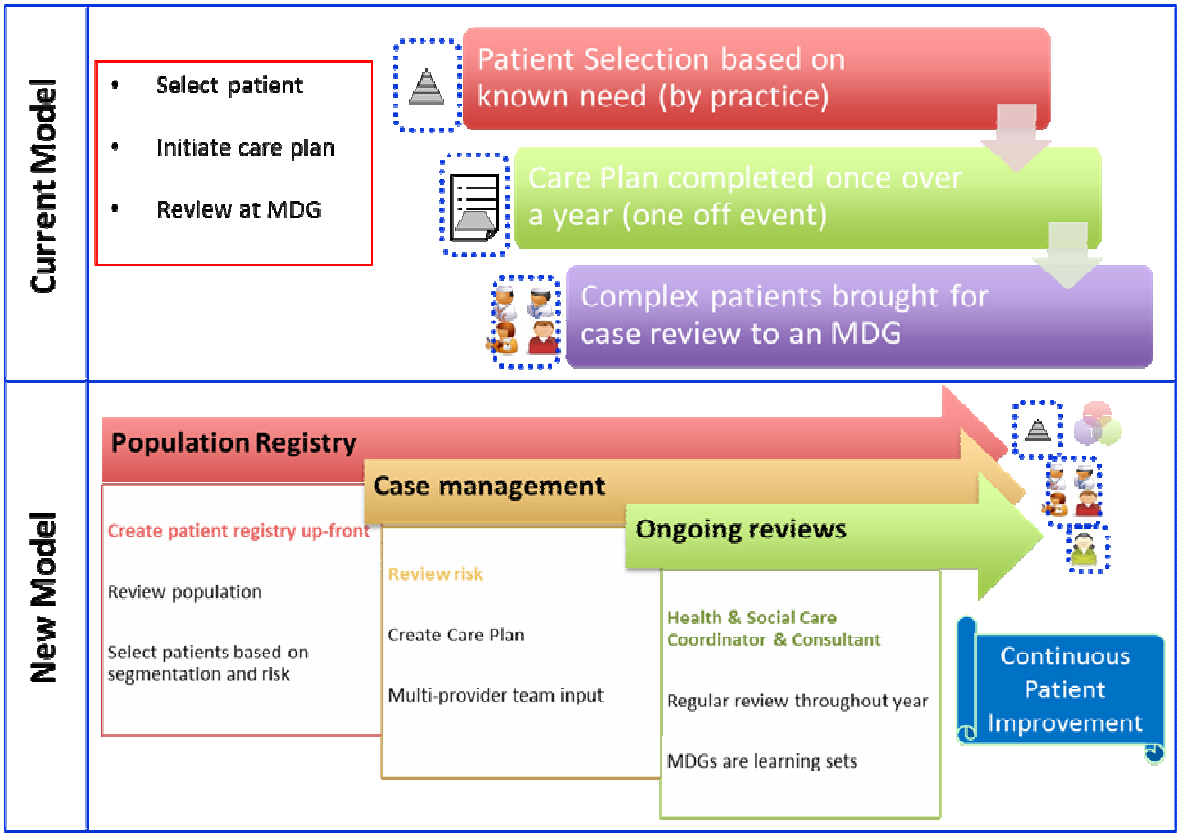
5.1. Key Operational Changes

The key principles behind the 14/15 model are shown in the diagram below. Broadly, these are:

- Up-front identification of a specific integration registry in each practice and MDG at the start of the year using segmentation guidance and a risk stratification tool;

- Changing the way care planning works so that it is no longer a static process and responds to changing patient needs;

- Creating the new role of the Health and Social Care Co-Ordinator to ensure that patient care is co-ordinated and actions are followed up. This role will work within the ICP team and will transition to the provider networks as they are formalised during the course of 2014/15.

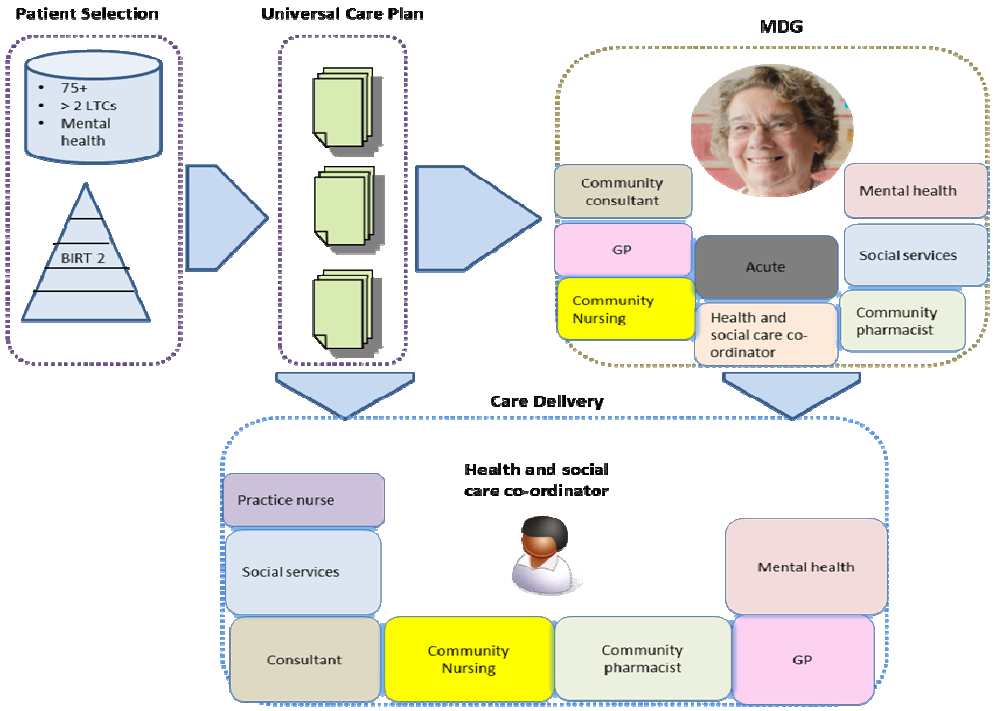


At a more detailed level, the specific changes proposed to the model are shown in the table below.

Specific Changes to the Model in 2014/15

Component	2014/ 15 Development
1 Organisation	• Formalise partnership arrangements in response to Whole Systems Integrated Care
2 Role of Networks	• Working with existing MDG configurations in their movement to development of formal networks. Wrapping services around the practice population and the network
3 Population Segmentation	• Using the population segmentation approach adopted developed through the co-design phase of the Whole Systems Programme, starting with 75+ and those with 2 or more long-term conditions.
4 Clinical Protocols and Packages	• Developing new clinical care pathways for dementia and neuroscience
5 Care Planning	• Care plan a further 2% of the population of those 75+ and 2 or more LTCs. • Reviews built into the process
6 Care Delivery	• Making care pro-active and responding to triggers for a review of the care plan. • Setting up an MDG Clinic and health and social care co-ordinators
7 MDGs	• Professional development for individuals in multi-disciplinary teams . • Discussion of themes arising from care plans and MDG clinics
8 Performance Review	• More information to be reviewed at practice and MDG level • Use of "I" statements as self-reported measures of integrated care
9 Informatics	• Supporting the North West London data warehouse • Using EMIS Web and Vision to link practices together and draw out clinical metrics
10 Organisational Development	• Learning from other Pioneer sites • Training and development programme for motivational interviewing and clinical needs

Under the new model, care plans will be reviewed at key points throughout the year in response to **'trigger events'.** The ICP will ensure that patients receive multidisciplinary input into their care plan, utilising the health and social care co-ordinator as the 'glue' within the system to ensure that care plans are followed up.



5.2. Role of the ICP as the Integrator Organisation

Whilst our individual partner provider organisations consider how best to respond to the commissioners' intentions in relation to whole system integration and how best to work together under more formalised partnership agreements, we will continue to work together as the Harrow Integrated Care Programme to deliver integrated care to our shared patient populations.

5.3. Role of Networks

Any configuration of service delivery across Harrow will be based upon our MDG networks and population-based approach to care. We will therefore work together to strengthen these arrangements, including wrapping more of our services around the network practice populations and strengthening the performance metrics that hold us jointly to account for patient outcomes.

6. Outcomes Expected Through This Change

The ICP is expected to deliver a number of quality, patient experience benefits and ultimately, reductions in non-elective activity.

The table below shows the range of expected benefits from the improved model, including detail setting out how they are measured:

Expected Benefit	Source of Data	Method of Measurement
Reduction in Non-elective admissions	SUS/NWL Data Warehouse	Expected versus observed
Reduction in A&E attendances	SUS/NWL Data Warehouse	Expected versus observed
Increase in diagnosis rates for dementia	Practice registers	Trend over time comparing 2013/14 as baseline with 2014/15.
Overall cost impact on care planned patients	SUS/ NWL Data Warehouse	Expected versus observed
Improved Clinical Metrics (e.g. HbA1c, BP, % COPD patients with yearly flu vaccinations etc)	NWL Data Warehouse *(dependent on successful implementation of data warehouse)*	Monthly changes in metrics across care planned patient group
Improved Social care metrics (e.g. number of people still at home 91 days after hospital discharge into a reablement programme) – links to Better Care Fund	Harrow Council databases (*subject to agreement with Harrow Council):*	Trends over time
Improvement in patient experience.	Based on questions developed in Picker Institute "i-statements" contained in paper "*Developing Measures of People's Self-Reported Experiences of Integrated Care*" (October 2013)	Patient/carer interviews and surveys.

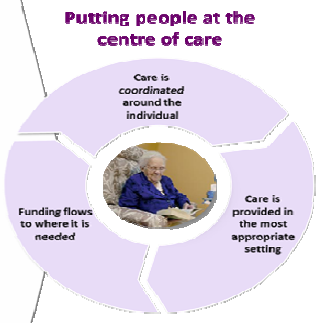
7. ICP Legacy

During the course of 2014/15, the ICP will transition to become part of the provider networks and the Whole Systems programme. By 1 April 2015 it is expected that this transition will be complete, and that ICP will have provided the foundations for successful provider networks that will take on the whole spectrum of care planning, case conferences, and ongoing 'year of care' provision to the most vulnerable sections of the population. In this way, the ICP programme will transition from being a time limited programme to being part of "business as usual" for a network.

Early adopters will move further and faster and share learning across NWL and must plan to implement the following criteria for Whole Systems

Criteria for Whole Systems and "Early Adopters"

Embedding Partnerships	✓ Use co-production to develop plans ✓ Commitment to move to personalisation, self care and use of community capital
Commissioning governance & finance	✓ Pool health and social care budgets ✓ Operate shadow capitated budgets ✓ Generate significant savings to system ✓ Agree binding performance management
Population and Outcomes	✓ Organise care models around people with similar needs ✓ Identify outcomes to be delivered
Provider networks	✓ Establish governance for networks, bringing together different types of providers around a GP registered population ✓ Reallocate money across a care pathway to fund innovative models of care regardless of setting ✓ Agree binding performance management
Information	✓ Ensure the flow of information to support care delivery, performance management and payment ✓ Information governance to support this across all providers



8. Next Steps

The CCG Governing Body has now agreed the model outlined above and the Finance Department has agreed funding from the marginal 70% rate.

The Health and Wellbeing Board is asked to note the progress that has been made with the ICP to date and to support the ongoing work throughout the course of 2014/15 to transition the model to Whole Systems.

Author: ICP Team