Harrow Better Care Fund Plan

Date: 9 January 2015

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Harrow Council
Clinical Commissioning Groups	Harrow CCG
Boundary Differences	The local authority and CCG are geographically coterminous
Date agreed at Health and Well-Being Board:	8th January 2015
Date submitted:	
Minimum required value of BCF pooled budget: 2014/15	£4,445,000
2015/16	£14,373,000, including capital
Total agreed value of pooled budget: 2014/15	£4,445,000
2015/16	£14,373,000, including capital

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Amol Kelshiker
Position	Chair, Harrow CCG
Date	

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

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Anne Whitehead
Date	

c) 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
No additional documents	

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

We have developed our priorities based on a comprehensive understanding of our population, aligning this with our plans for keeping them well.

Using a well-established process, NHS Harrow CCG, the London Borough of Harrow and other partner organisations develop and manage the **Joint Strategic Needs Assessment (JSNA)**, which provides the robust evidence base for both our commissioning and our BCF plan. The JSNA tells us:

- Harrow has a higher proportion of elderly people and adolescents compared to other boroughs in London, and the average age of the population is increasing;
- Whilst life expectancy compares well nationally, there is a higher-than-average prevalence for many major conditions, including CHD, CHF, Stroke, Hypertension, Diabetes, Cancer, Asthma and CKD and growth rates are higher than average;
- There are inequalities in health and wellbeing, with people from the poorest parts of Harrow living on average seven years fewer than those in the richest areas.

Our focus is on people and pathways.

Care is personal and what we do makes a difference to people's lives. Our plan has therefore been made with people in mind. It has also been developed with people, for people. Through our plan and our work are three constant thoughts, **Annie, Nigel and Mo**. More information is presented about them in section 2b of our plan and throughout the document.

The **2013-16 Joint Health and Wellbeing Strategy (JHWS) for Harrow**, formulated in partnership across the borough, focuses on prevention, early identification and avoiding acute admissions, shaped around seven priorities:

- Long term conditions:
- Cancer
- Worklessness
- Poverty
- Mental Health and Wellbeing
- Supporting parents and the community to protect children and maximise their life chances
- Dementia

The JHWS reiterates the ambition for integrated and co-ordinated quality services, many of which focus on preventing problems from arising, especially for vulnerable groups, and all of which put users in control, offering access and choice, and ultimately avoiding unnecessary admissions to hospital.

We have engaged with service users to understand their priorities

There is frequent engagement with our population to ensure that their priorities are captured in our plans, and that our plans deliver them. Engagement has included a Health and Social Care Integration Summit as well as workshops for the planning and design for whole systems integrated care. Service users and patients want:

1. Better access to care when it suits them
2. Self-care and self-management
3. Minimal handovers, which happen effectively and avoid loss of information
4. To avoid having to repeat their story to multiple providers
5. Support to set meaningful goals and care which is designed to help them meet their needs
6. A system where the constituent parts communicate effectively with each other
7. Information that is easily accessible
8. Care plans which are up to date and that they have control over
9. Unpaid and family carers to feel more empowered and able to provide day-to-day care.

The Harrow-wide vision for whole systems integrated care is to improve the quality of health and social care for individuals, carers and families, empowering and supporting people to maintain independence and lead full lives as active participants in their community.

Partners across Harrow believe that truly empowering people to help themselves requires support to be provided around people and not around existing organisational arrangements. Well before 2019/20, our vision for health and social services is to deliver an integrated approach built around the needs of service users. By working in this way we believe we will:

- Improve the quality of life for everybody in our borough by providing proactive, joined up services;
- Work together, share information, expertise and experience better;
- Deliver co-ordinated seamless care, in particular to those with the most complex health needs, including those with multiple long-term conditions;
- Improve the efficiency of the existing system by reducing inter agency referrals;
- Reduce the utilisation of acute care resources to support our residents;
- Make it easier for everybody, however sick or frail, to continue to live happily and safely at home.

To inform our Better Care Fund Plan we have developed four key themes

Harrow Better Care Fund Plan Themes	
	Make life better for the people of Harrow.
	Prioritise home and community-based support to keep people well, and reduce the overuse of the emergency care system.
	Joined up, cost-effective services, making the most of the available resources.
	Planned in partnership between those that use them, stakeholders, providers and commissioners to ensure that they best meet the needs of Harrow.

b) What difference will this make to patient and service user outcomes?

The table below sets out the difference that our BCF Plan will make to patient and service user outcomes by 2019/20.

Harrow Better Care Fund Plan Themes		Patient and User Outcomes to be delivered by 2019/20
	Make life better for the people of Harrow.	• Named care coordinator for all patients with a care plan • Single integrated health and social care assessment and care planning process in place for all service users/patients at high risk of hospital admission • Personalised whole systems integrated care in place for for older people with one or more long term condition, adults with one or more long term condition and children with one or more long term condition • Continued prioritisation of personalisation and choice • Continues support for people with eligible level of need • Continued investment in re-ablement and carer support
	Prioritise home and community-based support to keep people well, and reduce the overuse of the emergency care system.	• Significant reduction in likelihood of non-elective admission • Better arrangements for managing hospital discharge process • Continued investment in re-ablement services to support people to live at home • Fully coordinated social and health care, and support • One point of contact for people who need support and for their carers
	Joined up, cost-effective services, making the most of the available resources.	• Single Point of Access for Community Services • Integrated community services, staff working as one team and better alignment with primary, acute and social care • Increased range and capacity of services available within the community • Resources optimised to protect social care
	Planned in partnership between those that use them, stakeholders, providers and commissioners to ensure that they best meet the needs of Harrow.	• Joint commissioning of community social care and health services • Integrated multi-disciplinary teams established at sub-network level • Users, carers and other stakeholders are central to development of strategy in Harrow

To assist in measuring the difference that the BCF Plan will make the following targets have also been set. Progress in achieving these targets will be monitored by the Harrow Health and Wellbeing Board.

	Baseline	Target	Target 5	Person	BCF	BCF

		(15/16)	years	Focus	Theme	Scheme
Non-elective admissions	88 per 1000 **22,783**	3.5% (798) reduction **21,985**	20% (4557) reduction **18,226**	Annie Mo		Integrated Care Intermediate Care Protecting Social Care
At home after 91 days	82%	80% (definition changed)	80%	Nigel		Intermediate Care Protecting Social Care
Delayed transfer of care (days) per 100,000	2,313	2,249	2,197	Nigel		Intermediate care Protecting Social Care
Residential admissions, older people / 100,000 population	308	385 (definition changed)	385	Annie Nigel		Protecting Social Care
Social Care User Satisfaction	45.9%	46.5%	50%	Annie Nigel		Protecting Social Care
Patient experience – GP satisfaction	80%	83%	88%	Annie Nigel Mo		Primary Care Transformation

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

By 2019/20, we anticipate change in five substantive areas through the better configuration of services. Three of these areas will be supported with BCF funding:

- **Protecting Social Care**. We set out what we mean by protecting social care in Harrow in section 7a. Both Harrow Council and CCG remain committed to working together to implement the Care Act, to maintain support for people with substantial or critical levels of need, and to continue to deliver high quality reablement and rehabilitation
- **Whole Systems Integrated Care (WSIC)**. We will roll out of multi-disciplinary teams to provide personalised long term care and support for individuals at high risk of hospital admission, beginning with older people with one or more long term condition
- **Transformation of Community Services**. Through the re-commissioning and re-configuration of community services, services provided in the community will be better aligned with GP practices and the range of services provided will be increased

More information about each of these is presented below.

Two areas of change will not be supported by BCF funding but form key parts of our integrated care strategy and align closely with our BCF plans:

- **Reducing reliance on acute services**. By 2019/20 most of the reconfiguration associated with the *Shaping a Healthier Future Strategy* will be completed. The current trend of increasing NELs will be reversed, A&E Services will be under less pressure, and more treatments will be available within the community
- **Primary Care Transformation**. Harrow plans to commission three Walk In Centres open from 8am to 8pm seven days a week, providing a combined total of 36,000 primary care appointments per year. These will be operational by the end of 2015/16, and a Harrow-wide GP Federation will be fully operational. At present we operate a single Walk In Centre delivering services from 8am to 8pm seven days a week and a second Walk In Centre delivering reduced hours.

More information about each of these is presented in section 6.

Protecting Social Care

Detailed information about what protecting social care means in Harrow is presented in section 7a however by 2019/20 it is anticipated that social care services will be fully aligned with the target operating model for community services (see below) in order to maximise the support available within the community and to prevent reliance on acute services. At the same time, the Council will continue to fulfil the statutory obligation that support is available for service users with substantial or critical levels of need.

Whole Systems Integrated Care (WSIC)

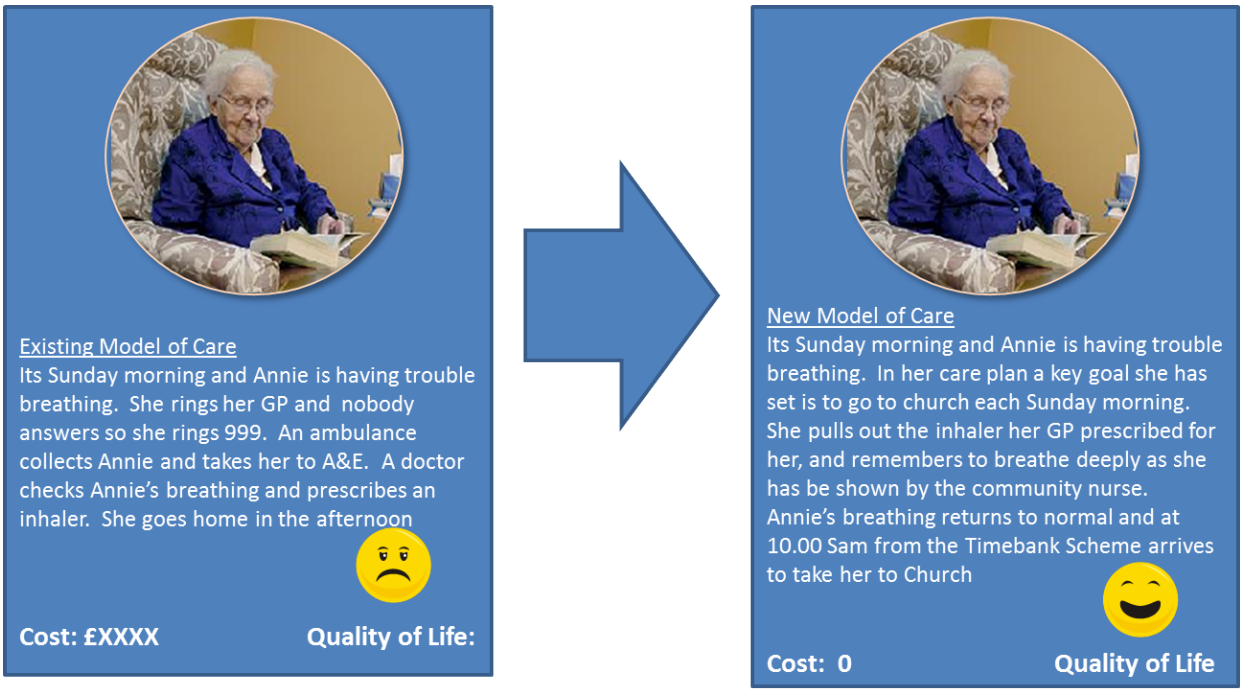
The Harrow-wide vision for whole systems integrated care is to improve the quality of health and social care for individuals, carers and families, empowering and supporting people to maintain independence and lead full lives as active participants in their community.

Whole Systems Integrated Care (WSIC) means……. **building care and support around individuals** rather than organisations, and providing more care outside of hospitals and in the community. It also means **tailoring different care solutions for different population groups** and re-prioritising the use of resources so that more is spent on **prevention and proactive long term support** and less is spent on reactive emergency and unplanned care.

This process will be GP led. Once individuals have been identified, they will be invited to meet with their GP to develop with them a personal care plan. To assist with this process, service users will be encouraged to set personal quality of life goals such as: 'I want to live at home' or 'I want to visit my grandchildren every week'. At the same time their GP will undertake a risk assessment in order to identify the likely level of medical need the service user has, and in parallel a social care assessment will be undertaken. All of this information will be used to develop and agree a personalised care plan.

In Harrow older people with one or more long term condition have been identified as the priority group for developing a WSIC approach. By the end of 2015/16 the roll out of arrangements to support this group will be complete.

In 2016/17 the focus will shift to children and adults with one or more long term condition (more information about population segmentation and the case for change is set out in section 3)



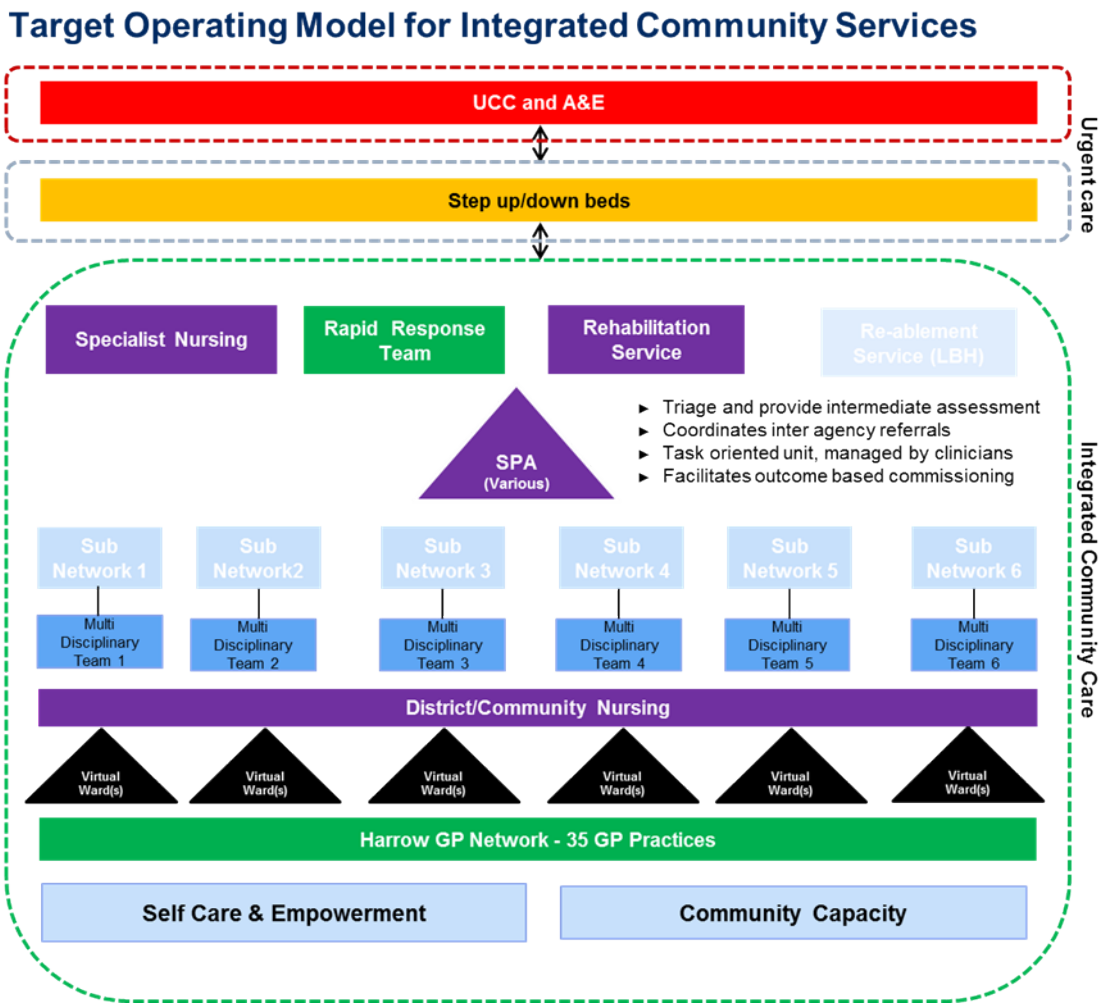
Partners in Harrow are confident that by 2019/20, everybody within the borough who would benefit from a long term care plan and care coordination support will have had this opportunity for some time.

Transformation of Community Services

To complement Whole Systems Integrated Care, work began in Summer 2014 to transform community services.

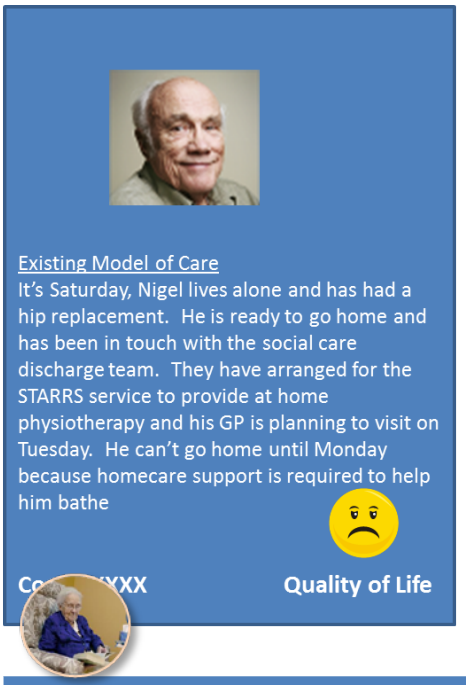
Transforming Community Services means……. focussing on providing **more and better services within the community** in order to **improve hospital discharge performance** and **reduce reliance on acute health services** and in particular non-elective/A+E admissions.

A key first step was the development of a future operating model, which was agreed by the Harrow CCG in November 2014 and is presented below.



- Care in the community will be integrated and delivered by six multi-disciplinary teams operating at a sub network level
- A single provider or group of providers will deliver community and district nursing services, a single point of access, specialist nursing, a rapid response team and a rehabilitation service
- The 35 Harrow GP practices will work together in a single GP Federation
- GP led multi-disciplinary teams will operate Virtual Wards to provide high quality and proportionate levels of support for people with high level needs

In December 2014, the CCG began a formal procurement process to identify a new integrated community services provider to deliver services from October 2015, initially for a five year period. This service will be part funded with BCF resources.



Harrow Better Care Fund Plan Themes		Changes in pattern and configuration of services by 2019/20
	Make life better for the people of Harrow.	• Integrated care assessment and planning process in place for all service users/patients at high risk of hospital admission • Named Care Coordinator and GP for all service users with Care Plan • Continued prioritisation of personalisation and choice • Continues support for people with eligible level of need • Continued investment in reablement and carer support
	Prioritise home and community-based support to keep people well, and reduce the overuse of the emergency care system.	• Reduced likelihood of non-elective hospital admission • One point of contact for people who need support and for their carers • Integrated multi-disciplinary teams established at sub network level
	Joined up, cost-effective services, making the most of the available resources.	• Single point of access for community services (health and social care) • Integrated community services, and staff working as one team • One assessment for all services
	Planned in partnership between those that use them, stakeholders, providers and commissioners.	• Joint commissioning of community social care and health services • Users, carers and other stakeholders are central to development of strategy in Harrow

Overall allocation of BCF Fund

The table below provides an overview of the proposed allocation of resources. Optimising the allocation of BCF resources has proved very challenging for both the Council and the CCG but the following allocation for 2015/16 has been agreed.

Schemes to be funded (2015/16)

BCF Fund	**14,373**
Protecting Social Care	5,411
Whole Systems Integrated Care	3,023
Transformation of Community Services	4,749
Total Revenue	**13,183**
Social Care Capital, DFG	1,190
Total planned investment	**14,373**

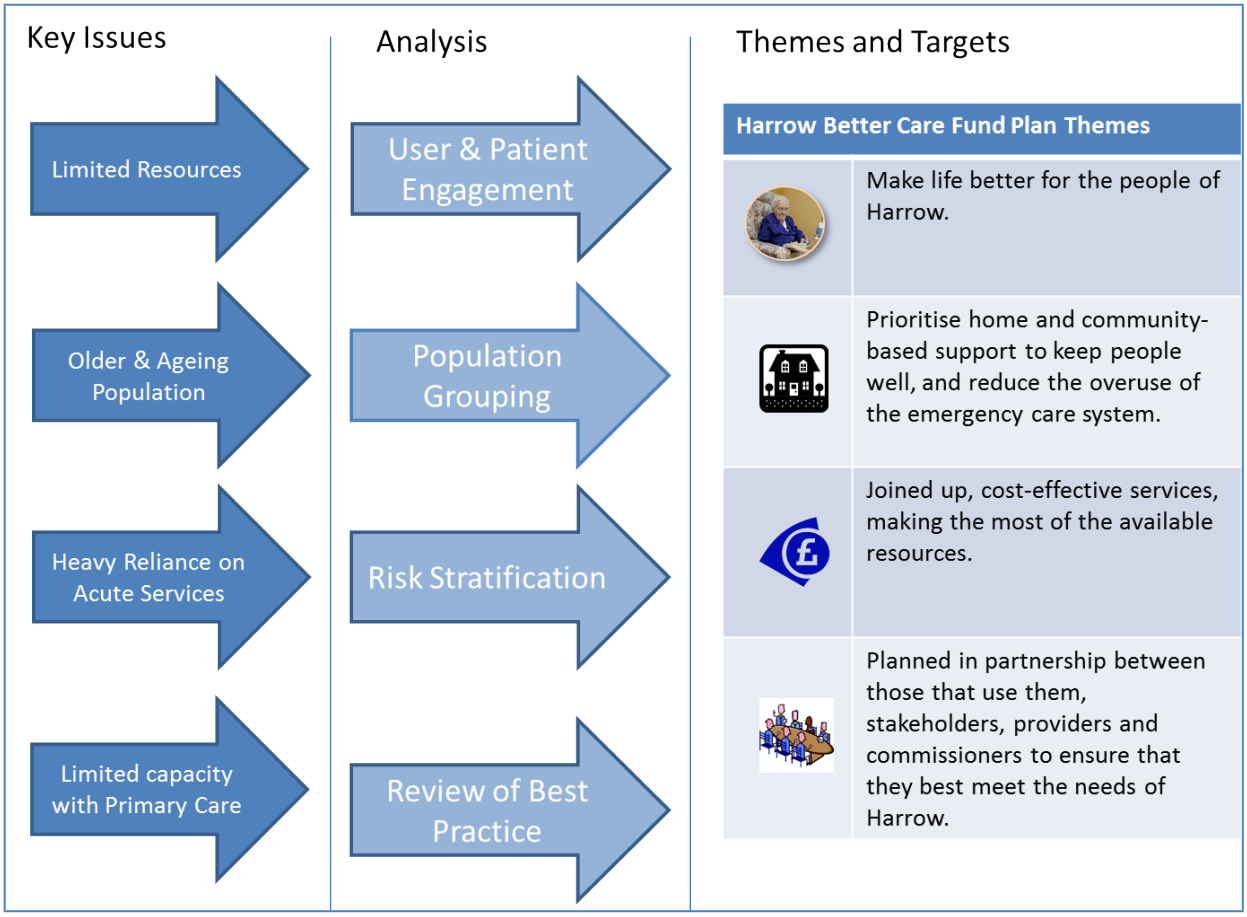
This represents a significant step forward upon the plan submitted in September 2014 which contained an over-commitment of £2.969 million.

The CCG and the Council have committed to working together during 2015/16 to increase the amount of funding allocated within the BCF available for Protecting Social Care. This will primarily be achieved through the agreement and delivery of the One Harrow, One Plan programme (see section 4 for more details), which will be overseen and monitored by the Harrow Health and Wellbeing Board.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The diagram below provides an overview of the case for change in Harrow.



More information about each aspect is presented below.

Key issues

Limited Resources

Both Harrow CCG and Harrow Council face very challenging financial positions.

Harrow CCG Financial Position

At the end of 2013/14 Harrow CCG's underlying deficit was £20m.

In June 2014 the **CCG submitted the final draft of its operating/medium term financial plan (14/15-18/19) to NHS England**. This Five Year Plan requires the CCG to deliver cumulative net QIPP savings of c.£51m (c.4% per annum) to achieve in year balance in year four (17/18) and a 1% surplus in year five (18/19).

The **Integrated Care work stream** of the Five Year Plan directly relates to the work within the BCF. The QIPP plans associated with this work-stream show a commitment to deliver a **net £12.4m saving over the period (c.24% of the total Harrow CCG QIPP)**.

Harrow Council Financial Position

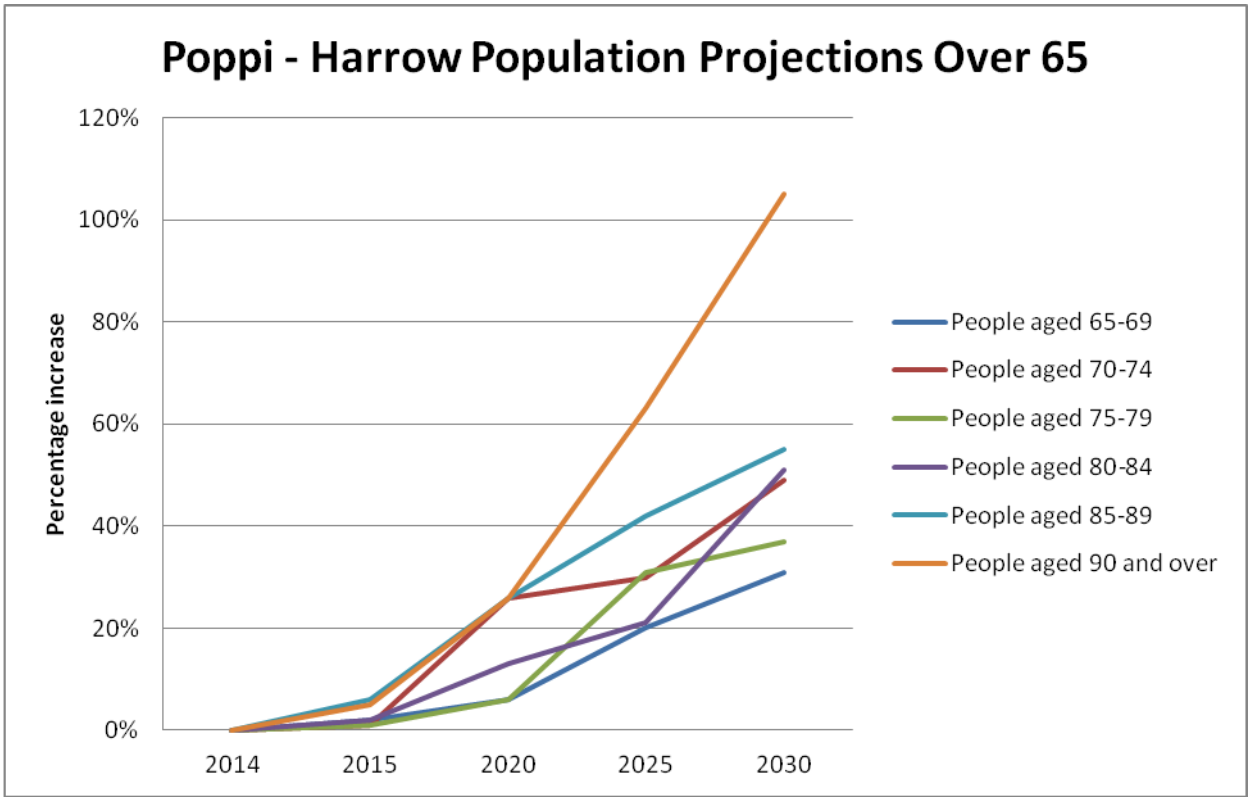
Since 2010/11, £10.7m demographic growth has been allocated to Adult Social Care, with savings of £15.8m over the same period, which has resulted in a **net reduction of £5.1m**.

Reductions in Government Funding mean that **the Council is looking to reduce its controllable expenditure of £141m by £75m (53%) over the next four years**. This means identifying new and innovative solutions to running services. In response to this, the Council has embarked on a consultation exercise with staff and residents to shape the future council services

As the largest directorate in the Council, the Community Health & Wellbeing Directorate (CHW), which includes **Adult Social Care, is expected to reduce expenditure by approximately £25m over the four year period to 2018/19 as part of a wider £75m Social Care saving programme**. As part of the annual budget process, proposals to reduce social care expenditure by £6.1m over the next two years were discussed with Members in October. These proposals fall short of the CHW reduction target by approximately £7.7m, It is not yet clear where the balance of this reduction will be found. This will be the subject of on-going budget discussions.

Older and Ageing Population

The demographics below detail the projected significant increase in the number of residents of the borough over the age of 65 over the next 15 years. As the overall population ages, demand on services and the complexity of needs is anticipated to increase.



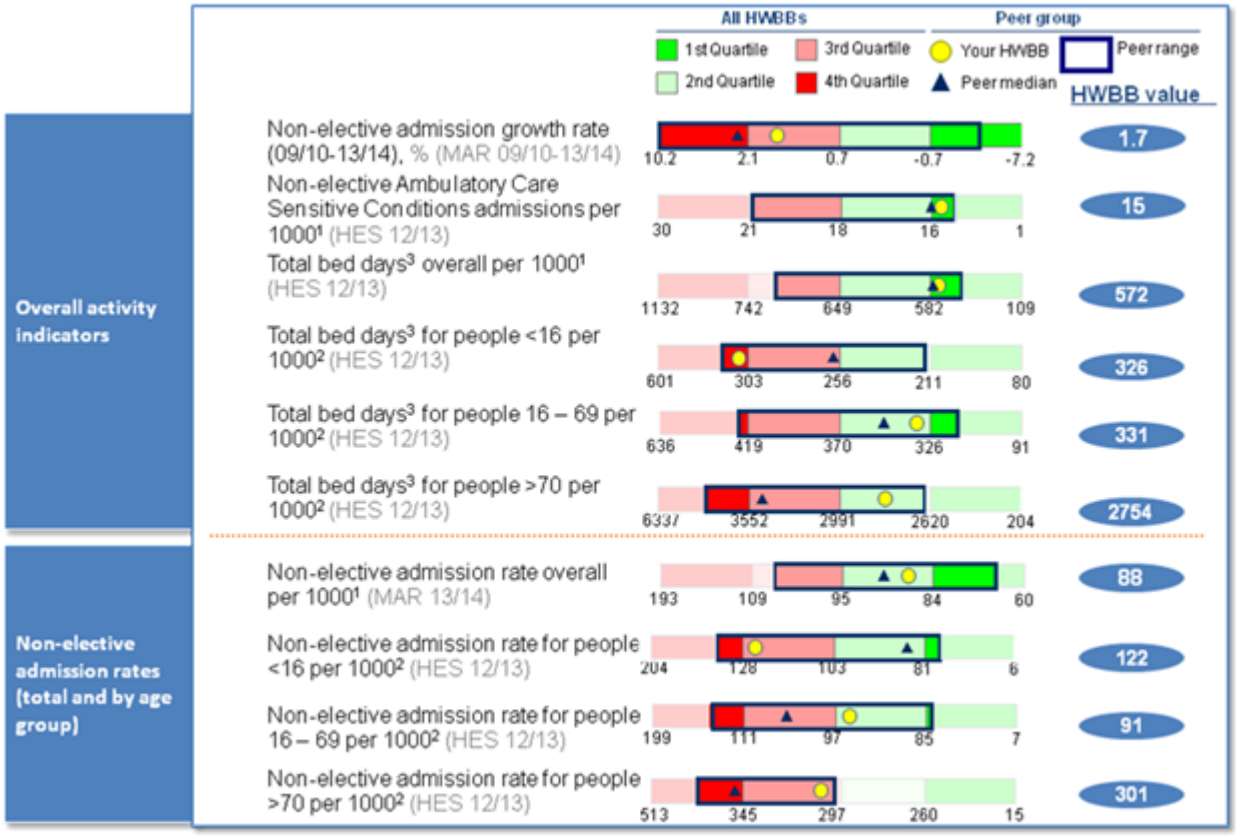
Heavy reliance on acute services

Detailed work has also been undertaken to quantify the opportunities for reducing non-elective and emergency admissions.

While the non-elective admission rate overall per 1,000 in Harrow is good and better than our peer group, there has been a growth in admissions between 2009/10 and 2013/14. In addition, while total bed days for people 16 and over compares favourably against national

trends and our peer group, significant improvement is required in the total bed days for people that are under 16.

Analysis of reablement and rehabilitation performance has also been undertaken.



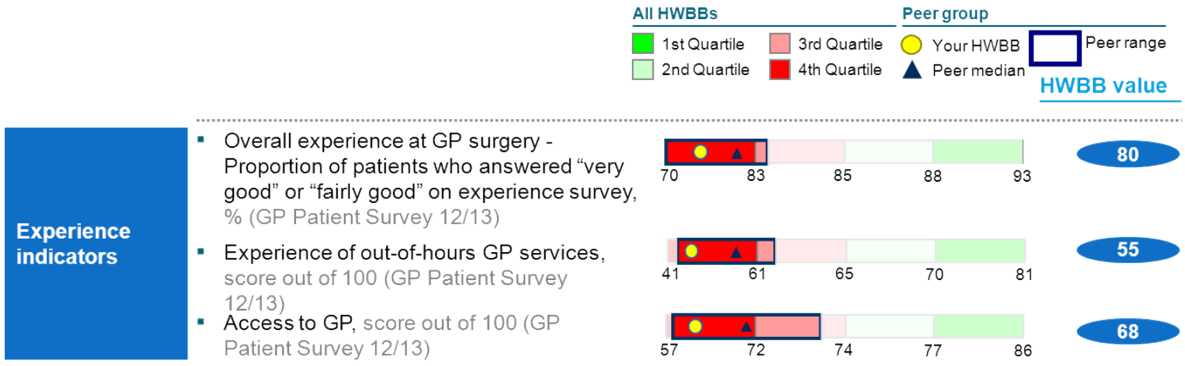
1 Number of admissions or bed days per 1000 population; 2 Number of admissions or bed days per 1000 population in the given age group; 3 Total bed days including excess bed days

Source: MAR 13/14, HES 12/13, ONS

Good performance is achieved in reducing delayed hospital transfer and in offering re-ablement and rehabilitation following discharge from acute or community hospitals.

<u>Limited capacity within Primary Care</u>

An analysis of primary care performance has also been undertaken.



1 Local Authority ASCOF Performance Indicators 2013-14
2 Provisional 13/14 data is now available and 13/14 is the baseline for the metric in the template that needs returning on 19 September
SOURCE: MAR 13/14, NHS England 13/14, HSCIC 12/13, GP Patient Survey 12/13, ONS

<u>We need to improve access to primary care in order to increase patient satisfaction</u>.

More information about our Primary Care Transformation Programme is presented in section six, but our new Walk In Centres and the Whole Systems Integrated Care programme will increase access to primary care services. In addition, more GP capacity will be released to focus on specific population cohorts with high levels of need.

Analysis

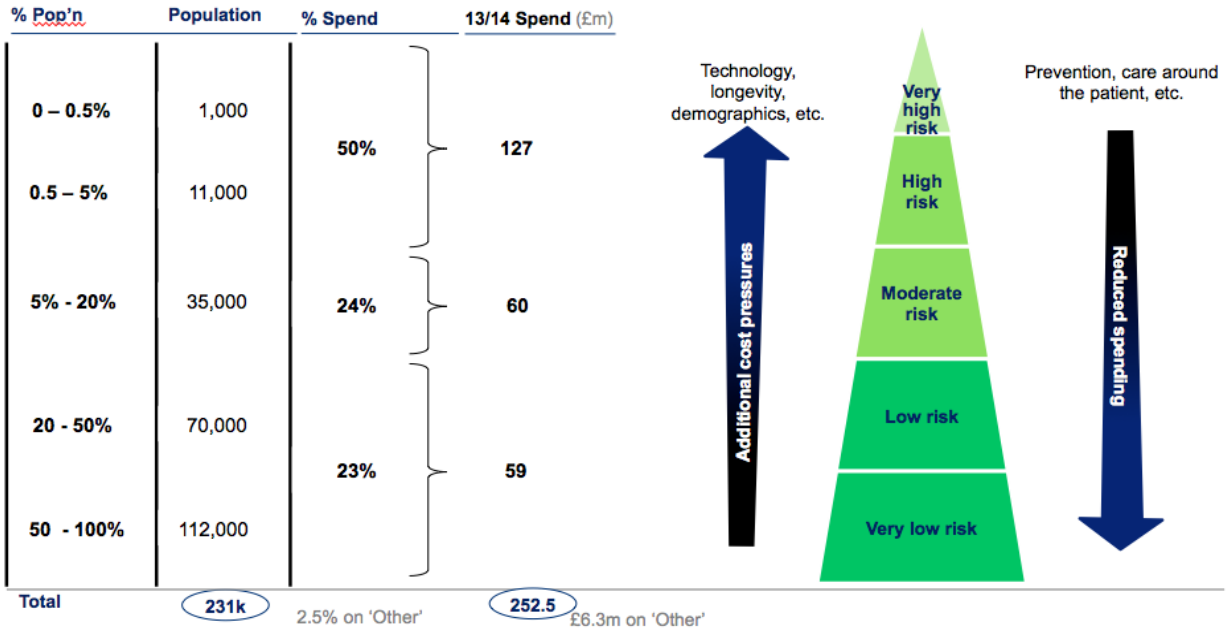
User and Patient Engagement

To inform the development of the BCF a Health and Social Care Integration Summit was convened. Service users and patients want:

1. Better access to care when it suits them
2. Self-care and self-management
3. Minimal handovers, which happen effectively and avoid loss of information
4. To avoid having to repeat their story to multiple providers
5. Support to set meaningful goals and care which is designed to help them meet their needs
6. A system where the constituent parts communicate effectively with each other
7. Information that is easily accessible
8. Care plans which are up to date and that they have control over
9. Unpaid and family carers to feel more empowered and able to provide day-to-day care.

Risk stratification of Harrow population

To inform our wider health and social care transformation programme we have undertaken a risk stratification analysis of the Harrow population using the BIRT 2 risk assessment tool and CCY performance and financial data.



SOURCE: NWL Whole Systems Integrated Care programme; local team analysis

As can be seen, 50% of available resources are currently utilised by only 5% of the population and this proportion of resource use is growing. Further analysis indicates that **high-risk patients are most likely to utilise acute services and are very likely to have more than one long term condition**.

Analysis of population by spend and patient segmentation.

As part of the National Integration Pioneer Programme, we have also undertaken an analysis of the population by spend and patient segmentation using the integrated care model data set provided by McKinsey. An overview of this data is presented below. In particular, we have used this analysis to quantify the number of people with long term conditions and the per capita and total spend on these groups.

2012/13 — Number of people x k £m Total annual spend £xx Average spend per capita — Relative size of spend per capita

	Mostly healthy	1 LTC	2+ LTCs	Severe Enduring Mental Illness	Dementia	Cancer	Learning disability	Severe Physical Disability
Children 0-16	Mostly healthy children 657 49.4 32.4	Children with 1 LTC 1,092 2.2 2.4	Children with more than 1 LTC 2,621 0.0 0.1	Children with SEMI 3,442 0.1 0.3	Children with dementia n/a - -	Children with active cancer 7,706 0.0 0.2	Children with learning disability n/a - -	Children with physical disability n/a - -
Adults 16-69	Mostly healthy adults 744 141.5 105.3	Adults with 1 LTC 1,819 22.0 40.0	Adults with more than 1 LTC 3,460 10.0 34.8	Adults with SEMI 10,573 2.3 24.7	Adults with dementia 13,390 0.1 0.8	Adults with active cancer 4,536 2.1 9.3	Adults with learning dis-ability 40,186 0.5 18.4	Adults with physical disability 17,550 0.2 3.5
Elderly 70+	Mostly healthy elderly 2,031 5.9 11.9	Elderly with 1 LTC 2,007 5.4 10.8	Elderly with more than 1 LTC 3,923 9.6 37.5	Elderly with SEMI 12,999 0.3 4.4	Elderly with dementia 12,508 1.0 12.6	Elderly with active cancer 4,416 3.0 13.1	Elderly with learning disability 30,529 0.0 1.0	Elderly with physical disability 17,096 0.9 14.9

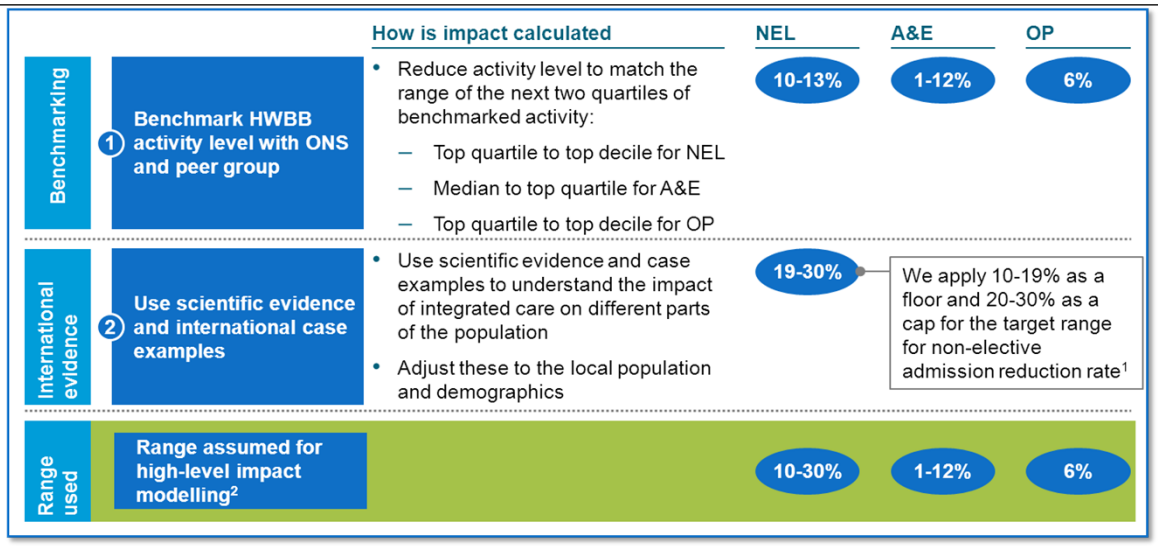
Source: ONS, McKinsey Integrated Care Model

As can be seen:

- £34.8 million is spent on supporting 10,000 adults with more than one long term condition; and
- £37.5 million is spent on supporting 9,600 older people with more than one long term condition.

Review of Best Practice (WSIC)

Work has been undertaken to quantify the potential benefits of whole systems integrated care in Harrow and this is presented below.



Source: McKinsey, MAR 13/14, HES 12/13

As set out above our conclusions are that a **reduction of between 10% and 30% in the number of non- elected admissions can be achieved in Harrow through the successful implementation of a Whole Systems Integrated Care approach.**

Themes and targets

As a result of our analysis and consideration we have agreed the following themes and performance indicators to measure our progress against.

	Baseline	Target (15/16)	Target 5 years	Person Focus	BCF Theme	BCF Scheme
Non-elective admissions	88 per 1000 **22,783**	3.5% (798) reduction **21,985**	20% (4557) reduction **18,226**	Annie Mo		Integrated Care Intermediate Care Protecting Social Care
At home after 91 days	82%	80% (definition changed)	80%	Nigel		Intermediate Care Protecting Social Care
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Social Care User Satisfaction	45.9%	46.5%	50%	Annie Nigel		Protecting Social Care
Patient experience – GP satisfaction	80%	83%	88%	Annie Nigel Mo		Primary Care Transformation

Key risks:

- A risk to Harrow, its BCF and wider operational plans is that the local acute provider (North West London Hospital Trust) has in the recent past experienced a **high level of growth of A&E activity**. Harrow CCG's Five Year Plan assumes an annual growth between 1.3-1.4% year-on-year. This growth could be further exacerbated through the Shaping a Healthier Future programme with the downgrading of Central Middlesex Hospital A&E and wider transitions across North West London sector. To mitigate this risk Harrow has a number of schemes in place (admission avoidance, case management, WICs and a UCC).

- **Non-elective admission rates in Harrow have increased over the period from September 2010 to March 2014 by 1.7%**. At the same time the non-elective rate per 1,000 population achieved in 2013/14 was 88. This represents second quartile performance nationwide and is above the average for our peer group. Reducing non-elective admissions over the next four years will therefore be challenging.

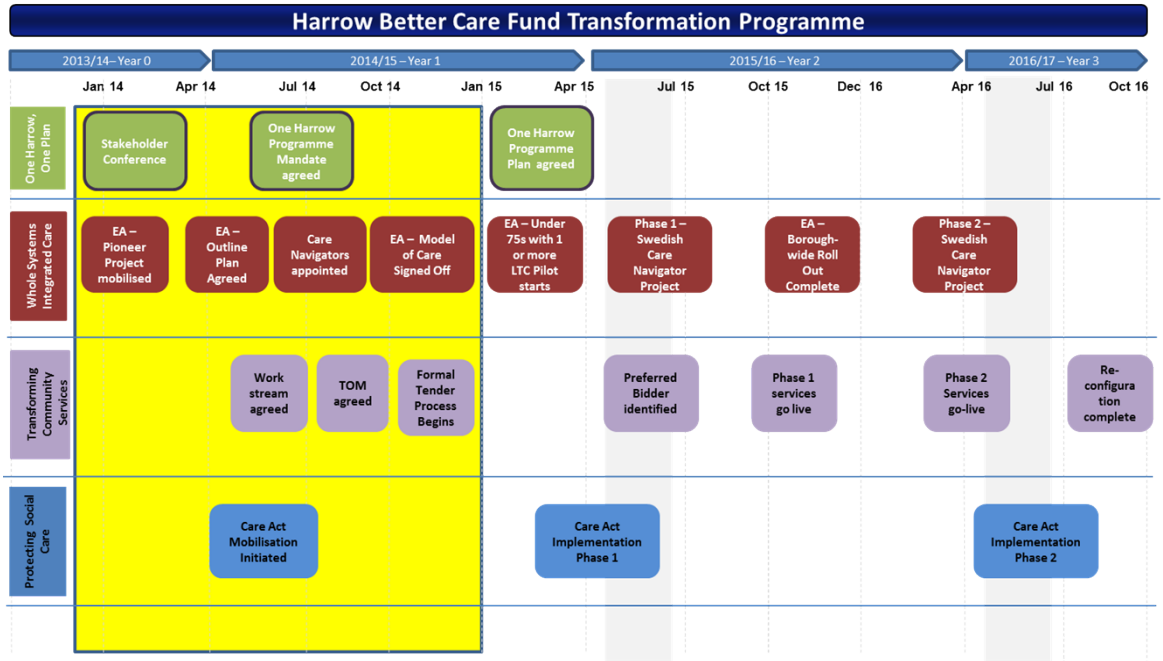
- Decreasing controllable resource within local authority will result in the **reduction of non-statutory services which could impact on non-elective admission, reablement and hospital discharge performance**.

- Our joint plans do not presently focus on **improving clinical outcomes for children**; in particular, the incidence of hospital admission for under 16s is too high and length of hospital stay is too long.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The diagram below provides an overview of the key milestones and interdependencies within the scope of the BCF Plan. More details about each programme stream is presented below. Those activities within the yellow box are complete.



One Harrow, One Plan

Work began on One Harrow, One Plan in **January 14** when a stakeholder conference was convened as part of initial Better Care Fund preparations. The key conclusion was that principal partners needed to work together to deliver better outcomes for Harrow residents and that this joint working needed to be informed by a clear understanding of patient needs. Partners agreed to work together on the WSIC Early Adopter Outline Plan (see below).

In **July 2014**, following agreement of the WSIC Early Adopter Plan the Harrow Health and Wellbeing Board agreed the **One Harrow, One Plan Programme Mandate** and the Council and the CCG appointed a Integrated Care Programme Director.

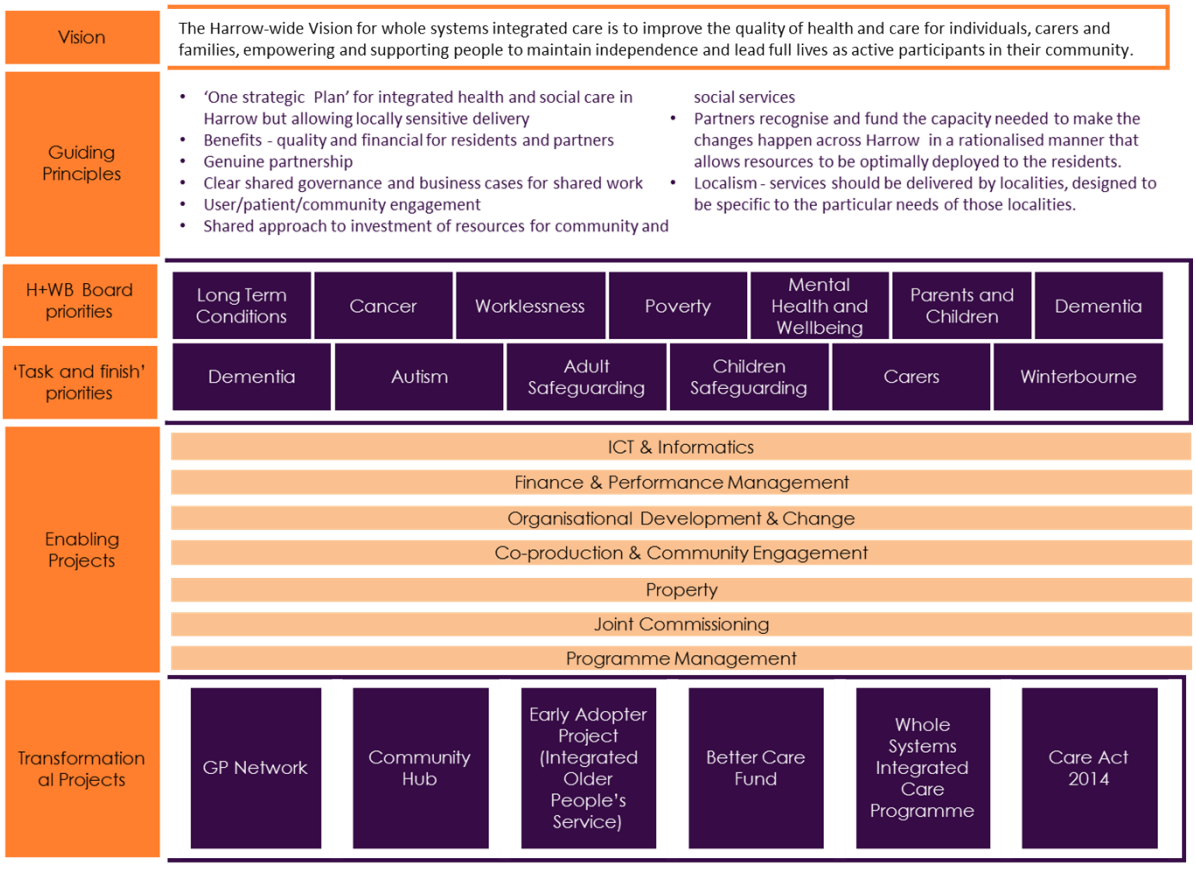
A key aspect of agreeing the Programme Mandate was agreement of a set of **Guiding Principles** to inform future joint working. Presented below are the Guiding principles and a Programme Overview.

One Harrow, One Plan: Guiding Principles

Subsequent to submission of the first iteration of the Harrow Better Care Fund Plan and as part of the submission of the Harrow WSIC Early Adopter Outline Plan key commissioners and providers have agreed to work together to develop **One Strategic Plan for Integrated Health and Social Care in Harrow**. This development was welcomed by the Harrow Health and Wellbeing Board at its meeting in July, where the following **Guiding Principles** were adopted.

- 'One strategic plan' for integrated health and social care in Harrow, allowing locally sensitive delivery
- Benefits - quality and financial for residents and partners
- Genuine partnership
- Clear shared governance and business cases for shared work
- User/patient/community engagement
- Shared approach to investment of resources for community and social services
- Partners recognise and fund the capacity needed to make the changes happen across Harrow in a rationalised manner that allows resources to be optimally deployed to the residents
- Localism - services should be delivered by localities, designed to be specific to the particular needs of those localities.

Harrow Health and Social Care Transformation Programme Overview



As can be seen **eight enabling projects** have been established as part of the wider programme which will each play a significant part in ensuring delivery of those projects identified as part of the Better Care Fund plan.

There are also **six separate transformational projects** which will be progressed as part of the programme.

Work on the detailed **One Harrow, One Plan Programme Plan** has been delayed pending agreement of the BCF Plan. It is anticipated the One Harrow, One Programme Plan will be presented to the Harrow Health and Wellbeing Board **in April 2015**.

The One Harrow, One Programme provides a governance arrangement and borough-wide framework to enable the delivery and coordination of the Better Care Fund Plan. It will also be the principal means for:

- Delivering integrated health and social care across Harrow
- Releasing further efficiencies to invest in future innovation and protect social care services

Whole Systems Integrated Care

Whole Systems Integrated Care (WSIC) was identified as a key priority for Harrow in 2012, and at that time the Integrated Care Programme (ICP) was established bringing together key partners including London North West NHS Trust, Harrow Council, Harrow GPs, voluntary sector organisations and the CCG. The **business case for the Integrated Care Programme** was agreed in **April 2014** and in July 2014 six Care Coordinators were appointed as part of the next phase of the programme.

More details about the WSIC Programme is presented as scheme 1.

In **February 2014**, as part of the North West London CCG Federation, Harrow was identified as a **Whole Systems Integrated Care Pioneer**. In March 2014 a programme director was appointed and over 100 individuals worked together through a programme of co-production (see section 8 for more details) to produce an **Early Adopter Outline Plan in May 2014**. Key to the Outline Plan was the development of a draft model of care. This was reviewed and endorsed by an International Panel of Experts.

Further work has been undertaken to develop the **WSIC Care Model** alongside the Target Operating Model for Community Services, which outlines the organisational structure. This was signed off in **November 2014**, and sub-network 6 was identified as the site to prototype the new arrangements. The WSIC Care Model will be initially implemented to support older people with one or more long term condition.

Prototyping of the **WSIC Care Model** began in sub-network 6 in **January 2015**. At the same time the **Two Year Business Case for Whole Systems Integrated Care** will be considered by the Harrow CCG Governing Body.

Roll out of the WSIC Care Model across Harrow will be complete by October 2015. The WSIC will be funded using BCF resources in 2015/16, and the activity undertaken will contribute directly to achieving the reductions in non-elective admissions which are planned for within this BCF.

In order to supplement the existing WSIC Programme agreement has also been reached to

undertake a Health Navigator Project in Harrow on collaboration with the Karolinska Institute in Stockholm, Switzerland.
Phase 1 of the Health Navigator Project will begin in July 2015 and phase 2 will begin in April 16. More details are presented in the panel below. This will not be funded using BCF resources but it will contribute to the anticipated reduction in non-elective admissions resulting from integrated care this year, and it is anticipated it will play a major part in achieving reductions next year.

Health Navigators Project

The aim of this project is evaluate the benefits of a health coaching model to support patients with a high risk of unplanned admissions in Harrow. The service will be delivered as part of a research study through a randomised controlled trial. Health Navigators as the service provider during this trial will offer Harrow residents 'Active Health Management' packages, consisting of telephone based activities to the support the patient to:

- Develop ways to remember what medicines to take and when
- Create own synthesis of condition, treatment and deterioration symptoms
- Set and following through on realistic goals for exercise, diet and other lifestyle goals
- Enrolling in programmes to stop smoking or drinking
- Finding new social contexts, or returning to old social contexts

Health Navigator (HN) is an organisation founded by physicians and researchers from the Karolinska Institute in Stockholm, Sweden.

Transforming Community Services

Re-commissioning community nursing services was identified as a priority for the CCG in **June 2014**, and a joint programme of community care transformation was identified as a priority in the One Harrow, One Plan Programme Mandate in July 2014. A new **target operating model based around six sub-networks was agreed in September 2014** to inform the re-commissioning, which was confirmed in the CCG's commissioning intentions and in the second submission of the BCF in September 2014.

In December 2014, tenders were invited to provide the reconfigured community services, which will combine community and specialist nursing services with a rapid response team and a home-based rehabilitation service currently provided separately through the STARRS Programme. Preferred bidder(s) to provide the new service will be identified in June 2015, following a competitive dialogue process.

Phase 1 of the new service will go live in October 2015 (community and specialist nursing) and phase 2 (STARRS, Single Point of Access) in April 2016.

BCF Funds will be used to fund the existing STARRS contract during 2015/16. This service will play a major part in delivering planned reductions in non-elective admissions. More information about the Community Care Transformation Scheme is presented in Annexe 1, Scheme 2

Protecting Social Care

Information about protecting social care services and preparing for the implementation of the Care Act is presented in section 7. As indicated above preparations for implementation of the **Care Act are well underway, phase 1 will be completed in April 2015 and phase 2 in April 2016**.

Key risks:

- Delays in agreeing financial aspects of Better Care Fund Plan will impact on key partner relationships and result in further delays to agreement of the One Harrow, One Plan Programme Plan
- Integrated Care Business Plan 2015/16 and 2016/17 does not incorporate all aspects of whole systems model (e.g. social care and voluntary sector involvement)
- Integrated Care Scheme does not deliver anticipated reductions in Non-elective Admissions in 2015/16
- Complexity and scale of community services re-commissioning project leads to procurement delays and failure to implement new operating models within agreed time-scale
- Existing STARRS Intermediate Care Service does not deliver anticipated reduction in non-elective admissions

b) Please articulate the overarching governance arrangements for integrated care locally

Following the submission of the first Better Care Fund plan, a Harrow Integration Board has been established bringing together key commissioners, providers, lay partners and a representative from Harrow HealthWatch.

healthwatch Harrow

Central and North West London NHS
NHS Foundation Trust

harrow carers
supporting family & friends

The North West London Hospitals NHS
NHS Trust

Harrow COUNCIL
LONDON

NHS
Harrow Clinical Commissioning

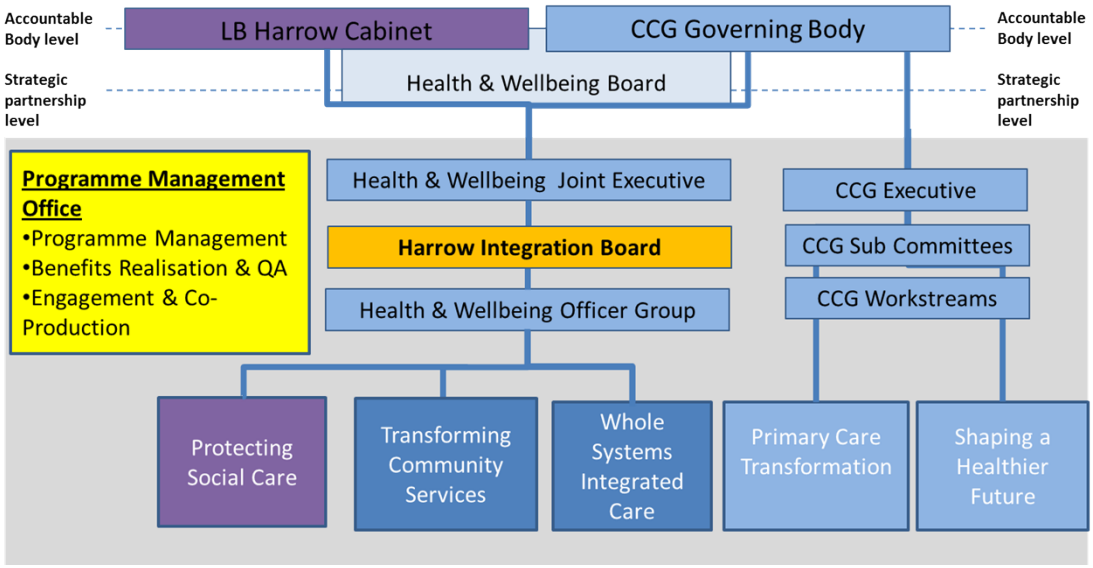
The initial task of the Harrow Integration Board is to develop the three year Integrated Health and Social Care Transformation Programme – One Harrow, One Plan, which will be completed immediately following the agreement and sign off of the Better Care Fund Plan.

The diagram below provides an overview of the governance arrangements that have been put in place to oversee the development of integrated care locally.

Key features of the new arrangement are:

- The Health and Wellbeing Board will be the key forum for strategy development and agreement and will receive at each meeting a progress report on the delivery of the overall programme;
- The Health and Wellbeing Joint Executive will operate as the key forum for senior stakeholders from the Council and the CCG to oversee and direct all health and wellbeing issues, including children's services and public health. It meets monthly;

Governance arrangements for Integrated Care in Harrow



- The **Harrow Integration Board** will operate as the Programme Board for **all health and social care integration projects, including Better Care Fund projects**. Membership includes principal commissioners, providers, a lay partner and a representative from Harrow HealthWatch. It will meet monthly during the alternative fortnight to the Health and Wellbeing Joint Executive and will receive a highlight report, risk review and a benefits realisation update;
- The CCG Executive will oversee those projects and initiatives which are exclusively NHS-focused and decisions will be passed to the CCG Governing Body for sign off;
- The Health and Wellbeing Officer Group will meet weekly to provide day-to-day direction and coordination to the programme;
- A **single programme office** and a common approach to project and programme management will be established to support the overall programme including the Better Care Fund elements of the programme.

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

Strong governance arrangements have been established to support the delivery of the wider health and social care transformation programme which incorporate at a programme board level chief officers from the CCG, the Council and key providers. There is also a direct reporting line to the Health and Wellbeing Board and on-going scrutiny and engagement.

A **Programme Director** has also been appointed to support and deliver the programme and oversight of key aspects (in particular Whole Systems and Early Adopter Projects) is also provided at a North West London level.

Work is presently taking place to draft a **Section 75 Agreement** to support the management and distribution of Better Care Fund resources, including risk sharing arrangements associated with the achievement of the non-elected admissions target expected to be agreed between the NHS Commissioners and providers. This will be presented for consideration and agreement to the Harrow Health and Wellbeing Board following completion of the Better Care Fund quality assurance process.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	**Whole Systems Integrated Care Programme** This is made up of the following elements: • Expansion of the ICP model of care into a local version of the NWL WSIC model **to provide an end-to-end case management service** with the patient and carer at the centre of the care plan • **Care navigation** to provide a single voice to support the service user • **MDT-led care planning** and care delivery in the community • Carers services • Telehealth services through the Health Navigator
2	**Transforming Community Services** This is made up of the following elements which will support improvements in the way people are supported to remain health in the community and avoid hospital admissions: • CCG **community services contract better aligning to primary care** • CCG STARRS **Intermediate Care Service better aligning with community and primary care** • Establishment of a **Single Point of Access** to community services • CCG redesigned pathway for **urgent assessment of mental illness** with a focus on avoiding acute admission and improving support to deliver care in community and home settings
3	**Protecting Social Care** To ensure that the social care provision essential to the delivery of an effective, supportive whole system of care is sustained. • Swift **access and assessment**, either from the acute sector or from a community setting, fully **aligned with integrated teams** wrapped around GP services • **Reablement** at the 'front of house' when people present to social care, • A diverse range of available services for those eligible, purchasable through **'personal budgets'**, • Comprehensive and effective **safeguarding** of vulnerable adults, and diligent quality assurance to ensure services are of a good standard.

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government

Summary of risk	Probab-ility	Severity	Risk Rating (PxS)	Mitigating Actions
Decreasing controllable resource within local authority will result in reduction of non-statutory services which could impact non-elective admission, reablement, hospital discharge performance and a requirement to change FACs eligibility criteria or reduce expenditure on reablement programme	1	5	5	• Harrow Council and CCG have prioritised allocation of available BCF resources to protect adult social care - in place • Harrow Council developed budget strategy to ensure existing FACs eligibility criteria and investment in reablement - in place • Previously established monitoring process at Harrow Council - in place
High level of growth within A&E activity. Harrow's five year plan assumes an annual growth between 1.3-1.4% year on year. This could be further exacerbated through the Shaping a Healthier Future programme with the downgrading of Central Middlesex Hospital A&E and wider transitions across North West London sector.	4	4	**16**	• CCG Harrow has jointly agreed an A&E Remedial Action Plan with local acute provider (LNWHT). A trajectory is included and also agreed by the Trust Development Agency. This looks to achieve 95% performance by Q3 2015/16 – in place • Harrow has invested across health and social care services system resilience funding after plans were signed off by NHS England. Performance of plans are monitored through the Brent and Harrow System Resilience Board – in place • Implementation of primary care transformation programme (in particular establishment of additional walk in centres – in development, planned service growth in Q1 2015/16 • UCC contract includes review points to ensure ability to react to system demand – in place • Roll out of whole systems integrated care programme to reduce likelihood of A&E referral for people with one or more long term condition – Phase 1 in place (ICP), phase 2 in development, planned implementation from April 2015 • Re-commissioning of community services to establish streamlined and more effective single point of access and enhanced – in development, planed go live October 2015
Acute activity reductions and the associated financial cost reductions do not materialise, as emergency admissions continue to rise due to demography and acuity of patient need (Non-elective admission rates in Harrow have	4	4	**16**	• CCG Harrow has jointly agreed an A&E Remedial Action Plan with local acute provider (LNWHT). A trajectory is included and also agreed by the Trust Development Agency. This looks to achieve 95% performance by Q3 2015/16 – in place

increased over the period from September 2010 to March 2014 by 1.7%).				• LHWHT as Harrow's main local acute and community service provider also provides Harrow's intermediate care admission avoidance service, having the ability to react to peaks in service demand – in place • Risk sharing arrangement in place between CCG and LNWHT to mitigate financial impact of STARRS NEL admission avoidance scheme underperformance – in place • Financial risk associated with under-performance of Integrated Care Programme rests with CCG as part of core QIPP Programme – in place • Performance to be monitored monthly and contingency actions put in place if required – in place • CCG Unscheduled Care Workstream involving CCG clinical, management leads and providers to monitor service delivery and react to performance demands – in place • Ambulatory Emergency Care Unit service expansion in place to treat via day case to avoid the need to admit for short stays – in place and expanding throughout 2015/16 • New A&E department operational which will support the management of acute flow to reduce need to admit – in place
Our joint plans do not presently focus on improving clinical outcomes for children; in particular, the incidence of hospital admission for under 16s is too high and length of hospital stay is too long.	2	4	8	• Programme to improve clinical outcomes to be prioritised and presented as part of One Harrow, One Plan submission to Health and Wellbeing Board in March 2015 • Priority area for 2015/16 • UCC commissioned to see all age groups with ability to fast track patients to A&E paediatrics – in place • Implementation of primary care transformation programme (in particular establishment of additional walk in centres – in development, planned service growth in Q1 2015/16
Integrated Care Scheme does not deliver anticipated reductions in Non-elective Admissions in 2015/16	2	3	6	• Scheme based on the established ICP scheme which is performing well against the targeted HRGs – in place • Plan to expand to WSIC model – in development: ○ 6 x Care Navigators to support each of the 6 multi-disciplinary group (MDG) – in place

				○ Health Navigator Education project - Apr 15 ○ MDG6 WSIC ramp up – from Jan 15 ○ MDG6 WSIC model evaluation Apr 15 ○ Phasing of MDG 1-5 WSIC transition from April 15 subject to MDG6 evaluation • CCG Harrow has jointly agreed an A&E Remedial Action Plan with local acute provider (LNWHT). A trajectory is included and also agreed by the Trust Development Agency. This looks to achieve 95% performance by Q3 2015/16 – in place • Ambulatory Emergency Care Unit service expansion in place to treat via day case to avoid the need to admit for short stays – in place and expanding throughout 2015/16 New A&E department operational which will support the management of acute flow to reduce need to admit – in place • Existing STARRS intermediate care admission avoidance service to support reduction in EL admissions – in place
Complexity and scale of community services re-commissioning project leads to procurement delays and failure to implement new operating models within agreed time-scale	2	4	8	• Competitive dialogue procurement process with clear timelines - in place: ○ Issue PQQ – Dec 14 ○ Evaluate PQQ – Jan 15 ○ Invite shortlisted bidders to dialogue - Jan 15 ○ Competitive dialogue – Jan - Mar 15 ○ Issue final; requirement – Apr 15 ○ Bidders final submission – Apr 15 ○ Announcement of preferred bidder – May 15 ○ Sign contract – June 15 ○ TUPE consultation – June - Sept 15 ○ Mobilisation June - Sept 15 ○ Service commencement – Oct 15 • Procurement receiving support from commissioned procurement service in addition to local procurement project manager - in place • Procurement led by 2 CCG Clinical Directors meeting weekly – in place • Procurement reporting into weekly CCG workstream group to

				monitor delivery of timetable – in place
Existing STARRS Intermediate Care Service does not deliver anticipated reduction in non-elective admissions	2	4	8	• Contract review completed to support provider to achieve commissioned targets - completed • CCG Harrow has jointly agreed an A&E Remedial Action Plan with local acute provider (LNWHT). A trajectory is included and also agreed by the Trust Development Agency. This looks to achieve 95% performance by Q3 2015/16 – in place • LHWHT as Harrow's main local acute and community service provider also provides Harrow's intermediate care admission avoidance service, having the ability to react to peaks in service demand – in place • Risk sharing arrangement in place between CCG and LNWHT to mitigate financial impact of STARRS NEL admission avoidance scheme underperformance – in place • Financial risk associated with under-performance of Integrated Care Programme rests with CCG as part of core QIPP Programme – in place • Performance to be monitored monthly and contingency actions put in place if required – in place • CCG Unscheduled Care Workstream involving CCG clinical, management leads and providers to monitor service delivery and react to performance demands – in place • Ambulatory Emergency Care Unit service expansion in place to treat via day case to avoid the need to admit for short stays – in place and expanding throughout 2015/16 New A&E department operational which will support the management of acute flow to reduce need to admit – in place

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

As set out in section 2, there are significant financial challenges in the health and social care economy in Harrow.

In addition, ambitious targets for reducing emergency admissions have been built into the Harrow CCG 3 Year Recovery Plan and the subsequent Operational Plan which has been submitted to NHS England.

Risk share between health and social care commissioners

Both commissioners agree the need for joint working as outlined with the governance arrangements. However, given the current relative financial positions of both organisations, the agreement has been reached that in 2015/16, health will manage the risk in respect of the NEL reduction and Harrow Council will manage the risk relating to protecting social care services.

Risk share between providers and commissioners

Currently the local acute provider (LNWHT) is over-performing against its overall target for non-elective admissions within the borough and as a result a marginal rate of 50% will be levied for each non-elective admission above the agreed threshold in 2015/16.

Within the BCF plan partners have set a target of reducing non elective admissions by 3.5% or 798 NEL admissions during 2015/16. Achieving this target will still result in the total number of NEL admissions being above the agreed threshold.

It is therefore proposed that the existing risk share arrangement between Harrow CCG and LNWHT is utilised for the BCF Plan. The consequence of this is that LNWHT will receive only 50% of the agreed rate for each NEL admission that is not avoided; Harrow CCG, as commissioner will be accountable for the remaining 50% (approximately £745) of the cost of each non elective admission.

Performance against the agreed threshold for non-elective admissions is monitored on an on-going basis by the CCG and the LNWHT and reviewed monthly.

The table below provides an overview of the non-elective admissions which it is anticipated will be reduced through the BCF plan.

No	Scheme	Element	NEL Target
1	Whole Systems Integrated Care		132
2	Transforming Community Services	a) Improved performance of existing STARRS Scheme	300
		b) Ambulatory Emergency Care Unit (AECU)	366
Total			**798**

More information about the specific arrangements for managing this risk within each scheme is presented below.

1: Whole Systems Integrated Care (WSIC):
The new model of WSIC is responsible for saving 132 non-elective admission of the 798 target.

The risk for the delivery of this level of demand management sits with Harrow CCG. However the CCG has developed the service pathway with local service including acute and community services provided by LNWHT. By involving our local acute provider we feel there is increased ability to succeed in the deliver if this increased non-elective avoidance target above the existing baseline.

2a: STARRS Risk Share:
STARRS is responsible for saving 300 non-elective admission of the 798 target.
The risk share in place with LNWHT as the STARRS intermediate care service provider will mitigate an element of this non delivery. Essentially, Harrow CCG is funding LNWHT to avoid a number of non-elective admissions within their own A&E and within the borough of Harrow through developing pathways with Harrow primary and community services

The core principals of the risk share are:

- Covers LNWHT activity, Harrow CCG purchased only
- Risk share will apply to the total contract value for STARRS Harrow
- Risk share will be applied and calculated annually
- This is applied on a sliding scale starting from a minimum requirement of avoided admissions and A&E attendances avoided and takes into account both achievement of demand management calculated via the admission avoidance definition and the level of direct GP referrals.
- There is a 10% threshold set against the annual non-elective and A&E demand management target before the risk share is applied
- If the service does not achieve a minimum demand management target non-elective a fundamental contract review is initiated.

2b: Ambulatory Emergency Care Unit (AECU):
The AECU is responsible for saving 366 non-elective admission of the 798 target.
LNWHT is the provider of this service and is therefore incentivised to delivery appropriate activity to the AECU to avoid non-elective admissions. Non delivery is mitigated through existing contractual rules within the LNWHT contract where AECU activity is not funded if the patient is tracked in SUS data as being admitted. This is expected to be part of the 2015/16 contract for acute services with LNWHT.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

As set out in section 1c there are two areas of change which form a key part of our integrated care strategy but which are not directly funded, or part of it. More information about each of these is presented below.

Reducing reliance on acute services (Shaping a Healthier Future)

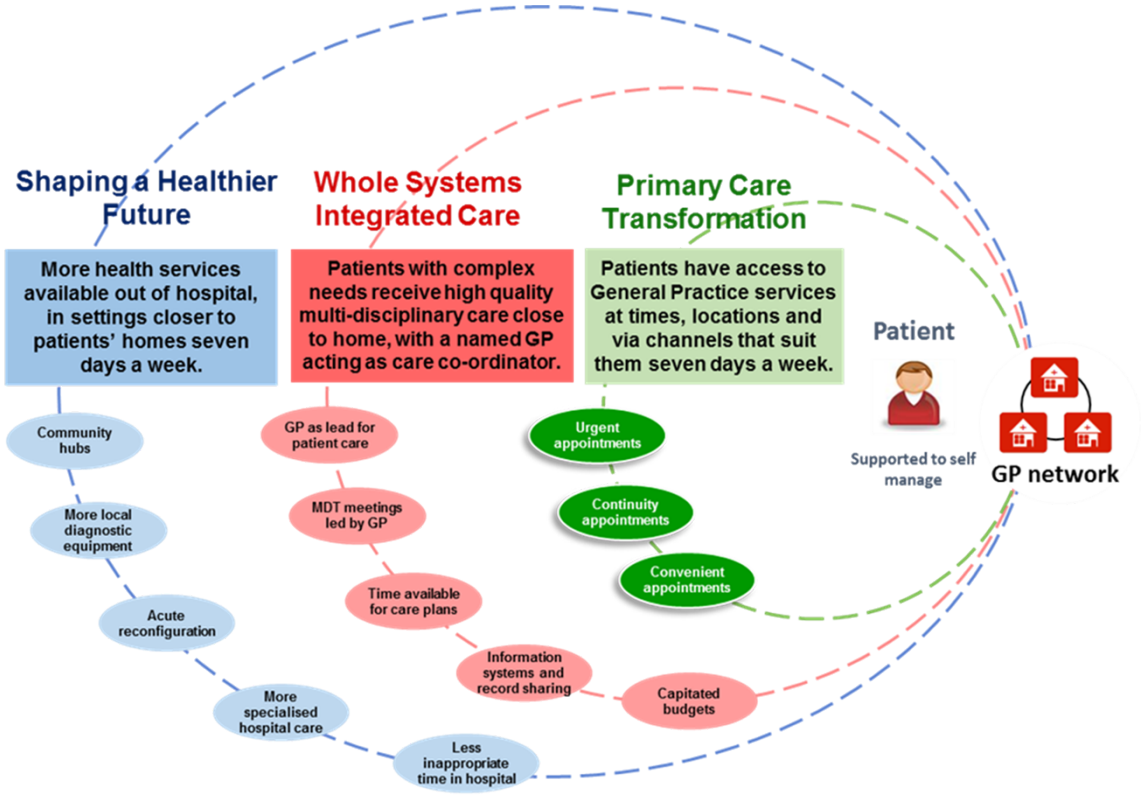
The Shaping a Healthier Future (SaHF) Programme will have progressed considerably by 2018/19. Across North West London a review of existing hospital services has been undertaken and agreement reached by commissioners and providers to reconfigure hospitals differently and to work together to provide those services which can best be provided outside of hospital in the

community in order to:

- Improve clinical outcomes for patients;
- Improve patient and carer experience;
- Release resources to invest in community health and social care services.

For Harrow, this means that the main Northwick Park Hospital will provide A&E and other acute services for a larger proportion of the NW London population from late 2014. It is also anticipated that **by 2018/19, the current projected growth in expenditure on acute services in Harrow will stabilise** and resources invested in community health and social care will have risen.

The diagram below outlines the interdependencies between the reconfiguration or acute services, whole systems integrated care and primary care transformation.



Primary Care Transformation

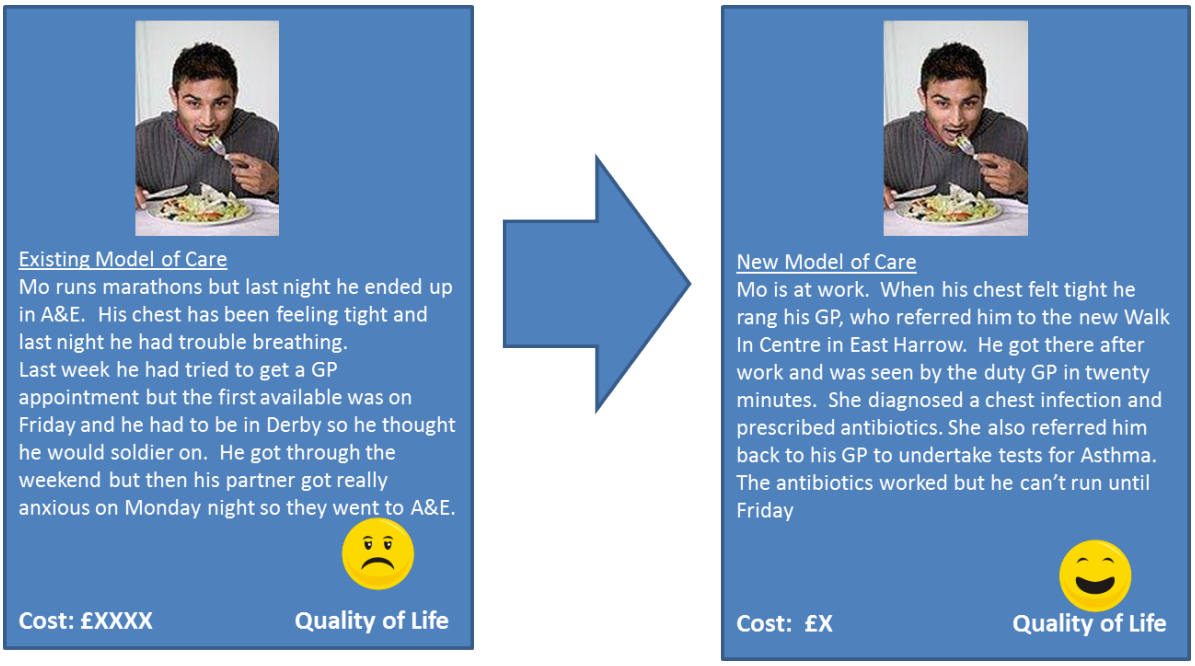
The final element of the transformation in Harrow is the improvements planned for primary care. This work will improve access to GP services and patient satisfaction.

In November 2014, Harrow CCG invited proposals to provide a third Walk In Centre in the East of the Borough to be operational by April 2015. At the same time negotiations are taking place to increase the capacity of the two existing Walk In Centres

In 2015/16 Harrow plans to commission three Walk In Centres open from 8am to 8pm seven days a week, providing a combined total of 36,000 primary care appointments per year. This will be operational by the end of 2015/16, and the GP Federation will be fully operational. At present we a single Walk In Centre delivering services from 8am to 8pm seven days a week and a second Walk In Centre delivering reduced hours. By having this additional capacity in primary

care, we aim to increase access to primary care, reduce pressure on A&E and Urgent Care services and increase customer satisfaction.

As part of the Prime Ministers Challenge Fund, project work is also underway to improve telephone and on-line access to GP services and to increase weekend access to GP surgeries.



Finally, from 2015/16 an additional £1 million per year will be invested in practice based community nursing, primarily to provide case management support to assist with the whole systems integrated project and the Transformation of Community Services

Harrow is also investing in organisational development and training to help GPs undertake the wide range of activities that they are responsible for. In particular, work is underway with GPs to reduce referral rates to acute services, improve the quality of care planning and coordination and to increase the range of specialist services that are provided at GP surgeries. This includes investment in transformational change in Mental Health, which sees care increasingly wrapped around the individual in general practice and identification of their carers

Work is also progressing to establish a single Harrow-wide GP Federation. This will provide greater capacity to improve access and enable the delivery of more specialist services at GP surgery level. Development at this scale will also create an organisation able to take on a different approach to assuring health and wellbeing utilising capitated health budgets to incentivise GPs and other providers to work together better to look after people closer to home, out of hospital and on an on-going and long term basis.

By 2019/20, Harrow will have a more joined up Primary Care Service which is playing a greater role in maximising health outcomes for residents, utilising resources more effectively and reducing pressures on acute services. None of these improvements will be funded with BCF resources.

b) Please describe how your BCF plan of action aligns with existing two-year operating and five-year strategic plans, as well as local government planning documents

The Better Care Fund plan for Harrow **fully aligns** with Harrow CCG's **existing two-year operating plan** (2014/15 – 2015/16) and also with the Harrow CCG five-year strategic plan: **'Everyone Counts – Planning For Patients 2014/15 - 2018/19'**.

Specifically the BCF plan aligns in the following ways.

- The plan aims to improve the proportion of people having a positive experience of care. This will be achieved through the following.
    - **Re-design of whole system case management pathways** to develop care plans with patients and carers to support their health and social care intermediate care pathways.
    - Work underway as part of the Prime Ministers Challenge Trust Fund, this aims to improve experience by consistently offering across Harrow increased access to primary care services.
    - **Aligning of intermediate care services across acute discharge, community services** including social care and admission avoidance, to reduce the need for service users to attend acute settings as more of their conditions and exacerbations can be managed in the community through shared care plans, aligned pathways, increased data sharing and key co-ordinating/navigating roles.

- The plan will affect the rate of emergency admissions through the use of pooled budgets, which will in turn have a positive impact on local acute providers by supporting the management and admission avoidance of ambulatory care-related conditions in the community. Intermediate care and whole system pathways will support both proactive and reactive pathways in the community.

- The intermediate care service will expand to incorporate **both the traditional physical condition management pathways and mental health pathways**, ranging from Improved Access to Psychological Therapies (IAPT) through to dementia programmes.

- The local priority to use telehealth as part of the Health Navigator project to evaluate the benefits of a health coaching model to support patients with a high risk of unplanned admissions in Harrow. The service will be delivered as part of a research study through a randomised controlled trial. Health Navigators as the service provider during this trial will offer Harrow residents 'Active Health Management' packages, consisting of telephone based activities.

The BCF also aligns fully with **the Five Year North West London strategy** which has been agreed by the NWL CCG Confederation which identifies the following priorities:

1. **Health Promotion, Early Diagnosis and Early Intervention**: provide effective prevention and screening programmes, with collaborative working between partners including Public Health teams within Local Authorities, NHS England Direct Commissioners for screening and early years (immunisations), Public Health England, and CCGs.
2. **Out of Hospital strategy, including Primary Care transformation**: strengthen out of hospital service, delivering a greater range of well-resourced services in primary and community settings, reducing demand for acute services.
3. **Whole Systems Integrated Care**: places the person at the centre of their care provision and organises services around them.

4. **Transforming Mental Health services**: developing integrated services, which are responsive, easy to access, navigate, provide care close to home where possible and improving the lives of users and carers.
5. **Shaping a Healthier Future Acute reconfiguration (SaHF)**: reshaping acute and out-of hospital health and care services across the region, to centralise the most specialist services (such as A&E, Maternity, Paediatrics, Emergency and Non-elective care), as this will lead to better clinical outcomes and safer services for patients.

There are no schemes within the Better Care Fund that are not absolutely central to the operating and strategic plans for health and social care in the London Borough of Harrow.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The **eight North West London CCGs submitted a joint bid to pilot co-commissioning of services** with NHS England, **the bid was successful** and it is proposed the pilot will commence in October 2014.

To enable healthcare to be more responsive to patient need the eight CCGs in NW London agreed to pilot co-commissioning as an enabler to achieving their vision of better care for people.

Primary Care Co-commissioning will support the BCF because there will be an alignment between NWL and NHS England's visions for transforming primary care:

- Co-commissioning will enable the **commissioning of whole patient pathways across providers**
- Co-commissioning will help to align incentives across providers and the health system
- Co-commissioning will enable commissioning for GP Federations
- Having a coordinated strategy will help to achieve SaHF goals
- Co-commissioning will enable the **securing of investment needed in primary care**
- Co-commissioning will enable primary care to develop by providing the support it needs.

While the focus of this discussion is largely on general practice, it also recognises the critical role wider primary care services and the third sector can play in a new model of care.

In a number of areas, co-commissioning could allow specific changes enabling the achievement of NW London's vision. Co-commissioning will support the BCF in helping general practice to secure the right level of investment, providing greater flexibility to innovate, and supporting practices to improve quality of care and achieve better outcomes for patients.

Plans for co-commissioning have been discussed with Harrow CCG Clinical Directors and with all 35 local providers through monthly GP Forums and their representative body, the London wide Local Medical Committee. This has been an outgoing process, which started in September 2013 as part of the CCG's commissioning intentions to enhance integrated care services.

While stakeholders are in support of the principles of co-commissioning and understand the advantages of this, GPs are reluctant to assume the role of performance managing colleagues. The NW London proposals has identified that performance management will

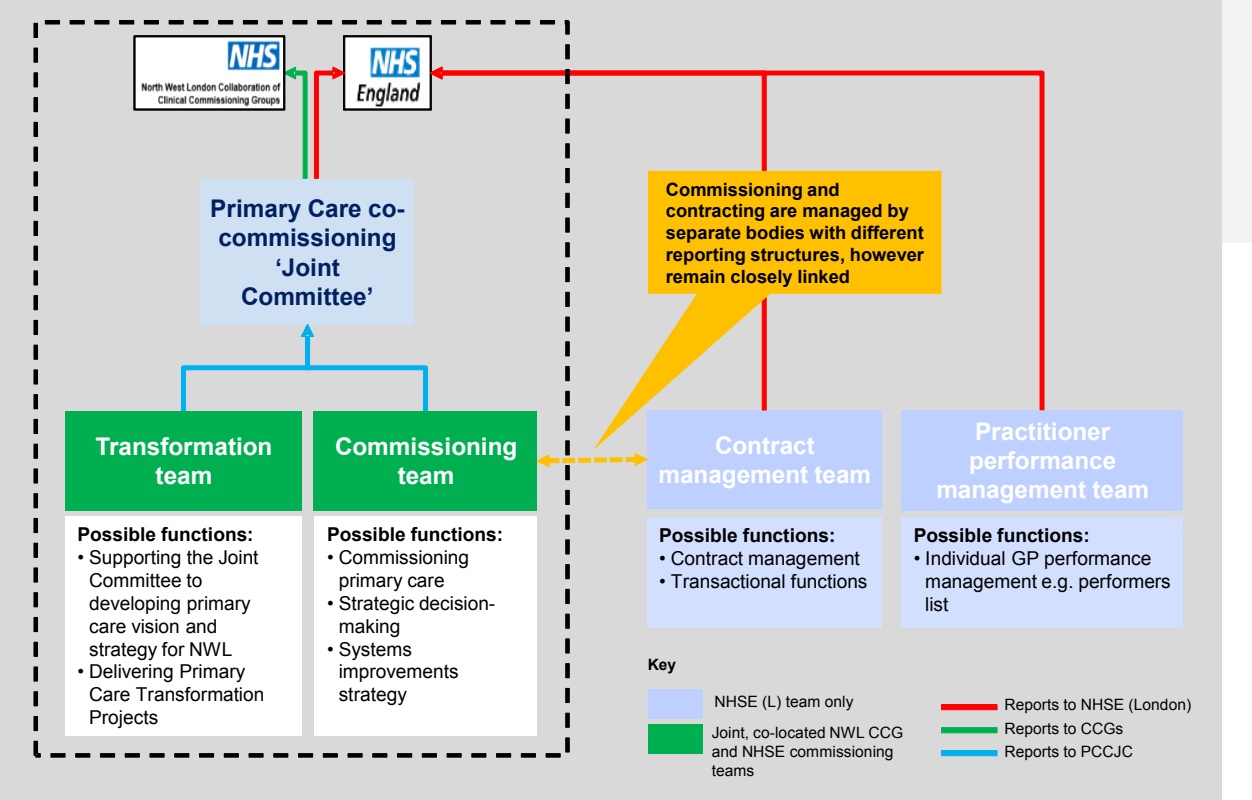
remain with NHS England.

Work is also progressing to develop an '**Enhanced GP Service'** through '**Transforming Primary Care**'. The following enhanced, or Local Improvement Scheme (LIS) aims to ensure that local providers are providing care locally.

- **Dementia management** – management of patient care in the community supported by Tier two clinicians. Co-ordinated management of patient care between providers;
- **Out of Hospital LIS** – management of endometriosis within community;
- **Safeguarding adults and children** – co-ordinated support for families and joint working across sector to protect vulnerable patients.

The early thoughts to primary care co-commissioning are shown in the diagram below:

Early designs: NWL & NHS E Joint Committee



The suggested timelines for this process is:

- September – October 2014: All the GPs in NWL will be asked to make a decision to formally support Primary Care Co-commissioning plans (agreed)
- October – November 2014: Based on feedback from GPs, the NWL CCGs will agree on shadow Primary Care Co-commissioning arrangements (agreed)
- November 2014: The Primary Care Co-Commissioning joint Committee will be established in shadow form to test out plans (agreed)
- April 2015: Based on lessons learned in the shadow phase, Primary Care Co-

commissioning joint Committee will be formally established

Key risks

- The demands on primary care to provide greater access, improved pro-active management of patient care has resulted in a constraint on time available for innovation. This could impact the BCF as primary care providers do not engage with the programme as it is not part of their core contract. This is mitigated through the development of the existing integrated care programme which supports primary care involvement above existing core contracts, engages with patients and carers to develop care plans which in turn will lead to greater MDT involvement in the co-ordination and delivery of these plans resulting in fewer non-elective admissions. The BCF provides an opportunity for practices to improve services for patients and as a result a commitment to deliver this agenda is paramount.

- The potential risk that Harrow has considered is the potential conflict of interest that could arise from the CCG co-commissioning primary care services locally. To mitigate this risk Harrow CCG has implemented a procurement panel with a non-conflicted membership with the remit of reviewing proposals, business cases and recommending to the CCG Governing Body key decisions where conflicts arise. This process has been tested throughout 2014 across wider CCG business areas.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

There are six key elements to protecting social care in Harrow

1. **Safeguarding.** A key priority for all health and social care partners in Harrow is an effective approach to safeguarding. Harrow has a well developed joint approach to safeguarding, and the planned joint working and allocation of resources will ensure that this continues to be a focus
2. **Personalisation and Choice**. This is a core principle for social care in Harrow. Harrow is a national leader in personalisation, the utilisation of personal budgets, and the use of technology to support them (MyCommunity e-purse). Maintaining and developing this approach further is at the core of our joint work to protect adult social care services
3. **Supporting people with eligible levels of need**. Partners in Harrow are at present committed to maintaining the existing FACS-defined levels of eligibility. In April 2015, this will be replaced by the Care Act national eligibility framework, and the requirement to meet 'substantial' levels of need will be nationally prescribed.
4. **Responsive Assessment and Advice Services.** In Harrow the number of social care contacts has increased significantly in recent years as our population has aged and levels of need have increased. All partners remain committed to providing timely and high quality advice and information for all and assessment and support where required. With the implementation of the Care Act, we anticipate demand to increase further in 2015/16. BCF resource will contribute towards supporting this demand.

5. **Reablement.** Harrow provides one of the most effective and high performing reablement services in London, and this plays a significant part in ensuring effective hospital discharge processes and in maximizing the percentage of people at home 91 days after a hospital stay. Protecting this service remains a key priority for Harrow.
6. **Carers Support**. Set out in section 7a) v) below is the extensive joint work underway to support carers, partly funded by the BCF.

Preventative investment is also a key priority for Harrow. Under the Care Act the local authority will have a duty to provide a range of preventative services.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Under the leadership of the Health and Wellbeing Board, the partners in the Harrow local health economy are committed to the integration of community service delivery through Whole Systems work. This work to 'meld' and better coordinate a range of community interventions will help to ensure that the statutory duty of the local authority can be met in the context of increasingly challenging financial circumstances. This Whole System work will be part-funded by the BCF, and will be the driver of this integration.

By focusing on three principal schemes

- Protecting social care
- Whole Systems Integrated Care
- Transformation of Community Services

we anticipate that we can maximise the likelihood of Annie, Nigel and Mo living happily and safely at home with limited long term support from health or social care partners.

£5,411,000 of BCF Funding has been allocated towards the protection of social care in 2015/16. Without this funding it would not have been possible to maintain substantial and critical FACs eligibility criteria, or to continue to operate the very successful Harrow Reablement Programme

In particular, we think that by focussing on people with one or more long term condition through our whole systems integrated care approach we can reduce demand and expenditure on acute services. We can use the resources saved to invest in more community services and further protection of social care.

Finally, through our reconfiguration of community services we will

- Reduce duplication and referrals
- Improve the effectiveness of the hospital discharge process, and
- Reduce the likelihood of hospital admission

And these resources will be used to invest more in community based services and protecting social care.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£5,411,000 of BCF Funding has been allocated towards the protection of social care in 2015/16. This includes the following funding streams:

- NHS funding transfer to local authorities for social care (S256) - **£4.445m**
- Care Act Duties Funding - **£0.545m**
- Additional funding towards the protection of social care services **- £0.421m**

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Work is presently underway to fully quantify the effect of the Care Act reforms upon Adult Social Care services in Harrow. Even so, **good progress is being made to ensure that the local authority is able to fulfil its statutory responsibilities** and this represents one of the key projects that make up the wider Health and Social Care Transformation Programme.

Set out below are the key changes we are working to deliver.

April 2015

- Number of assessments required will increase due to
  - Introduction of national eligibility criteria
  - requirement to assess all carers, including those who do not care for FACS eligible service users, and
  - potential commencement of requirement to support/assessment of self-funders;
- Adult safeguarding becomes a statutory responsibility;
- Universal deferred payments agreement applies;
- Local authority assumes responsibility for a range of other 'duties', e.g. for Information, Advice and Advocacy, prevention and wellbeing, etc.

April 2016 – subject to further legislation

- Charging threshold for social care increases from £23,500 - £118,000. Many more people will be eligible for funding support;
- Care Accounts for all eligible users
- Capped charging to commence

Preparation is well underway to meet these challenges, and the local authority is engaged in work streams both within Harrow, and also in the London and national contexts.

Financial modelling of the impacts of the Care Act **conservatively estimates a shortfall in resource for estimated costs in 2015/16 of around £3.4 million**. The resource due to Adult Social Care through the BCF will be crucial in supporting these challenges, and beyond that the service reconfiguration efficiencies of the 'whole systems' transformational work will be essential if the delivery of social services are to remain viable.

In Harrow, the £545k committed to the authority to fulfil Care Act duties will supplement the following lines of activity.

- The implementation of a new multi-agency commissioning strategy for Carers. At the centre of this is a Carers' Hub, which will be procured from an independent provider. The hub will be a 'one-stop' shop to which carers will be signposted by NHS, social care and associated services, and from which they will receive information, advice and guidance, and be able to access support.

- The procurement of a single advocacy service for eligible people in the borough, which is being specified following the consolidation of a range of specialist and generalist advocacy functions. The resource for the IMCA (Independent Mental Health Advocacy) service been combined with the Care Act advocacy resource.
- The purchasing capacity to mitigate the anticipated increase in demand that will be the inevitable consequence of the Care Act duties.
- The formalisation of the statutory Safeguarding Board in Harrow
- The development of deferred payment mechanisms
- The development of provider quality profiles

Work on all of these lines of activity is well underway as part of Harrow Council's preparation for the Care Act.

v) Please specify the level of resource that will be dedicated to carer-specific support

Providing support for carers is a key element of protecting social care, transforming community services and implementing whole systems integrated care in Harrow and as a consequence over £800,000 per year is invested in providing support, including £505,000 from the Better Care Fund Plan schemes.

A multi-agency commissioning strategy for carers is at present under development. It will be complete by the end of 2014. This strategy is being developed with the involvement of the local authority, the CCG, representatives from Harrow carer organisations and the voluntary sector.

The strategy considers the fundamental challenges for the social care and health economy posed by the additional duties of the Care Act, as reflected above. The specific carer-orientated elements of the BCF will be determined through this strategy.

Subject to the ratification of the contributing organisations, this strategy will propose a range of initiatives that will enable carers in Harrow to seek the support that they need in a manner appropriate and proportionate to their needs. For example, the majority of carers solely need information and advice, and the strategy proposes easily accessible ways of doing this.

The following elements are proposed for prioritisation.

- A jointly commissioned 'one-stop' carers support hub for Harrow.
- Better identification of carers by GPs and other professionals, and better 'signposting' for those identified
- Better support for carer families and young carers
- Improved mechanisms for the use of Personal Budgets for carers.
- Better engagement of carers in future planning

This strategy will build upon some of the excellent work that has happened in recent years to support carers in the borough. Following the development of the Joint Carers Plan in 2012 Harrow CCG and Harrow Council funded a number of services in line with national priorities:

- Identification and recognition
- Realising and releasing potential
- A life outside of caring
- Supporting carers to stay healthy

These services included the following.

Service	Current Use
2014/15 CCG Local Improvement Scheme (LIS)	The aim of the LIS is to encourage GP practices to take a pro-active approach to the registration and management of patients who are carers.
AASH - Carers of ADHD/Autism Nurturing Project	This project supports the carer's life outside the group by taking a holistic approach towards mental and physical good health. The autism awareness and coping strategies delivered by the psychotherapist should have an impact on the participant's life outside the group, reducing stress and the risk of family breakdown. AASH have arranged a similar group for adults with autism which will run in parallel to the carers group.
Harrow Carers - Carers Training programme	The Carers Training Programme raises awareness with people from BME and seldom heard communities who support a vulnerable person and who may not be aware of the support available to them. It raises awareness and understanding of conditions and legislation
Harrow Carers - Carers Respite & Support	This outreach service works in partnership with GPs, hospitals, community health teams, employers and social workers to form connections with carers requiring support under criteria of the project; the service targets those who are isolated and/or housebound.
Harrow Carers – Positive Psychology	http://www.carershub.org/content/positive-psychology-and-practical-education-mental-health-carers-further-details This service has 2 aspects (1) to provide carers with skills to enable them to cope better with their caring roles and (2) psycho-educational training which is designed to educate carers about specific mental illnesses. This service has been hugely successful and has also won the Innovation Award from the British Association of Counselling and Psychotherapy (BACP).
Age UK - Carers Support Project	The aim of the project is to improve the wellbeing of carers over 60 by enabling carers to take time out of their caring role. This service is designed to give short term support to carers to build up confidence to make new friends and become more involved in their local community.
Mencap - Advocacy and Peer Support for Carers in Harrow	The project is to train Carers as peer advocates and Carers in digital media so they are less cut off and have more say in the issues that affect Carers lives.

There is a significant risk that additional demand from carers upon the local authority as a product of the imposition of Care Act duties in 2015/16 will put additional pressure on the delivery of Adult Social Care.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The financial challenge faced by the local authority has developed since the agreement of the initial BCF document in early April.

Subsequent to the submission of the first BCF the local authority has initiated a further three-year savings programme. **This requires further reductions of £75 million for the authority**

over the next four financial years, which represents a 53% of the controllable budget. Social care services are required to deliver a significant element of this budget reduction and consequently proposals are being prepared to **reduce the LB Harrow social care net budget by £6.1 million in 2015/16 and 2016/17**, and by a total of £25 million by 2018/19. The release of the chancellor's Autumn Statement did nothing to improve the financial outlook.

These unprecedented challenges pose major questions of service sustainability in upcoming years, particularly if the CCG planned QIPP savings mean that efficiencies from the acute providers transferred into the community are not able to further protect social care services until at least after 2018/19.

b) Seven day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Harrow, as part of North West London was selected from amongst 70 applicants as one of 13 Early Adopter sites to progress the seven day services agenda at scale and pace. The seven day services agenda is entirely consistent with the vision of the *Shaping a Healthier Future* programme, and work is already underway across NWL to progress it. It is estimated that around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week (Pan London study, 2011).

We have engaged with a wide variety of stakeholders to get agreement and commitment to the seven day plan. A number of engagement events have been held, which have covered the scoping and agreement of plans for seven day working:

- Co-design working sessions held for Whole System Integrated Care in April and May 2014. These sessions included patients, the Local Authority, GPs, Acute provider
- Primary Care sessions through month GP Forums and weekly project group supporting the implementation of a Harrow wide GP Network with support from the National Prime Ministers Challenge Fund.
- Series of workshops with North West London Hospital Trust regarding their transition to wider use of seven day services
- North West London Sector wide sessions delivered through the Strategy and Transformation Team to share development plans, ideas and best practice

The intention is to **implement the national standards for seven day services in urgent and emergency care NHS-wide over the next three years.** To support the movement to seven day services, Harrow will align existing programmes, including Whole System Integrated Care, the Better Care Fund and existing services, to achieve the national seven day standards in time.

We have developed a programme across three years to **embed seven day services into core contracts for services.**

The intention is for all of the clinical standards to be incorporated into the national quality requirements section of the NHS Standard Contract for Harrow's provider services. To facilitate implementation we have prioritised the national targets and will phase implementation starting with the following:

- Time to first consultant review

- Diagnostics
- Transfer to community, primary and social care
- Multi-disciplinary review and on-going review
- Interventions / key services

Across each setting of care we will deliver the quality standards, firstly within the Service Development and Improvement Plan section of the National Contract followed by the National Quality Requirements, as set out in the following table:

	2014/15	2015/16	2016/17
Acute NWLHT	• CQUIN to support seven day working i.e. • Improve Consultant cover to meet 12 days • Implementation of in-patient consultant review (six days week) • Multi-disciplinary Working seven days week • Review of weekend discharge processes to support seven day working	• Providers working to stretched CQUIN and SDPs after 2014/15 CQUINS embedded in core contract and quality schedule	• Providers working to national seven day standards as part of core quality schedule
Mental Health CNWL (CCG)	• CQUIN to support extension of working hours	• Seven day working to be embedded in core contract and quality schedule	• Providers working to national seven day standards as part of core quality schedule
Community Ealing ICO/STARRS (NWLHT)	• Community beds seven days a week – plan to widen admission hours over 24 hours		
Social Care – Harrow Council	• New packages and restarts across five days • Assessment and brokerage across five days • 24/7 Emergency Duty Service • 7 day Approved Mental Health Professional (AMHP) service		
Primary Care Services • *35 Practices* • *GP Network* • *Walk in*	• Seven day working in place • Core practice hours, extended hours, UCC 24/7 • Out of hours provision • To be further enhanced through GP network and WSIC Programme		

Further detail is provided below:

- **Acute and Mental Health:** CQUINS will be used in improving consultant cover, inpatient review, multi-disciplinary work and review of weekend discharge processes. In Mental Health Psychiatric Liaison is available seven days a week, 24 hours a day in emergency departments in all eight main acute sites.

- **Urgent Care Centres:** hours of operation are being lengthened. Harrow already has a 24/7 commissioned service co-located with local A&E service.

- **Delayed Transfers of Care:** these are supported through the recent movement to seven day acute therapy services.

- **Primary Care:** Work underway towards improved access and efficiency outcomes facilitated by implementation of GP networks, building on the existing peer group arrangements. This will facilitate collaborative models of care as well as extending opening hours. This will be established by December 2014 and fully operational by April 2015.

- **Pharmacies:** Harrow has a number of pharmacies that are open seven days and extended hours. These are integral to our wider plans to transition to a whole system model and supporting patients to access appropriate services out of hospital at a time that is convenient to them.

- **Community**: as part of the vertical integration of North West London Hospitals Trust and Ealing ICO a new integrated community health model will be deliver integrated community services including nursing, specialist nursing, equipment and rehabilitation beds seven days a week and aligned to primary care, admission avoidance and ambulatory services within NWLHT.

- **Social care:** social work and OT teams will continue to operate seven days per week through the Emergency Duty Teams to support care planning for transfer home and a seven day AMPHS services for Mental Health services.

- **Other initiatives:** telehealth is currently commissioned through the integrated care pilot, which aligns to admission avoidance within the STARRS service. This is under review to understand the impact, and if there is potential to extend as part of future service development. The national NHS111 service specification is under review by NHS England and once agreed there is an intention to enter a procurement for a North West London wider procurement to offer additional efficiencies i.e. direct booking into services and enhanced levels of clinical triage.

<u>Key risks</u>
The key risk associated with delivery of seven day services will be implementation of the clinical standards for 7DS by acute providers, acceptability of 7DS amongst staff and population demographics related to acuity.

In addition there is a risk that the lack of additional funding will mean that resources for core services are stretched over the extended access time.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Harrow recognises the need to share both data and information appropriately across a broad range of health and social care service areas in order to provide the greatest possible benefit to our local community, our staff and our healthcare colleagues. Our basic principles of information sharing are to:

- Provide each other with the information to help promote each other's objectives as necessary within the agreed information sharing protocols;

- Integrate engagement activities wherever possible, so as to ensure a coordinated and joined-up approach to involving Harrow residents in service design/re-design and decision making. In short, in decisions that directly affects them.

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

An integrated IT project is being developed as part of the WSIC programme, which will support all health providers to input directly onto GP web-based systems.

Existing social care systems already allow the entry of the NHS number. The number will be adopted 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.

The national Health and Social Care Information Centre offers a secure Migration Analysis Cleansing Service (MACS) to bulk trace NHS numbers for social care users whose details are logged on the council's Frameworki system. As a first stage Harrow Council intends to use this in the short term, to ensure that swift progress is made towards universal use of the NHS number as the primary identifier by end March 2015.

Later in 2015/16, it is intended that the council becomes connected via the NHS N3 network, and from there is able to securely source information through the Patient Demographics Service (PDS), which will ensure that in the future the NHS number will be used as a matter of course.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The interoperability of Harrow systems is a crucial enabler to achieving the BCF plan and its schemes, in particular those around Whole Systems Integrated Care. In Harrow, plans are underway to

- Ensure that the relevant data sharing agreements are in place;
- Adopt relevant programming and interoperability standards;
- A project has been scoped to deliver a shared data warehouse for WSIC.

Following extensive advice with a third party expert law firm, as part of the WSIC Early Adopter Project, **data sharing agreements are being put in place** between the Local Authority, the CCG, GP Practices and other relevant third parties, to support the ability to extract, transform and combine data from source health and social care systems. It is anticipated that this will be

complete by March 2015.

In Harrow, there is a commitment to adopting systems based upon Open APIs, Open Standards and other standards relevant to robust ICT infrastructure:

- All Harrow GP practices have now agreed to use 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
- Primary Care also uses industry standard, secure methods of data transfer and information exchange, including Docman EDT and The Medical Interoperability Gateway
- The user interface, application and realisation layer of the new data warehouse will use standards that promote appropriate access for those providing and commissioning care; these will be documented and published
- Harrow already conforms to the secure email standards through use of the PSN connection. A project will examine the new national secure e-mail standards (due to be released in January 2015) to ensure compliance.
- Secure systems for communicating between social care and health (including NHS Mail and gcsx and cjsm mail) are used where required
- The Local Authority and CCG, via their contracted ICT providers, have formal processes for signing off the design of new systems
- Where appropriate decisions are reviewed by the CCG Informatics Project Group, which is led by a CCG Board member.

Good intelligence is critical to enabling and delivering whole systems integrated care. In support of this a project has been mobilised to create a **North West London data warehouse**. This project is been led by McKinsey and the next phase of the project is ongoing.

The data warehouse will:

- aggregate data from different sources into a consistent format
- have the NHS number as the primary identifier for care records
- provide one view over the whole systems of health and social care
- share information between individuals providing care, to improve delivery to service users
- allow queries and analyses to take place across multiple, separate systems
- improve data quality by identifying gaps or inconsistent records
- be available 24/7/365.

Overall, this will support collaborative working between different organisations, facilitate improved flow of information about patients and eliminate duplication, all without the need for costly replacement of existing legacy systems.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

There is a firm commitment to ensuring that appropriate IG controls are in place.

In Harrow, we acknowledge and support the findings of the Caldicott 2 review and the inclusion of the new seventh principle: that the duty to share information can be as important as the duty to protect patient confidentiality. This is especially important when implementing new Whole System models of care delivery.

The partners to the Harrow BCF (acute/community health providers, the local authority and the CCG) are actively committed to their compliance with the 26 recommendations emanating from the report. The key areas which require new protocols and information systems to support them are common to all UK NHS organisations and local authorities, and Harrow partners are forward-thinking in the approach to resolve them.

Within the commissioning organisations, there are Information Governance policies and procedures in place, and these have been reviewed and updated within the last 12 months. IG training is mandatory for all staff and those staff handling sensitive information and data are required to complete the relevant advanced training in information governance.

Since April 2014, all contracts are based on either the NHS Standard Contract or the Local Authority contract standing orders. These contain clauses relating to information governance.

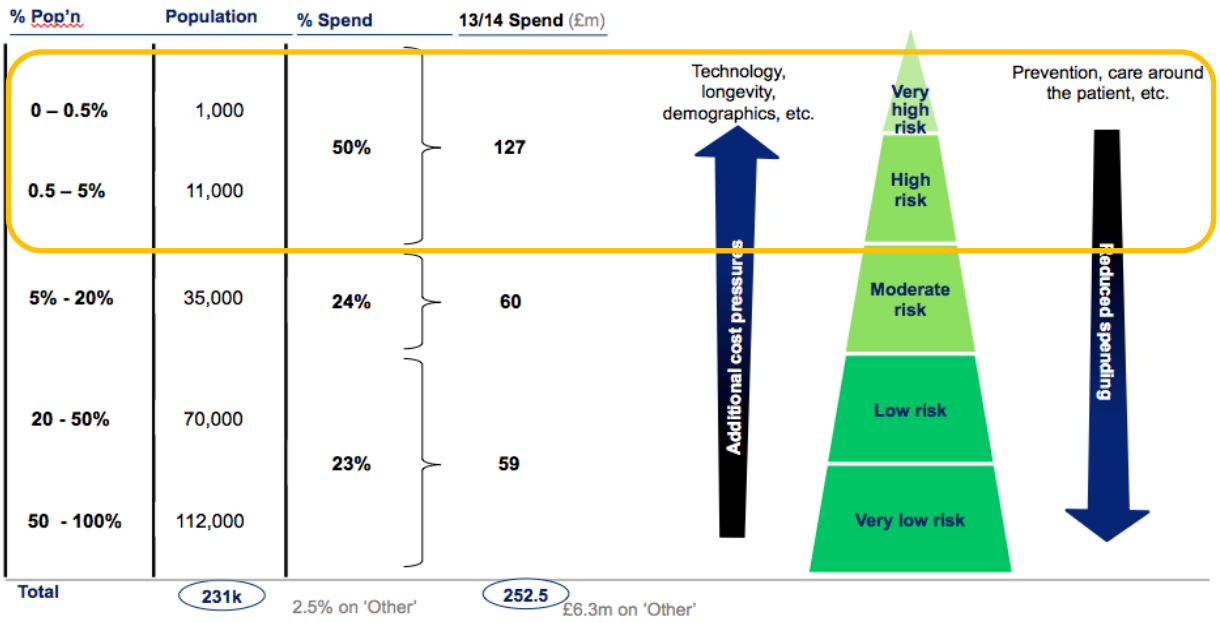
The participants in the health and social care economy in Harrow are committed to maintaining five rules in health and social care to ensure that patient and service user confidentiality is maintained. The rules are:

- 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 and systems in place to ensure the confidentiality rules are followed.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The following diagram specifies the proportion of the adult population in Harrow that has been identified as high risk of hospital admission:



SOURCE: NWL Whole Systems Integrated Care programme; local team analysis

Sixteen thousand people in Harrow are classed as at high risk across all age groups. This represents 6.25% of the total GP registered population (256,000) and **7.8%** of the total adult population.

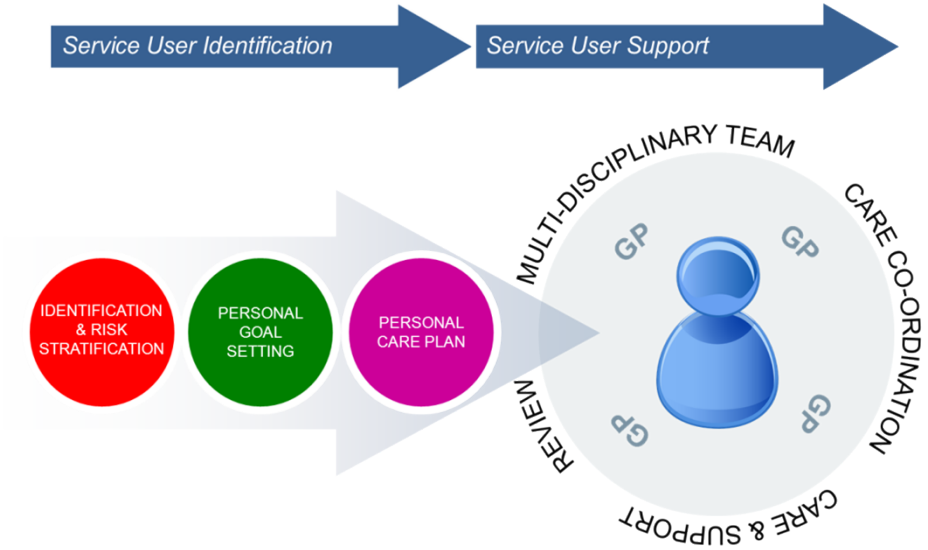
Analysis undertaken as part of the WSIC project and presented in section 3 of the Plan indicates that people over 75 with one or more long term condition, and people with dementia are most at risk of hospital admission.

Risk stratification work utilising the BIRT 2 risk stratification tool undertaken as part of the Harrow Integrated Care Programme (ICP) has qualified these 'broad brush' assumptions.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

In Harrow a WSIC Care Model has been developed and put in place to assess risk, plan care and allocate a lead professional for patients and service users that are at high risk of hospital admission. This process was undertaken utilising co-production as part of the Integrated Care early Adopter Project.

The diagram below provides an overview of the model.



In 2015/16 the Harrow WSIC Programme will focus on over 75s with one or more long term condition.

Identification and risk stratification

In order to identify patients potentially at risk of hospital admission an initial risk assessment is undertaken using the BIRT 2 risk stratification platform. This information is then provided to a patient's lead GP for review.

Lead professional

For all service users/patients that are identified as at risk of hospital admission their named GP will be identified as the lead professional. Since July 2014, GPs have been supported in providing care coordination by six Care Coordinators.

Personal Goal Setting and Care plan

The named GP will meet with the service user/patient to develop and agree a care plan. To assist with this process, service users will be encouraged to set **personal quality of life goals** such as: 'I want to live at home' or 'I want to visit my grandchildren every week'. At the same time their GP will undertake a supplementary risk assessment in order to identify the likely level of medical need the service user has, and in parallel a social care assessment will be undertaken. All of this information will be used to develop and agree a **personalised care plan**. The panel below provides an overview of the information which is recorded within the care plan.

- The patient;
- Their health, lifestyle, environment and support;
- Assessment of risk and barriers to good health and independent living and contingency plans;
- The persons' social care and clinical history;
- Feedback on the most recent tests, assessments, medication and services already provided;
- Their goals and what they want to achieve next;
- Health, mental health and social care needs to achieve these goals;
- Daily living advice and dedicated section for self-care for the person and their carer;
- Notes for the person and carer on how to act in certain situations and when to seek further help and who to contact in the case of change of circumstance or condition (anticipatory care planning);
- Details of who the care co-ordinator, named GP and other providers are who care for the person;
- Providers who will provide agreed health and social care services, e.g. secondary, community, primary or third sector providers.

Delivering the Care Plan

Once the Care Plan has been agreed, the service user will receive support from a **multi-disciplinary team,** which will be based near the service user's home. This multi-disciplinary team, which will be made up of a range of carers, nurses and other health and social care professionals, as well as informal carers and contributors from the third sector, will be responsible over the long term for supporting the service user to meet their personal goals, stay healthy and stay out of hospital. The exact configuration and scale of these teams will be developed as the plan progresses to ensure that they operate with optimum efficiency and maintain the necessary professional and organisational networks/links.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Based on November 2014 data Harrow currently had **3,846** live care plans of which c70% of this number are aged over the age of 75 years.

This represents approximately 255 of the population at high or very high risk of hospital admission.

This shows an improvement from our previous BCF submission where 1,282 high risk individuals has a care plan in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Harrow CCG and Harrow Council have a strong commitment and track record in patient, public and service user engagement and this is reflected in **user/patient/community engagement** being identified as one of the Guiding Principles to inform **One Harrow, One Plan**.

Effective engagement has been key to the development of the Better Care Fund Plan so far.

Health and Social Care Integration Summit

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 organisations; 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 Harrow 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 seven day working.

Key conclusions from the summit include service users and patients want:

1. Better access to care when it suits them
2. Self-care and self-management
3. Minimal handovers, which happen effectively and avoid loss of information
4. To avoid having to repeat their story to multiple providers
5. Support to set meaningful goals and care which is designed to help them meet their needs
6. A system where the constituent parts communicate effectively with each other
7. Information that is easily accessible
8. Care plans which are up to date and that they have control over
9. Unpaid and family carers to feel more empowered and able to provide day-to-day care.

Co-production – Whole Systems Integrated Care Early Adopter Project

Between April and May 2014, Harrow Council and Harrow CCG undertook a large scale co-production exercise to develop the Outline Plan for the implementation of WSIC in Harrow. The

Harrow WSIC Early Adopter Project is part if the wider NWL Integrated Care Pioneer Project. WSIC is one of the three priority schemes to deliver the BCF.

Key to the success of the co-production process was agreeing the following shared principles**.**

We are committed to our shared principles for co-production in the programme

1. Co-production for the Whole Systems programme starts with co-design, through which we can then embed co-delivery. This is the core of our programme and is embedded throughout the whole process.
2. We are dealing with new relationships for which we need a new language of inclusion: we will avoid "consultation" and aim at all times to have "conversations" for a genuine partnership.
3. We are people driven: we will actively reach out to those individuals whose voice is rarely heard.
4. We are all responsible for driving progress and educating each other along the way.
5. We recognise the political and social context in which the programme sits.

Key strengths of this approach include:

- Over 120 different stakeholders have been involved in developing Harrow's plans for Integrated Care;
- Patients, service users, carers and frontline staff have provided valuable insight and experience of existing arrangements Harrow-wide and this has been crucial in applying research, concepts and theories set out in the toolkit into the local Harrow-wide environment;
- Colleagues from the third sector, providers and commissioning organisations have played key role in adding value and insight;
- Lay partners have been involved in the working group sessions and Steering Group.

The diagram below provides an overview of the topics covered as part of the co-production process

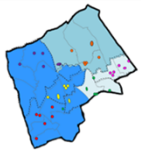
Workshop 1 – Co-Design & Vision

- Agreed to utilise co-production to inform development of the Early Enabler Project
- Agreed to focus on developing a vision based around a service user

Workshop 3 – Population Group

- Agreed to focus on population group consisting of older people with one or more long term condition

Workshop 4 – Model of Care (2)



- Agreed to establish multi-disciplinary teams at a locality level

Workshop 4 – Outcomes

- Agreed that quality of life and quality of care outcomes should key focus of model
- Identified Outcome Stars an effective way of measuring personal outcomes

Workshop 5 – Model playback and costing

- Considered whole systems model
- Begun thinking about costing new model of care

Out of the co-production process came a number of important outputs including the Harrow WSIC model of care and a clear conclusion that work should focus on user outcomes and not on organisational changes as shown in the table below.

Outcome Domain	Highlighted priorities for the new model of care
Quality of life	• People are supported to set meaningful quality of life goals and their care is designed to help them meet these goals • People feel better able to self-care and self-manage • Involvement in decisions and respect for preferences • Support for social engagement in the community
Quality of care	• Un-paid and family carers feel more empowered and able to provide day to day care • Percentage of people reporting a good level of insight into their care plan • Percentage of people who feel that information is easily accessible • Percentage of people who feel that the whole system is communicating effectively with all elements of the system • Percentage of carers offered care assessments
Operational indicators	• Continuity of care - % of service users who have a named GP or care professional • Continuity of care - % of service users with a named care co-ordinator • Care is provided in a timely manner • Maintained and up to date care plans • Handovers happen effectively and avoid loss of information – perception of people that they do not have to repeat their story to multiple providers
Professional indicators	• Professionals are satisfied with their experience in the work place • Training is provided and well attended by professionals
Financial sustainability	• Harrow requires an outcome that delivers a more cost effective service to the population

Following further review of the identified outcomes at the final working group session the following were identified, in priority order, as being most important:

1. People are supported to set meaningful quality of life goals and their care is designed to help them meet these;

2. People feel better able to self-care and self-manage;

3. Percentage of people who feel that the whole system is communicating effectively with all elements of the system (care is joined up).

WSIC Coffee Mornings

Following agreement of the WSIC Outline Plan in July 2014, Harrow Health and Social Care commissioners invited local residents and voluntary service groups to a coffee morning in November 2014 to test the developing model of care in addition to understanding the views on existing service provision and future service developments.

The main themes that have been built into the 2015/16 WSIC model is the need to not only have a team to design and review the care plan with the patient and carers (the existing service), but to have a dedicated team of health and social care professionals to deliver the day to day care plan alongside the care navigator and the lead professional. This dedicated team is a new element. The Q4 2014/15 Multi-Disciplinary Group 6 transition to the WSIC model will take this suggestion and design a team to be included within the existing ICP team.

We are designing this with or local acute and community provider LNWHT to support the staffing of the model pre evaluation.

Harrow CCG Patient Participation Network

With support from the CCG, the 35 Harrow GP Practices have developed **Practice Patient Participation Groups**. These groups focus on sharing developmental opportunities and passing patient views to the practice to support continuing service development. Each group has a dedicated volunteer lead who is a registered Harrow patient to each GP Practice. These leads meet as **a Patient Participation Network (PPN).**

Harrow CCG meets regularly with the PPN with the aim of understanding their views and experience of commissioned services. The CCG uses this time to test ideas with the PPN. The CCG tested the idea of a new dedicated team to support the delivery of the day to day management of the care plans as part of the WSIC developing programme. This was endorsed by the PPN.

CCG consultation on Commissioning Intentions

Following submission of the first iteration of the Better Care Fund Plan Harrow CCG undertook a further programme of consultation with patients, service users and the public to inform the development of its 2015/16 Commissioning Intentions. This included facilitating a Commissioning Intentions Summit attended by over 30 stakeholders. This was advertised through our website, Twitter, communications through the CCG's Equalities and Engagement Sub Committee and through Harrow's Voluntary Services Forum and Practice Participation Network. There were stalls laid out for each area within our intentions and members of the CCG

team available throughout the event to receive feedback. Public Health information was tabled only. The received comments helped shape the CCGs intentions for 2015/16 where the on-going commissioning of community and whole systems integrated care services are an essential part of the CCG's delivery plan. The engagement event further consolidated the importance of working in partnership with Harrow Council and the importance of protecting social care.

Conclusions from CCG consultation on Commissioning Intentions

WSIC:

- Whole System Integrated Care is a priority for NHS Harrow CCG and we will work collaboratively with the North West London Strategy Team to support the development of integrated care and where possible implement pilot schemes to accelerate this required model of care in line with the national integration agenda. Integrated Care is a wide programme of schemes which cover:
- The commissioning of models of care from Provider Networks in the community and delivering where possible through existing community Hubs and in newly commissioned Hubs throughout 2015/15.
- The transition of the Integrated Care Programme into the WSIC Programme. This will provide enhanced case management for the over 75 year old cohort with 1 or more LTCs before expanding across wider patient cohorts.
- Implementation of Year of Care budgets to the provider to manage the total care of the individual. This will initially be supported by the CCG through a shadow arrangement.
- Establishing Harrow wide education programmes to support the transition to whole system models of care delivery and awareness of working with wider MDTs across multiple organisations.
- We will participate in the co-design process and pilot new models based on the outcomes of this process.

Transforming Community Services:

- The implementation of the Out of Hospital and Whole System Integrated Care strategies will require the integration of community nursing services with primary care and the review and realignment of community bedded services.
    - The CCG intends to decommission its community services commissioned from Ealing ICO. The CCG will re-procure a new contract within 2015/16 through a competitive procurement process.
    - The CCG will commission an integrated community and specialist nursing.
- Specialist Palliative Care nursing will form part of the integrated care model, with a shared palliative care pathway, commissioned through a lead provider.

Harrow Council Budget Consultation - Take Part

There is a commitment from the Administration to have an ongoing discussion with residents over the next four years about services the Local Authority delivers in Harrow and therefore this initial phase of engagement is just the start of an ongoing discussion.

The Take Part Consultation was held over an eight-week period from 11 September to 8 November 2014. There was an excellent response within this period

The consultation commenced with a multi-agency steering group meeting, which included representation from Voluntary Organisations, Unions, Housing Associations and representation from across the council. The voluntary sector worked closely with the council to understand the impact of the proposals for savings.

A variety of consultation mechanisms have been used to ensure residents and stakeholders were given the opportunity to respond to this initial phase of the Take Part discussion in a way that suited their needs. The consultation mechanisms used to engage the community included the following.

- 100,000 Take Part Consultation booklets and surveys distributed to residents and key stakeholders/organisations within the community
- 6,000 booklets and surveys distributed as part of the events held across Harrow
- Survey available online at www.harrow.gov.uk/takepart
- Take Part email/telephone number were made available
- Take Part Road Shows and Drop in sessions across Harrow led by Councillors and Senior Managers
- Discussions held at 50 Community Group Meetings

The consultation generated the most engagement with the council within recent years. The numbers of responses received include the following:

- 1696 paper surveys
- 1151 online surveys
- Residents were given the opportunity to send their views in by video –4 video responses received
- A Take Part email address was set up and included within the consultation information – 53 emails were received
- Letters – 33 letters were received including 23 formal responses
- 32 Telephone Calls
- Face to face activity included Roadshows, Drop in sessions, events, community group meetings, workshops and discussion groups – 50 meetings held and over 6000 people spoken to and 361 in depth conversations undertaken
- Tailored survey developed by the Voluntary sector with users of their services
- Tailored survey developed by Harrow Youth Parliament completed by 495 young people
- Twitter – An average of 9,300 Individual timelines received a tweet about #TakePart per week
- Facebook - Post on 24th September reached by 61 people
- Post on 23rd September reached by 915 people, 12 shares, 1 comment

- Cover photo put up on 22 September – 58 reaches.
- 15 petitions received both online and in hard copy total of 15,845 signatures
- The Labour Group office specifically received 35 emails, 10 letters and 6 telephone calls

As a result of the Take Part findings Members have decided to amend the following proposals:

- a reduction in the proposed number of library closures

- The arts centre and museum have a year's reprieve within which officers will be working closely with the community to develop a sustainable business plan that will fully remove the council subsidy in years 16/17.

There has also been a reduction in the number of childrens centres proposed for closure, and a significant reduction in cuts to both the voluntary sector and Supporting People.

b) Service provider engagement
Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The NWL Hospital NHS Trust, Ealing Hospital NHS Trust and CNWL NHS Trust along with the Council and the CCG have been founding partners of the Harrow Whole Systems Integrated Care Programme and are also active partners in the development of the Whole Systems Integrated Care Early Adopter Project.

Prior to consideration by the Harrow Health and Wellbeing Board this Better Care Fund Plan was reviewed and considered by the Harrow Integration Board, at which each of the principal providers is represented.

Prior to submission of the first BCF Plan in April 2014, a service provider stakeholder engagement event took place on 10 December 2013. The following organisations attended.

- North West London Hospital Trust
- Central and North West London Mental Health Trust
- Ealing Integrated Care Organisation

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 two year plan with Harrow's key stakeholders
- Understand from Harrow's key stakeholders the opportunities in how to locally achieve the national plan conditions

ii) Primary care providers

GPs in Harrow are fully engaged in delivering the shared vision for health and social care by

2019/20. In particular:

- A Prime Ministers Challenge Fund Project Team made up of GPs from across the 35 GP practices has been established to lead work to establish a GP Federation and to improve access to primary care services;
- Integrated Care is a standing item on each of the Harrow's six GP Peer Group meetings, which are the main forums for GPs to consider in-depth key operational and strategic issues;
- Regular presentations have been provided at the Harrow GP Forum about Whole Systems Integrated Care and commissioners plans to improve health and social care in Harrow;
- Six GPs have been elected to sit on the WSIC Pilot Project Board and to chair each Multi-Disciplinary Project Group, and the WSIC Pilot Project Board has recently been engaged in further work to finalise the WSIC Early Adopter Project Model of Care;
- Seven GPs have been elected to sit on the CCG Board and these have played a key role in developing the wider health and social care transformation plan and shaping this Better Care Fund Plan.

iii) Social care and providers from the voluntary and community sector

This Better Care Fund plan has been developed jointly by a group of officers from the CCG and the Local Authority. Its development has also been overseen by the Health and Wellbeing Joint Executive which is made up of chief officers from each organisation.

An overview of the draft BCF plan was jointly presented by the CCG and the local authority to Borough Chief Officer's Group which brings together senior community leaders from across Harrow including representatives from the voluntary sector.

Providers from the voluntary and community sector played a key role in the development of the model of care as part of the Integrated Care Early Adopter Project (see above).

Prior to submission of the first BCF Plan in April 2014, a service provider stakeholder engagement event took place on the 10 December 2013. The following organisations attended:

- Harrow HealthWatch
- Harrow Mencap
- Harrow Age UK

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 two 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) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Harrow's BCF will have implications for London North West Healthcare Trust as our main acute provider

The expected implications are:

- Reduction of Non elective admissions in 2015/16 of 3.5%
- Reduction in delayed transfers of care of 1 % annually
- Maintained proportion of people over the age of 65 remaining at home 91 days after discharge from hospital
- Increased patient experience of GP services with aims to reduce inappropriate acute attendances
- Increased social care service user satisfaction with an aim to reduce inappropriate acute attendances through breakdown in packages of care

The reduction of non elective activity is outlined below and the quarterly phasing:

Reduction in non elective activity	
Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	22,783
Change in Non Elective Activity	-798
% Change in Non Elective Activity	-3.5%

The impact of the reduction of the 798 non elective admissions is shown in our accompanying excel submission and is reflected to the marginal rate for both financial years covered within the period as per the table below.

BCF NEL Target	Cumulative - Activity reduction (NEL spells)				Total
Year	14-15	15-16	15-16	15-16	
Quarter	Q4	Q1	Q2	Q3	
Target NEL activity reduction	207	408	601	798	**798**
Target % NEL reduction	-0.9%	-1.8%	-2.6%	-3.5%	-3.5%

Cost reduction (£)				Total
14-15	15-16	15-16	15-16	
Q4	Q1	Q2	Q3	
£ 92,529	£ 149,745	£ 143,785	£ 146,765	£ 532,824
-0.9%	-1.8%	-2.6%	-3.5%	-3.5%

Our non elective admission cost is based on the nationally issued figure of £1,490 per spell

For 2014/15 the 30% marginal rate has been applied
For 2015/16 the 50% marginal rate has been applied

Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Harrow's local plans are consistent with strategic commissioning plans as part of the CCG's QIPP plan and the Council's MTFS plan.

Our local provider, LNWHT has built these assumptions into their existing contract and the 2015/16 activity is part of the 2015/16 contracting discussions due to be concluded in Quarter 4 2014/15.

The overall impact of Harrow CCG allocations and BCF and QIPP requirements over a five year period is already modelled within the operational planning submissions made by the CCG for the 2014/15 planning round. Commissioner plans outline significant reductions in activity across all points of delivery within acute settings, along with an increase in delivery within community

settings.

The CCG is working closely with providers to ensure that this service shift is managed proactively, and aligned to LNWHT's financial sustainability. The BCF particularly outlines the development of the work on intermediate care and whole system integrated care to support a reduction of acute activity that can be managed more proactively in the community through the use of GP Federations, care joint planning, care navigation and MDT working across health and social care.

As commissioners we have shared with providers forward projecting finance and activity plans which is supported through the annual contracting round.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

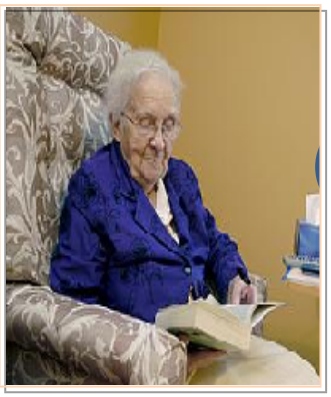
For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Harrow 001
Scheme name
Whole Systems Integrated Care Programme (WSIC)
What is the strategic objective of this scheme?

The Harrow-wide Vision for whole systems integrated care is to improve the quality of health and social care for individuals, carers and families, empowering and supporting people to maintain independence and lead full lives as active participants in their community.

The strategic objective of the Whole Systems Integrated Care Programme is to provide better, more integrated care for over 75s with one or more long term condition and to use the learning from focussing on this population cohort to develop and deliver a similar model of care for under 752 with one or more long term condition in future years.

Focussing on over 75s with one or more long term condition means focussing on people like Annie, and helping her to live happily at home. This means focussing on self care and self help, prevention and ensuring that when Annie is as high or medium risk of going into hospital a care plan and a support network is in place to keep Annie safe and well.



Whole Systems Integrated Care means focussing on people like Annie:

- Identifying a named GP
- Working with Annie to agree a care plan based around personalised quality of life outcomes
- Providing integrated care coordination and support where required
- Establishing a support network utilising a multi-disciplinary team operating at sub-network level
- Involving and engaging carers, family members and community organisation s where appropriate.

Partners across Harrow believe that truly empowering people to help themselves requires support to be provided around people and not around existing organisational arrangements. We believe that this can best be achieved by working with the person to develop and agree a single care plan and using this to inform all health and social care interventions and providing a speedy, accessible response to urgent needs outside the hospital, 24/7.

We also believe that people require consistency, continuity and collaboration in the way that support is provided and that this is best provided in multi-disciplinary teams rather than by a range of different organisations providing different elements of the support required. By working in this way we believe we will:

- Improve the quality of life for older people in our borough by providing proactive, joined up services;
- Work together, share information, expertise and experience better;
- Improve the efficiency of the existing system by reducing inter agency referrals;

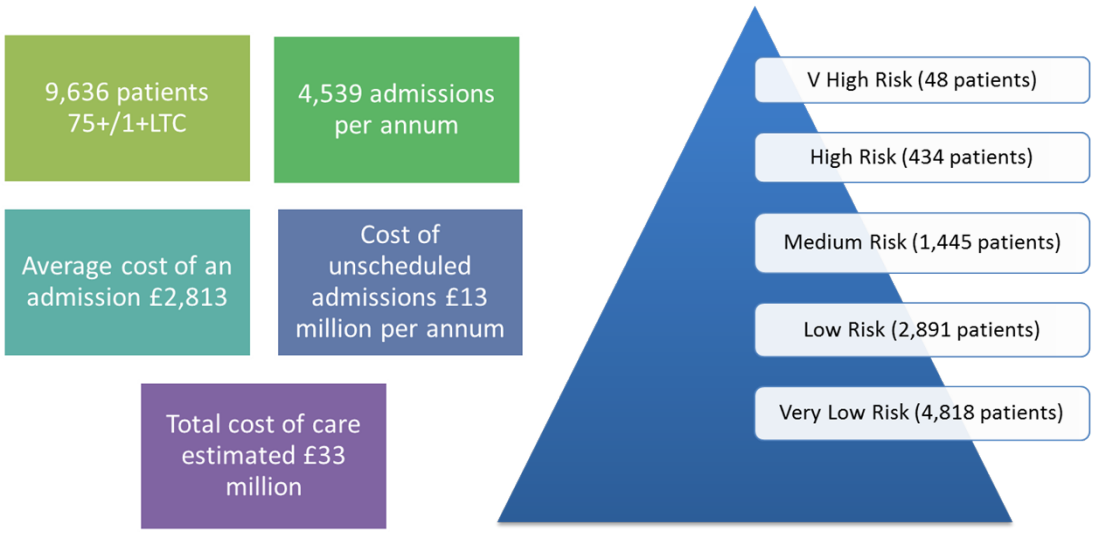
- Reduce the utilisation of acute care resources to support older people;
- Make it easier for older people to continue to live happily and safely at home.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

As set out in section 3 Harrow has undertaken a population segmentation of its population. It has identified over 75s with one or more long term condition as its priority group because it believes there is the greatest opportunity to improve the quality of life and to reduce the likelihood of hospital admission for this group through the implementation of a whole systems integrated care approach to health and social care.

Whole Systems Integrated Care (WSIC) means……. **building care and support around individuals** rather than organisations, and providing more care outside of hospitals and in the community. It also means **tailoring different care solutions for different population groups** and re-prioritising the use of resources so that more is spent on **prevention and proactive long term support** and less is spent on reactive emergency and unplanned care.

The diagram below sets out some of the key characteristics of this group.

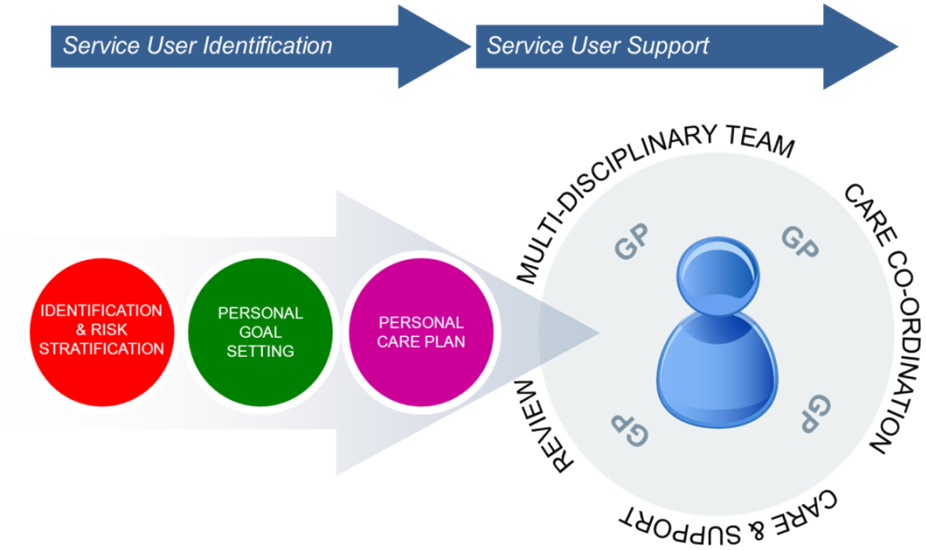


For several years Harrow has successfully operated and developed the **WSIC Pilot Project** which has incorporated the roll out of care planning, multi disciplinary groups and a range of preventative schemes, including the Home not Hospital project operated by Age UK Harrow.

In 2014/15, the project has also been expanded to incorporate Care Navigators and a target set for reducing elective admissions. This project will continue in 2015/16 and be incorporated into the wider Integrated Care Transformation Programme.

Harrow is **an Early Adopter Pioneer Partner** for whole systems integrated care and has produced an Outline Plan setting out its proposals to implement a whole systems model of care, initially for older people with one or more long term condition.

The diagram below sets out the agreed WSIC Care Model and which underpins our WSIC approach, which envisages two key stages for service users and is similar to the existing care pathway that has been developed as part of the Harrow WSIC Programme.



The first stage involves identifying those people within Harrow that are **over 75 and have one or more long term condition**. This process will be GP led. Once individuals have been identified, they will be invited to meet with their GP to develop with them a personal care plan. To assist with this process, service users will be encouraged to set **personal quality of life goals** such as: 'I want to live at home' or 'I want to visit my grandchildren every week'. At the same time their GP will undertake a risk assessment in order to identify the likely level of medical need the service user has, and in parallel a social care assessment will be undertaken. All of this information will be used to develop and agree a **personalised care plan**.

Once this has been achieved the service user will receive support from a **multi-disciplinary team,** which will be based near the service user's home. This multi-disciplinary team, which will be made up of a range of carers, nurses and other health and social care professionals, as well as informal carers and contributors from the third sector, will be responsible over the long term for supporting the service user to meet their personal goals, stay healthy and stay out of hospital. The exact configuration and scale of these teams will be developed as the plan progresses to ensure that they operate with optimum efficiency and maintain the necessary professional and organisational networks/links.

Focus for 2015/16

Focus in 2015/16 will be on:

- establishing effective multi disciplinary teams
- developing and rolling out the utilisation of virtual wards
- testing the use of community consultants to support these
- recruiting additional nursing capacity, based within GP Practices to provide hands on patient care, undertake and oversee case management and provide care coordination
- testing and utilising the new WSIC NW London Data Warehouse to enable the tracking

at patient level of long term conditions and health and social care activity
- undertaking the Health Navigator Project outcomes
- Rolling out the new approach, initially in sub-network 6 and then Harrow-wide by October 2015

Providing this approach is successful, the **scale of the service will be increased to provide support for adults with one or more long term condition from April 2016**.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Delivery of the Whole Systems Integrated Care Early Adopter Project is currently being led by the Programme Director (Integrated Care), but as work on devising and agreeing the model of care is completed it is anticipated a shadow provider organisation will be established in order to enable the establishment and operation of multi-disciplinary teams.

The Project is overseen directly by the Harrow Integration Board.

In January 2015 the roll out of the new approach began in sub network 6. The roll out will be completed in October 2015

Key partners involved in the WSIC Programme and represented on the Harrow Integration Board are presented below.

healthwatch Harrow
Central and North West London NHS
NHS Foundation Trust
harrow carers supporting family & friends
The North West London Hospitals NHS
NHS Trust
Harrow Council LONDON
NHS
Harrow Clinical Commissioning

Providing the new arrangement is successful and progress has been made with establishing a NWL data warehouse, to enable the collation of accurate activity data for the population cohort **commissioning intentions for 2016/17 will be published in October 2015 utilising a capitated approach to budgeting for health budgets**. In addition, the scope of the initiative will be expanded to incorporate under 75s (including children) with one or more long term condition.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Whole Systems Integrated Care scheme is an extension of transformation, which is already under way in North West London. International research has demonstrated the significant benefits of integrated care on patient satisfaction and cost reduction. Extensive work by Richardson & Dorling evidenced lower admission rates, reduction in A&E attendances, reduced length of stay in hospital and patient satisfaction of over 90%.

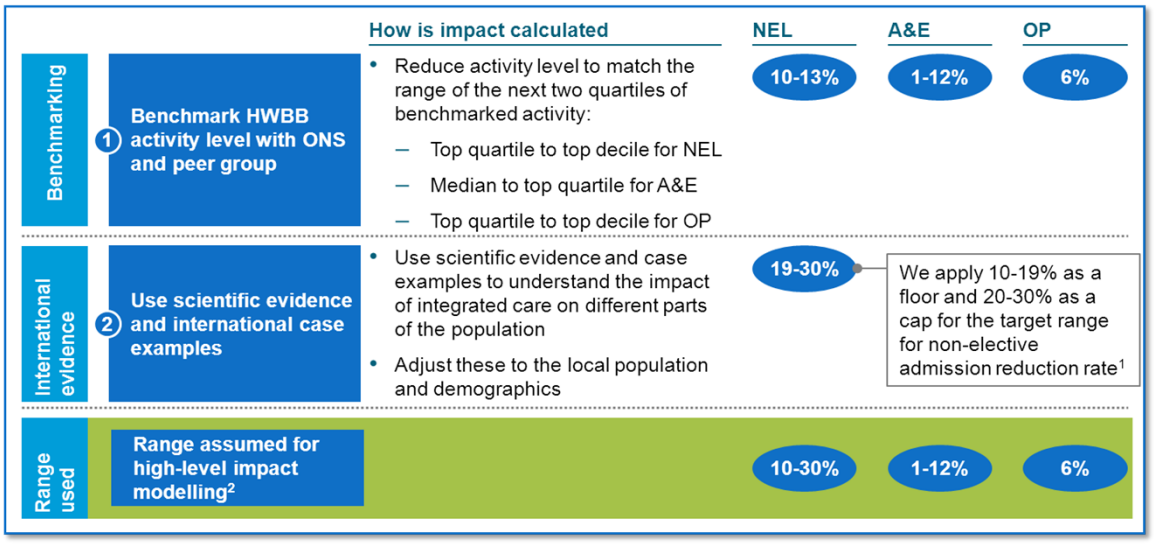
The same research pointed to four key components of integrated care, critical to reduction in non-elective admissions; self-empowerment and education, multi-disciplinary teams, care coordination and individualized care plans.

In North West London the pilot scheme has seen the following outcomes:

- Reduction in emergency admissions by up to 15%
- Reduction in A&E attendances by up to 30%
- Reduction in emergency inpatient days

As a WSIC Pioneer Partner, Harrow has reviewed extensively this evidence, in order to support a whole systems approach. The information provided within the NWL WSIC Toolkit has also been shared extensively with partners in Harrow.

The table below provides an overview of the most current thinking as to the anticipated performance improvement which could be achieved in Harrow over next 3 to 5 years through implementation of best practice integrated care:



Source: McKinsey, MAR 13/14, HES 12/13

As can be seen, by doing the same things better and emulating the highest level of performance achieved by our peer group members we anticipate that reductions in non- elective admissions of between 10 and 13% can be achieved. However, in Harrow we have committed to a whole systems re-design based upon scientific evidence and international case studies. On this basis over the next 3 to 5 years the CCG has committed to a:

- 20% reduction in non- elective admissions
- 25% reduction in A&E admissions
- 10% reduction in elective
- 20% reduction in out patient referrals

These targets were devised and validated as part of work to develop a 3 year recovery plan for Harrow CCG in November 2013. Subsequently, the accompanying savings and investment assumptions have been built into the Harrow CCG 3 Year Operating Plan which was submitted to NHS England in June2014.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

	Baseline	Target (15/16)	Target 5 years	BCF Scheme
Non-elective admissions	88 per 1000 **22,783**	3.5% reduction **21,985**	20% reduction **18,226**	Integrated Care Intermediate Care Protecting Social Care
At home after 91 days	82%	80% (definition changed)	80%	Intermediate Care Protecting Social Care
Delayed transfer of care (days) per 100,000	2,313	2,249	2,197	Intermediate care Protecting Social Care
Residential admissions, older people / 100,000 population	308	385 (definition changed)	385	Protecting Social Care
Social Care User Satisfaction	45.9%	46.5%	50%	Protecting Social Care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Integrated care represents a key element of the Harrow CCG 3 year Operating Plan and is identified as a key workstream within the plan. Progress in delivering the outcomes of this scheme is therefore monitored and reviewed monthly as part of the core business of the CCG.

This progress is also reported to the formal CCG Executive Board.

In addition the design and the delivery of the ICP Programme is led and overseen by the Harrow Integration Board as part of the One Harrow, One Plan Initiative, which in turn reports the Harrow Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

There are four critical success factors for the implementation of this programme

- **Effectiveness of whole systems approach**. While there is considerable evidence which suggests the success of a whole systems approach because of the very challenging financial circumstances within Harrow ambitious target have been set to be

delivered through WSIC. If these targets are not met within the timescale set or with the resources available then this will have a substantial negative impact on the financial position of the CCG and will place delivery of its 3 year Recovery Plan in significant jeopardy.

- **Speed of programme delivery**. While Harrow is fortunate in being part of the NWL WSIC Pioneer Partnership Programme and the expertise, capacity and support that this provides the timetable for the establishment and implementation of a WSIC is very challenging in order to meet the financial targets set; in particular, delays in the establishment of a GP Federation or an Accountable Care Partnership will have a significant impact and the next six months of the programme represent a very significant period
- **Effective partnership working**. Whole systems requires commissioners and providers to work together differently. Within a very financially challenged environment already going through significant change this will present very significant challenges
- **Clinical leadership and GP participation**. At the centre of the WSIC approach is the role of the GP in providing clinical leadership in the management of patients with long term conditions. This will need to be provided at the same time that GPs adjust to working as part of the new GP Federation and focus on improving patient satisfaction levels by increasing access to services and implementing the requirements of the Prime Ministers Challenge Fund and the separate Seven Day Services initiative.

Scheme ref no.
Harrow 002
Scheme name
Transforming Community Services
What is the strategic objective of this scheme?

There are four strategic objectives for this programme:

- To achieve a step change in the quality of community services across the borough, in particular around satisfaction levels with the existing community nursing service, referral rates for under 16s to acute settings and with the effectiveness of the hospital discharge service;

- Align community services effectively with primary, social and acute care in order to discharge patients more effectively from hospital and reduce the need for service users to attend acute settings as more of their conditions and exacerbations can be managed in the community through shared care plans, aligned pathways, increased data sharing and better care coordination;

- To align existing community services with the new whole systems approach to support service users with long term conditions and to develop and agree a three year route-map to support the proposed transformation;

- To ensure the optimum allocation on community services resources across the system and where possible to release resources to protect social care services and invest in a whole systems approach through the reduction of service duplication, implementation of more streamlined care pathways and through the introduction of greater incentivisation to reduce referrals to acute services and to hasten hospital discharge.

-

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

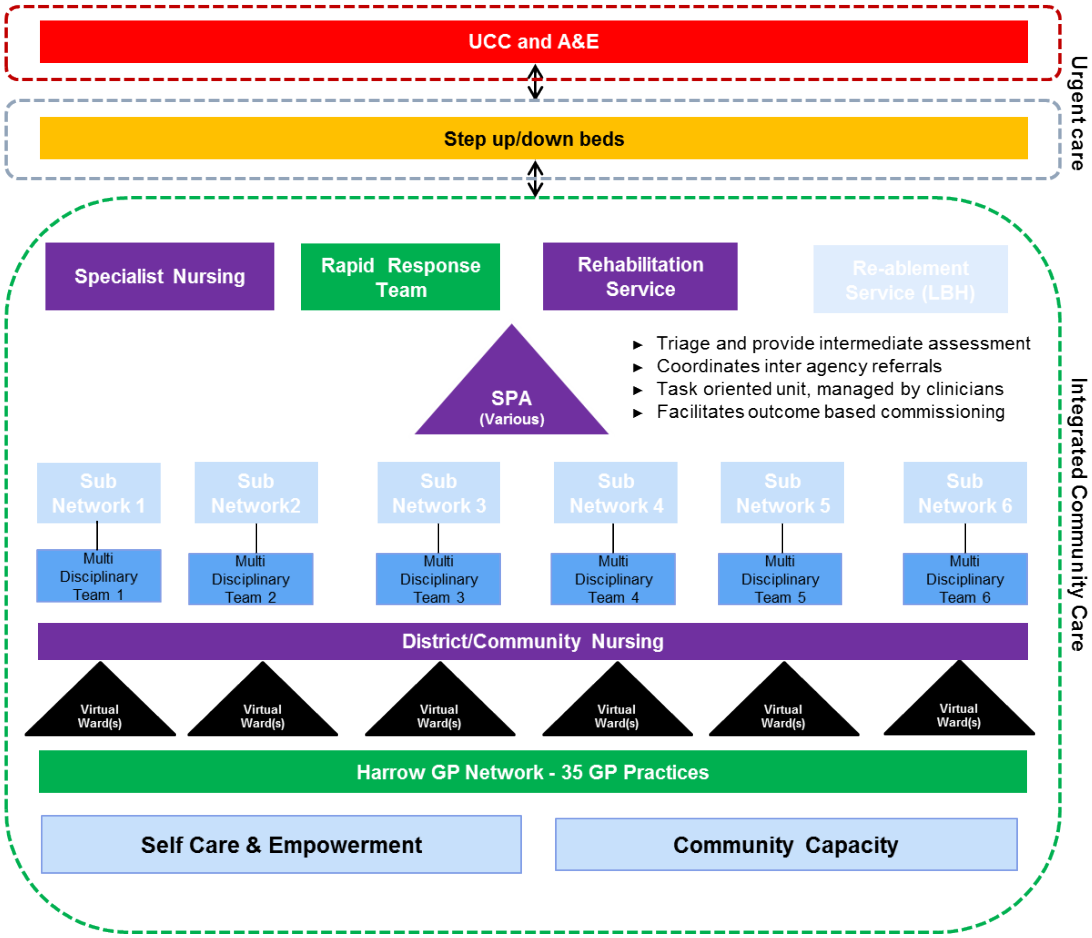
The scope of the transforming community services project is to examine all of those services and functions identified within the community in the light of the changes anticipated to Primary Care Services following the establishment of a GP Federation and the introduction of a whole systems approach (see programme 1 for more details) and the changes to acute services which are taking place as part of the Shaping a Healthier Future Transformation Programme (see main plan, section 2c for more details).

To enable this a **Target Operating Model for Integrated Community Services** has been developed and agreed and this is presented below. Implementation of the model will deliver the following objectives:

- improving patient's experience of care;
- commissioning more proactive and clinically value added services;
- delivering more integrated services;
- improving and aligning provider incentives;

- introducing flexible commercial models which reflect quantity and quality of resources together with performance in terms of outcomes;
- delivering better integration between primary care and social care providers;
- complementing GP practice nursing capacity;
- reducing unnecessary non-elective admissions.

Target Operating Model for Integrated Community Services



At the core of the Harrow model is self-care and self-empowerment and utilising community capacity. Patients will be encouraged and supported to help themselves and the role of carers and other support within the community will be recognised and valued.

GPs will work together, with the new community services provider(s) and other key stakeholders at sub- network or locality level to provide care for patients. This will be achieved by establishing **multi-disciplinary teams within each sub-network**. Each will be GP led and will be made up of professionals from a range of different organisations, including the new community services provider(s).

In order to provide day-to-day support to those patients with high levels of need **Virtual Wards** will be established to provide the coordination necessary.

Harrow CCG is investing in a team of Enhanced Practice Nurses (EPNs) to complement the community services nursing team to reduce non-elective admissions. EPNs will provide additional capacity to support people who are situationally or episodically housebound and complement the

community nursing team who will focus on patients that are long term housebound and require continuing care. The EPN's will also provide capacity and support for GPs within MDTs to provide case management within MDTs for over 85s with one or more long term condition.

The new model for integrated community services will encourage development of the community nursing role, encourage closer relationships with practice nurses so complex care packages can be delivered and ensure patient care in their own home is joined up and seamless.

The **Single Point of Access (SPA) will become the cornerstone of the new community services and integrated care model**; referrals for other community services such as Community Nursing, Specialist Nursing, Community Rehabilitation and Community Consultants, will be made to the SPA directly from GP practices and other key professionals.

There will be a **named community nursing team for each sub-network/MDG** and a **named community nurse lead for each GP practice**, who will work closely with GPs and practice nurses. When more specialist input is required (e.g. diabetes, COPD, HF) the patients will be referred to the specialist nursing team.

Where specialist advice is required from a consultant, patients will be referred to the community consultant, which is in scope of the community services contract.

Existing Services

The table below provides an overview of the existing Community Services within the scope of the review, their key activities and outcomes and annual cost

Service	Commissioner	Service	Outcomes 2015/16
STARRS (Short term assessment, rehabilitation and re-ablement service)	Harrow CCG	• Admissions avoidance (Rapid response Team) • Discharge support • Rehabilitation (home based)	To avoid 3315 non-elective admissions and 2080 A&E attendances
Ambulatory Emergency Care Unit (AECU):	Harrow CCG	The AECU is responsible for saving 366 non-elective admission of the 798 target.	• To avoid 366 non-elective admissions
Northwick Park Intermediate Care Service	Harrow CCG	Early supported discharge through • Health intermediate Spot Placements • Elderly mentally ill community rehabilitation beds • Social Care Hospital discharge team • Intermediate Care Bridging Fund	• Reduction in NEL admissions • 40 admissions per week into community rehabilitation beds • Maintain acceptable level of DTOC
Community Nursing Service	Harrow CCG	• Community Nursing Service	• Range of service benefits

Re-ablement Service	LB Harrow	Provision of re-ablement service	• % of service users still at home 91 days following discharge from acute or community hospital
Hospital Discharge Social Care Team	LB Harrow	• Hospital discharge support	
Home Not Hospital Scheme (Age UK Harrow)	Harrow CCG	Provision of short term practical support for service users at risk of hospital admissions. In particular • Falls Support • Home Support • Night Carer	

Presently Community Services are provided for all population cohorts though the service is predominantly utilised by people with one or more long term condition and the elderly.

A key element of the existing approach to intermediate care in Harrow is the **STARRS service** provided by LNWHT. There are three key elements to the service:

- **Admissions avoidance**: Individuals at very high risk of hospital admission are referred by GPs to the service for intensive support and stabilisation;
- **Discharge support**: To improve the quality and accelerate early discharge multi disciplinary support and coordination is provided by the service;
- **Rehabilitation**: Following major surgery or a significant life event rehabilitation services are provided.

For STARRS the existing service has expanded considerably. In 2013/14, the service was commissioned to support an avoidance of 1,700 non-elective admissions. In 2014/15 the number of individuals supported by the scheme ramps up to 3,065 FYE and plans are in place to expand to 3,315 FYE target for 201/16 (an increase of 250). Linked to this service expansion are ambitious targets to reduce unplanned hospital admissions, which form a key element of the performance related element of this BCF Plan.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Delivery of the Community Services Transformation Programme is currently being led by the Programme Director (Integrated Care) and overseen by the Assistant Chief Officer, Harrow CCG.

The Programme is currently overseen by the Harrow Integration Board and by the Harrow CCG Procurement Panel.

Harrow CCG is presently the primary commissioner of community health services but Harrow Council are also a key partner in the programme.

Key milestones for the re-commissioning of community services are presented below:

- Issue PQQ – Dec 14
- Evaluate PQQ – Jan 15
- Invite shortlisted bidders to dialogue - Jan 15
- Competitive dialogue – Jan - Mar 15
- Issue final; requirement – Apr 15
- Bidders final submission – Apr 15
- Announcement of preferred bidder – May 15
- Sign contract – June 15
- TUPE consultation – June - Sept 15
- Mobilisation June - Sept 15
- Service commencement – Oct 15

The evidence base

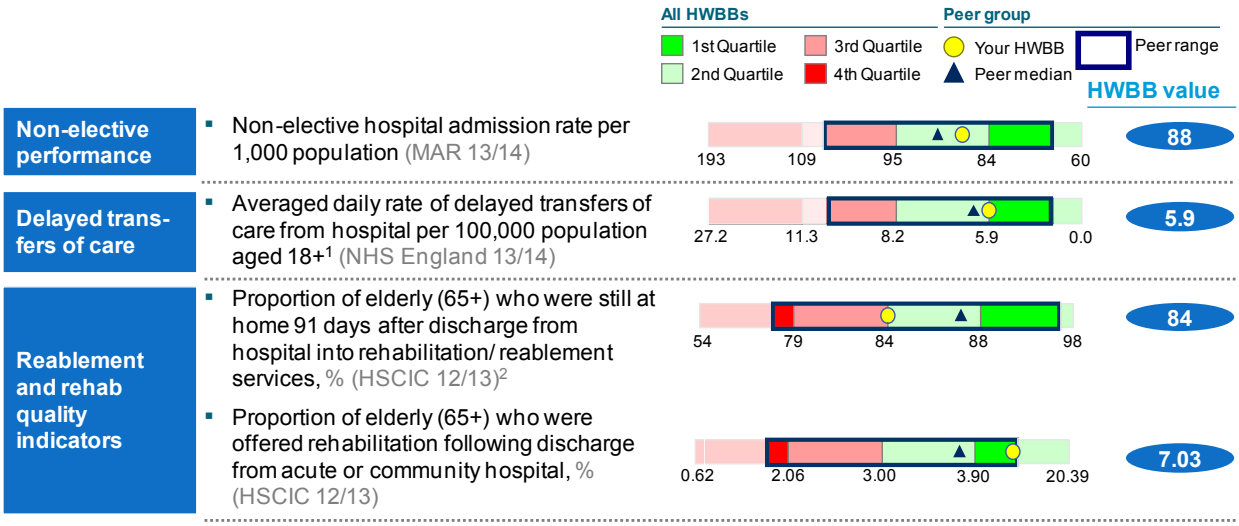
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Since the DH Intermediate Care guidance in 2001 and '*NSF for Older People, supporting implementation. Intermediate Care: moving forward'* in 2002 there has been a steady increase in intermediate care services across the country, however, these have been implemented in a variety of different forms.

Further guidance was produced in 2009 due to this growth (DH *Intermediate Care – Half Way Home Strategy (updated guidance for the NHS and Local Authorities, July 2009)*, this defines intermediate care as 'a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living'.

The table below providers an overview of key performance indicators in Harrow.



1 Local Authority ASCOF Performance Indicators 2013-14
2 Provisional 13/14 data is now available and 13/14 is the baseline for the metric in the template that needs returning on 19 September
SOURCE: MAR 13/14, NHS England 13/14, HSCIC 12/13, GP Patient Survey 12/13, ONS

As can be seen Harrow performs well in avoiding non-elective admissions though there is still considerable opportunity for improvement, good performance is also achieved in reducing delayed discharge and in providing rehabilitation and re-ablement services. However there is considerable room for improvement in increasing the proportion of elderly (65+) who were still at home 91 days after discharge from hospital into rehabilitation/re-ablement.

Improving performance in this area will be a key focus for the Intermediate Care Transformation Programme.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

	Baseline	Target (15/16)	Target 5 years	BCF Scheme
Non-elective admissions	88 per 1000 **22,783**	3.5% reduction **21,985**	20% reduction **18,226**	Integrated Care Intermediate Care Protecting Social Care
At home after 91 days	82%	80% (definition changed)	80%	Intermediate Care Protecting Social Care
Delayed transfer of care (days) per 100,000	2,313	2,249	2,197	Intermediate care Protecting Social Care
Residential admissions, older people / 100,000 population	308	385 (definition changed)	385	Protecting Social Care
Social Care User Satisfaction	45.9%	46.5%	50%	Protecting Social Care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Community Services is a key element of the Unscheduled Care workstream in the Harrow CCG 3 year Operating Plan and specific QIPP targets have also been devised and agreed to monitor the effectiveness of the existing service. Progress in delivering these is therefore monitored and reviewed monthly as part of the core business of the CCG.

This progress is also reported to the formal CCG Executive Board.

In addition, the Transformation of Community Services Programme is led and overseen by the Harrow Integration Board as part of the One Harrow, One Plan Initiative, which in turn reports the Harrow Health and Wellbeing Board.

In 2015/16 as part of the delivery of Transforming Community Services Programme it is anticipated that further QIPP schemes will be devised to support implementation and to monitor progress in 2016/17.

What are the key success factors for implementation of this scheme?

There are three key success factors for the implementation of this programme

- **Delivery of whole systems integrated care programme**. A key aspect of the transforming community services is aligning existing services with the proposed new whole systems approach; consequently good progress needs to have been made with the WSIC Programme in order to deliver maximum benefit from the transformation of intermediate care
- **Effective partnership working**. Both commissioners and providers recognise that there is duplication in existing service provision and opportunities to improve patient outcomes through re-designing patient pathways; this will require all key stakeholders to make changes to existing arrangements and to share risks differently. This will only be successful if trust and openness is maintained between key stakeholders
- **Effective programme management and governance**. Harrow faces unprecedented changes in the delivery and commissioning of health and social care services over the next two years: financial challenges are intensifying; a new GP Federation is being established and a whole systems approach to integrated care rolled out; key providers are merging and the range and quantity of services provided at Northwick Park Hospital is increasing. In order to ensure delivery of the Intermediate Care Transformation Programme within this challenging environment effective programme management and governance will be required

Scheme ref no.
Harrow 003
Scheme name
Protecting Social Care Services
What is the strategic objective of this scheme?
Under the leadership of the Health and Wellbeing Board, the partners in the Harrow local health economy are committed to the integration of community service delivery through Whole Systems work, and the prevention of unnecessary overuse of the urgent care system through the Transforming Community Services scheme. This work to 'meld' and better coordinate a range of community interventions will help to ensure that the statutory duty of the local authority can be met in the context of increasingly challenging financial circumstances. This Whole System work will be part-funded by the BCF, and will be the driver of this integration. The delivery of social care services is central both to the plan for an integrated community approach, and also for the work at the 'intermediate tier' that will enable people to remain living in their homes and communities for longer, prevent unnecessary hospital admission, and hasten discharge. As investment is made both in Whole Systems community service delivery and increasingly preventative approaches, resource presently invested in higher-level (often non-elective) acute activity will be invested to meet increasing demand for social care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
As noted in section 7ai, there are six key elements to protecting social care in Harrow • **Safeguarding.** A key priority for all health and social care partners in Harrow is an effective approach to safeguarding. Harrow has a well developed joint approach to safeguarding, and the planned joint working and allocation of resources will ensure that this continues to be a focus • **Personalisation and Choice**. This is a core principle for social care in Harrow. Harrow is a national leader in personalisation, the utilisation of personal budgets, and the use of technology to support them (MyCommunity e-purse). Maintaining and developing this approach further is at the core of our joint work to protect adult social care services • **Supporting people with eligible levels of need**. Partners in Harrow are at present committed to maintaining the existing FACS-defined levels of eligibility. In April 2015, this will be replaced by the Care Act national eligibility framework, and the requirement to meet 'substantial' levels of need will be nationally prescribed. • **Responsive Assessment and Advice Services.** In Harrow the number of social care contacts has increased significantly in recent years as our population has aged and levels of need have increased. All partners remain committed to providing timely and high quality advice and information for all and assessment and support where required. With the implementation of the Care Act, we anticipate demand to increase further in 2015/16. BCF resource will contribute towards supporting this demand. • **Reablement.** Harrow provides one of the most effective and high performing reablement services in London, and this plays a significant part in ensuring effective hospital discharge processes and in maximizing the percentage of people at home 91 days after a hospital stay. Protecting this service remains a key priority for Harrow.

- **Carers Support**. Set out in section 7a) v) below is the extensive joint work underway to support carers, partly funded by the BCF.

Preventative investment is also a key priority for Harrow. Under the Care Act the local authority will have a duty to provide a range of preventative services.

Social care services in Harrow will be central to the delivery of Whole Systems and Transforming Community Services scheme models of care delivery for the cohorts of people who are to be initially supported through them. It must also be emphasised (as above) that the cohort of people receiving social care support in the future will be determined through the application of the Care Act eligibility criteria, and delivered according to the statutory obligations of the Director of Adult Social Services.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Protecting Social Care Services scheme of the Harrow BCF will be delivered by the Adult Services Department of the London Borough of Harrow Council, under the auspices of the elected leadership of the authority.

As with the other schemes, the work will be overseen by the Harrow Integration Board.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The same evidence base applies for the Protecting Social Care Services scheme as applies to the Whole Systems and Transforming Community Services elements of the BCF: primarily that the population of Harrow tends to unnecessarily overuse often non-elective services at a high-level of acuity for want of more easily available and/or accessible community-based alternatives.

In addition to this, however, there is much evidence of increases in demand for social care services that demonstrates that there is an ageing population and that people who live longer often experience frailty, one or more long term conditions and complex needs.

Some increases in social care demand demonstrate this trend.

Referrals to (front of house) reablement services
- 5,000 in 2012/13
- 7,000 in 2013/14
- 14,000 (projected) in 2014/15

Demand for reablement homecare
- 2013/14 ave. 7 cases per week
- 2014/15 presently peaking at 45 cases per week

Approved Mental Health Professional (AMHP) assessments
- 2011/12 – 350

- 2012/13 – 400
- 2013/14 – 600

Deprivation of Liberty Safeguards (DoLS)

- 2013/14 – 114
- 2014/15 – 168 to date

- The average number of community hours required per adult social care service user has increased in the last three years from c.5 hours per week in 2011/12, to c.7.5 hours per week at the beginning of 2014. This increase in acuity reflects greater levels of need amongst people living independently in the community.

- There has been a noticeable increase in the age of people whose cases are presented at commissioning panels. People aged in their late 90s and early 100s is now the norm

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

	Baseline	**Target** (15/16)	**Target 5 years**	**BCF Scheme**
Non-elective admissions	88 per 1000 **22,783**	3.5% reduction **21,985**	20% reduction **18,226**	Integrated Care Intermediate Care Protecting Social Care
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Social Care User Satisfaction	45.9%	46.5%	50%	Protecting Social Care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Protecting Social Care Services is a key priority of the BCF, and of the London Borough of Harrow Council. Progress in delivering the outcomes of this scheme will be monitored through the BCF monitoring mechanism under the auspices of the Harrow Health and Wellbeing Board, and also by the council as part of its core business.

In addition the design and the delivery of the Protecting Social Care Services scheme will be overseen by the Harrow Integration Board as part of the One Harrow, One Plan Initiative, which in turn reports the Harrow Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

The following success factors apply to Protecting Social Care Services in Harrow.

- Social care services will become integrally embedded into the whole system delivery of community service activity, and will enable the fulfilment of the Harrow Better Care Fund theme objectives.
  - Make life better for the people of Harrow.
  - Prioritise home and community-based support to keep people well, and reduce the overuse of the emergency care system.
  - Joined up, cost-effective services, making the most of the available resources.
  - Planned in partnership between those that use them, stakeholders, providers and commissioners to ensure that they best meet the needs of Harrow
- Harrow Council will continue to maintain present high levels of performance in the delivery of social care services, and sustain its status as a national leader in personalisation through supporting the development of personal budgets across the life course within the NHS and social care services.
- The social care ethos will continue to feature strongly at the heart of developing partnership working in Harrow.
- Social services will remain economically viable in the borough.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Harrow
Name of Provider organisation	North West London Hospitals Trust
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	22,251 all providers (CCG Operating Plan)
	2014/15 Plan	21,806 all providers (CCG Operating Plan)
	2015/16 Plan	21,588 all providers (CCG Operating Plan)
	14/15 Change compared to 13/14 outturn	-2% (CCG Operating Plan)
	15/16 Change compared to planned 14/15 outturn	-1% (CCG Operating Plan)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-207
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-591
	BCF Baseline: 22,783, -798 (-3.5%) NEL reduction = 21,985	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes - this is subject to the outcomes of the annual contract discussions scheduled to be completed by the end of Quarter 4 2014/5. LNWHT is committed to working in partnership with commissioners to develop the intermediate care and whole systems integrated care programme to support the delivery of care closer to home. This fits with the Trust's long term plan to work in partnerships with local commissioners to provide the best possible outcomes for our served population. The Trust believes that this model of care once fully implemented, will be part of the solution to a sustainable health and social care pathway in Harrow, but currently this is too unclear to sign off formally.

2.	**If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?**	The Trust is aware of the CCG's 5 year plan to increase the level of NEL demand management **but at present is not fully assured** on the deliverability of this longer term plan, until elements of the existing 2 year plan are operational and performing, and the CCG and the LA are clearer about the investment impact. LNWHT remains cautious of commissioner's timelines to deliver the required programmes of work. The current Shaping a Healthier Future changes and the impact of the recent merger of LNWHT and Ealing Hospital Trust are relatively new and untested new models which will require a bedding in period, as will the requirement to establish out of hospital services including: • GP Federation • Enhanced ICP / WSIC • Enhanced 7 day services across community, primary and social care services to mirror acute 7 day services
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	LNWHT has been involved in the initial design and modelling sessions for the WSIC programme and is the provider of the majority of the intermediate care services. The Trust is aware of the high level plans commissioners are intending to deliver over the 2 year and 5 year programmes. However, LNWHT will consider in detail, the implications through the annual contracting process. Presently activity at LNWHT remains high against plan and requires significant support and community infrastructure to deliver a sustainable pathway in the community.