Harrow Better Care Fund Plan

Outline Plan 2016/17

Date: 3rd May 2016

Section 1: The Harrow Vision

The Better Care Fund Plan is the principle vehicle in Harrow to deliver Whole Systems Integrated 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 the development of the Better Care Fund Plan we identified the following themes in 2015/16 and will be utilising these themes to develop further the 2016/17 Plan

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.

Since the last BCF Submission we have also updated our Health and Wellbeing Strategy.
The vision of the local Harrow Health and Wellbeing Strategy is “To help each other to start, live, work and age well.”

This means:

- Start well – we want children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential

- Live well – we want high quality, easily accessible health and care services when we need them, sufficient and good quality housing, green and active spaces, healthy high streets and neighbourhoods
- Work well – we want to help people to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing
- Age well – we want to enable older people to remain well, connected to others and independent in their own homes for longer and enable dignified deaths

The key priorities are:

- Use every opportunity to promote mental wellbeing
- Empower the community and voluntary sector to collaborate to deliver alternate delivery models and funding solutions
- Provide integrated health and care services

The focus of Health and Wellbeing partners in the future will an emphasis on how they can contribute to making Harrow a better place to live and reduce the differences in life expectancy and healthy life expectancy between communities. See appendix 3 for details of the Health and Wellbeing Board's Mission.

1.1 What is planned to change?

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; Whole Systems Integrated Care (WSIC); and Transformation of Community Services.

The Better Care Fund Plan will support the delivery of the Whole Systems Integrated Care (WSIC) and Transforming Community Services (TCS) work in Harrow in 2016/17, supported by Harrow CCG and Council signalling their on-going commitment to further develop their joint and integrated working arrangements.

In 2016/17, the WSIC Programme will focus on providing anticipatory, multi-disciplinary care for people over 65, with one or more long term condition and high risk of admission to hospital. The aim for 2016/17 is to reduce hospital admissions and overall cost of delivery by shifting investment in resource and provision of services into the community rather than acute settings in line with the CCG's 'Out of Hospital' strategy.

The Transforming Community Services Programme will focus on delivering a single point of access to community services and a borough wide rapid response service. Community Hub multi-disciplinary teams (MDTs) will work closely with the new Community Services Single Point of Access and GP practices to improve the hospital discharge process by providing simpler contact for London North West Healthcare Trust (LNWHT) Services using local intelligence to facilitate referral in order to deliver the best care for Harrow patients.

The Protection of Social Care Programme will focus on implementation of the Care Act, to maintain support for people with eligible levels of need, and to continue to deliver high quality reablement and rehabilitation.

For adult social care the planned state post-plan delivery is to have maintained the level of service, meeting the demand profile of service users and delivering the intended target outcomes, for example, meeting the 91 day reablement performance indicator.

We are confident in maintaining and building on the performance levels of 15/16 BCF Plan and acknowledge that the increasingly challenging financial position requires continued and strengthened joint working between partners.

Section 2: Case for Change

The Health and Wellbeing Strategy and our Better Care Fund Plan have been informed by our **Joint Strategic Needs Assessment (JSNA)**, which has been refreshed since the last BCF submission. The assessment highlights some key issues, as set out below:

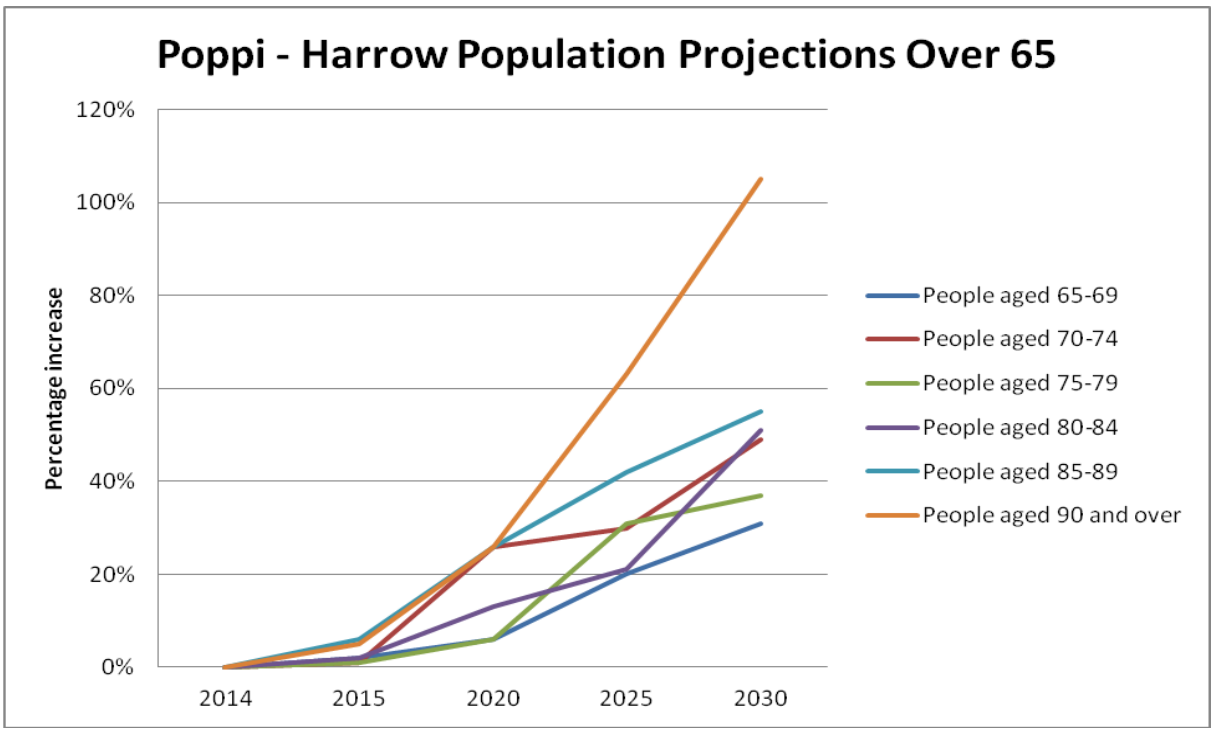
2.1 An Older and Aging Population and Some Challenging Circumstances

Around 243,500 people live in Harrow, 7% of the population are children under 5 years old and 7% are aged over 75. Compared to London, the population of Harrow has a greater proportion of older people and a lower proportion of people in their 20s and 30s. One third of over 65s have at least one long term health problem or disability and people are living longer with ill health (approx. 20 year gap in healthy life expectancy and life expectancy).

Over the next ten years, the population of Harrow is expected to grow over all. The proportion of people who are of working age (16-64) will decrease by 4% and the proportion of those over 65 will increase by 4%, increasing the ratio of dependency.

Large scale regeneration is planned and initial assessments suggest significant impact on primary care and education as a result of increased population in new housing developments – adverse impact needs to be mitigated.

Harrow is one of most ethnically and religiously diverse boroughs in country, which has implications for rates of e.g. diabetes and heart disease in BAME groups and cultural sensitivity. In addition, there are financial challenges across the system which will have an impact on future provision of services (health checks, weight management, and smoking). This presents a potential opportunity to collaborate with shared funding to improve outcomes.



The projected significant increase in the number of residents of the borough over the age of 65 over the next 15 years suggests that demand on services and the complexity of needs is anticipated to increase. This points to the need to invest more to maintain an even level and quality of service to counteract this projected growth in demand, however the financial challenges mean that this is unlikely therefore requiring the integrated approach to maintain services to an increasing population.

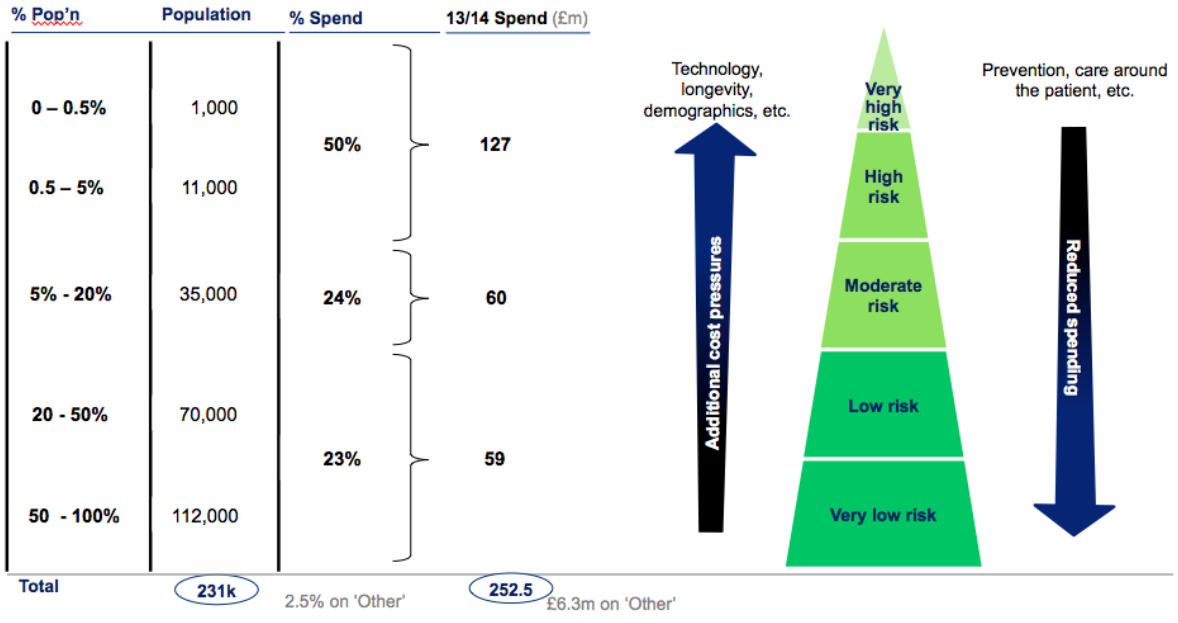
2.2 Heavy reliance on acute services

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.

Therefore there is an imperative to respond now to a growing issue to avoid non-elective, elective and accident and emergency admissions. Further relieve pressure by reducing delayed hospital transfer and in offering re-ablement and rehabilitation following discharge from acute or community hospitals.

2.3 Uneven distribution of need and cost to serve

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



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

The stratification exercise found that 50% of available resources are 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. This increases the cost to serve for that patient segment and severely diminishes the ability to provide for other segments.

Therefore the emphasis for Harrow should be on providing anticipatory and preventative care for these most at risk patients; those aged 65 and over with multiple long term conditions.

2.4 Opportunities currently under consideration in the STP

Harrow is already working as part of a wider collaborative of 8 CCGs across North West London, many of the mature change programmes already underway impact across all boroughs and have aligned visions to develop improve and sustain the very interconnected nature of the system.

The North West London (NWL) area will be the footprint for a Sustainability and Transformation Plan (STP) that will be developed by the seven NWL boroughs by 30th June 2016. Each borough will develop a local plan which will be combined with the others to produce the overall North West London STP.

Various opportunities to improve outcomes for people in Harrow and deliver more cost effective services, principally around prevention, partnering and highlighting the importance of self care, including:

- Older people - Falls prevention and social isolation (particularly important given people in touch with social care report less social contact than they would like)
- Primary prevention - Wide scale provision of information and brief advice on alcohol, physical activity, diet, smoking and mental health and signposting to appropriate services (MECC – Making Every Contact Count).
- As part of MECC, exploration of models with voluntary and community sector to explore how health champions could support provision and signposting
- Child health – related to poverty and mental health (evidence strong around Conduct Disorder), A&E attendances
- Diabetes - NWL approach to roll out and evaluation of NDPP- National Diabetes Prevention Programme, increase detection, reduce between practice variation in terms of detection/management (and link to action on hypertension)
- Mental health – Align with Like Minded programme, opportunity for transformation through joint working, early intervention, sign up to Time to Change campaigns to tackle stigma and particular attention to child mental health. (This raises the profile of MH in a number of local strategies and is a Harrow Health and Wellbeing Board strategy priority acknowledging local need and aspiration to highlight).
- Self-care – mapping and integrating services/facilities which support self-care with widespread use of Patient Activation Measure to segment the population according to ability to self-care, to tailor approaches and evaluate behaviour change. Also in this improved signposting for patients – opportunities to integrate public health, council, NHS (e.g. 111) mechanisms to ensure people find the same high quality information no matter where there first point of contact (as opposed to a single point of access).
- Integrated approaches to health and social issues – social prescribing acknowledging the significant impact that debt, housing, employment, income, etc. issues have in health and wellbeing
- Mental health - through prevention and earlier intervention as well as psychological therapies and (reducing spend on primary prescribing and improving outcomes against quality standards such as IAPT- Improving Access to Psychological Therapies impact, people with mental illness in settled accommodation, dementia diagnosis, assessment of depression severity at outset)

The development of the Harrow plan will be informed by the discussions held within a stakeholder group, formed of representatives of patient and the public engagement groups, the CCG, local authority, health and social care providers and the 3rd sector.

This group has signed off a 'base case' analysis that identified high level goals for the improvement of the population's health and existing plans in place to achieve them. This assessment will underpin the development of the STP, which is to be completed in June. The stakeholder group will continue to meet fortnightly to develop this vision into a final version of the plan.

2.5 Change planned through BCF to tackle the key issues

We know that levels of demand for social care services will continue (as per 2015/16) to place pressure on adult social care resources and it is imperative that we maintain and continue to provide services that meet this demand. The Better Care Fund Plan will be used to address key issues in the local area, including the following:

- Maximising service users ability to remain living independently in their own homes
- Reducing the need for long term social care service provision
- Reducing unnecessary admission to residential and nursing home placements
- Reducing delay transfer of care
- Reducing unnecessary admission to hospital
- Increasing service user satisfaction.

The details of the programmes that will deliver this change will be laid out in the next section.

Section 3: BCF Integrated Plans for 2016/17

The total value of the BCF Plan in 2016/17 will be £15.252m and comprises revenue funding of £14.071m together with capital funding of £1.181m.

The agreed schemes for 2016/17 will be:

Scheme	£m	Provider
Protection of Social Care Services	6.458	Local Authority
Whole Systems & Transformation of Community Services	7.613	CCG
Revenue BCF	**14.071**	
Capital Schemes	1.181	Local Authority
Total BCF Funding 2016/17	**15.252**	

The funding will be supported by a Section 75 agreement between the CCG and the Local Authority.

3.1 Protection of Social Care

In 2015/16, the Protection of Social Care Programme focused on implementation of the Care Act, to support people with eligible levels of need, and to deliver high quality reablement and rehabilitation. In 2015/16, the work looked at delivering:

- 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.

In 2016/17, the aim of this programme of work is to ensure that the social care provision essential to the delivery of an effective, supportive whole system of care is sustained and the same level and quality of service. Further detail of planned activity can be found in section 4.

3.2 Whole Systems Integrated Care & Transformation of Community Services

In 2015/16, two new initiatives were developed, both of which, though at an early stage of development are already delivering significant positive benefits to Harrow patients:

Virtual Ward Project. In order to provide more intensive support in the community for patients at high risk of hospital admission but not requiring the short term crisis level support provided by the Rapid Response Team, network based Virtual Wards have been established. These are led by dedicated GPwSI's – GP's with Special Interest and supported by a multi-disciplinary team which also incorporates a Virtual Ward Case Manager.

Enhanced Practice Nurse (EPN) Project. In partnership with the CCG, GP Practices across Harrow have employed Enhanced Practice Nurses to provide rapid and high level support for housebound patients at high risk of hospital admission. By 31 December 2015, over 724 patients had been supported, whose average age was 84 and all of whom were at risk of hospital admissions.

A key innovation for 2015/16 has been the development of the Anticipatory Care Plan element of the Care Plan which proactively sets out future goals and actions for each patient.

Another key area of work in 2015/16 has been measuring the benefits achieved through the delivery of the Whole Systems Programme. This focussed on the avoidance of non-elective, elective and accident and emergency admissions. Monthly monitoring indicates that by November 2015 435 non-elective admissions were avoided, which was ahead of a target of 384. In 2016/17, the primary objective of the Whole Systems (WS) Programme is to demonstrate the sustainability of a multi-disciplinary and collaborative approach to the provision of anticipatory care in the community to support a cohort of patients at high risk of hospital admission.

In particular, the aim of the WS Programme is to support patients who are over 65 and have one or more long term condition. In total, there are 28,400 patients within the borough that are over 65 with one or more long term condition and these currently account for 5,960 unplanned hospital admissions each year at an average cost of £2,628 and a total cost of £16 million per year.

Plans for 2016/17

In 2016/17, the WS Programme will focus on providing anticipatory, multi-disciplinary care for those 5000 people within the cohort, who through a systematic approach to case identification are identified as most likely to benefit from the support available.

In particular, the following three patient groups have been identified as those that will be supported through the WS Programme in 2016/17:

- People over 65, with one or more long term condition, and an EMIS IQ Risk Score of 40 or over
- People over 65, with one or more long term condition, recently discharged from hospital and who have had 3 or more hospital admissions in the last 12 months
- People over 65, with one or more long term condition, currently living in a residential or nursing care home in the borough.

By focusing support on a proportion (approximately 20%) of the over 65 with one or more long term condition cohort it is anticipated that through multi-disciplinary working partners will have a bigger overall impact on health outcomes and hospital admissions than if the resources available were spread over a larger cohort of people.

The target for the programme is that within the cohort of 5000 people, 500 fewer hospital admissions will be recorded in the six months following referral compared to the six months prior to referral. If this is achieved, then this would be equivalent to a saving of £1,314,000.
Seven further outcome measures have also been developed for the WS Programme in 2016/17 and performance against each will be measured throughout the year.

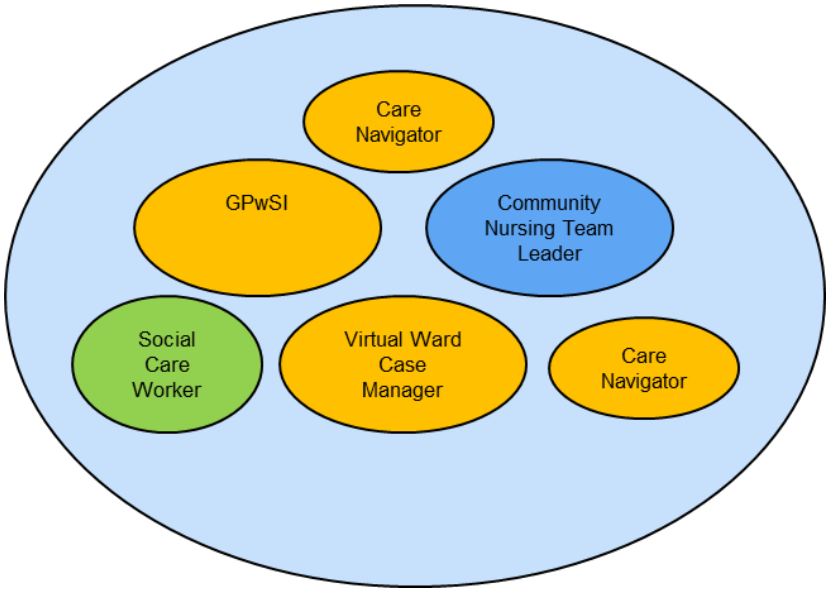
- Falls
- Dementia
- End of Life Care
- Non Elective Admissions
- Hospital Discharge Support
- Patient Activation
- Patient Satisfaction

Key Workstreams

In order to deliver the proposed Programme Benefits, six workstreams have been developed for 2016/17 and these are presented below:

1. Establishment of Community Hub Based Multi-Disciplinary-Teams

A key priority for 2016/17 is to ensure coordinated and effective joint working at a Peer Group level. For the delivery of community nursing, social care and virtual wards resources have been identified to work across two Peer Groups. In addition, Care Navigators are in place to support individual Peer Groups. The diagram below provides an overview of the resources available to support each Community Hub (two Peer Groups)



It is proposed that in 2016/17 these teams are physically co located and consideration is given to who is best placed to lead each of the three teams. In addition, it is proposed that they agree a shared work programme to ensure the most efficient attendance and

participation in Practice Case Reviews and Virtual Ward Meetings and that the team work collaboratively to deliver the best outcomes for the patients within the cohort.

This work stream will be led by CLCH – Central Community Healthcare NHS Trust and Harrow Health CIC. Success will be measured using the Health and Social Care Professional Satisfaction outcome measure.

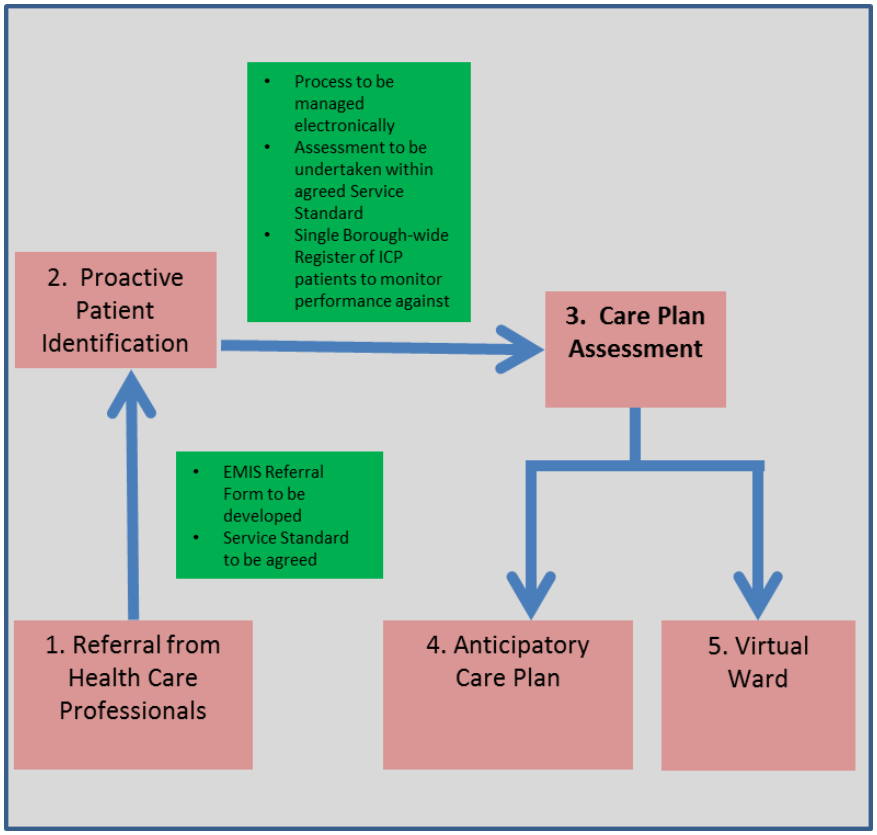
2. Systematic Case Identification

In 2016/17, Care Navigators will work with Enhanced Practice Nurses and Virtual Ward Case Managers to proactively screen patients who have been discharged from hospital with three or more admissions in the last six months or who have an EMIS IQ Score of 40 or more.

It is anticipated that across Harrow between 100 and 150 patients will be identified each week. Once identified then a GP within the host GP Practice will be required to assess whether the Patient is suitable for Anticipatory Care within 5 days of referral. If the GP considers that Anticipatory Care would be beneficial then a consultation with the patient should be scheduled and an Anticipatory Care Plan agreed within 15 working days of initial referral.

Part of the process of completing an Anticipatory Care Plan should include undertaking a Patient Activation Assessment and where appropriate utilizing the 'Coordinate My Care' computer system to enable other care professionals to be aware of patient wishes in the event of a deterioration in the patient's condition.

The diagram below provides an overview of the revised case identification process



3. Proactive Case Coordination

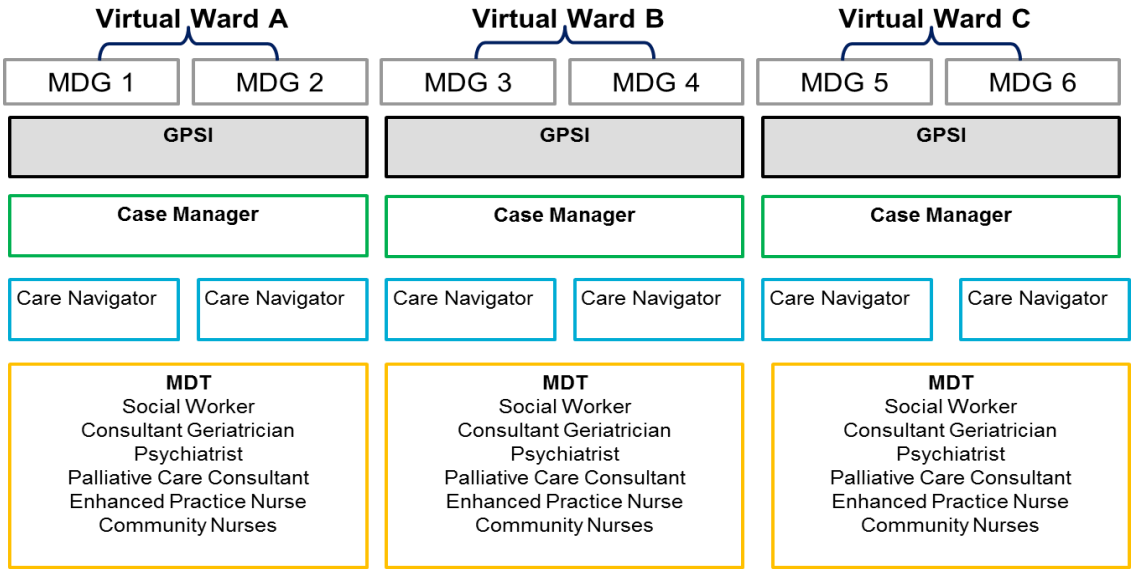
In 2016/17, new arrangements come into place to deliver community nursing in Harrow. These new arrangements will need to align with the existing Virtual Wards model, the work of Enhanced Practice Nurses and arrangements for providing GP Led Anticipatory Care (Care Planning).

Four principal activities will be supported through the WS Programme:

- The WS Programme Team will be responsible for ensuring a consistent approach for each and providing quality assurance for the work undertaken
- Fortnightly Case Review meetings
- GP Practices will undertake fortnightly Case Review Meetings to review new cases and ensure effective and on-going support for existing cases. These meetings will be led by a Practice GP and will be supported by a Care Navigator. Also in attendance will be an appropriate clinical members of the Community Hub MDT Team and the Enhanced Practice Nurse.
- A standard format will be agreed for Case Review Meetings which will build at a practice level on the good practice developed within Virtual Wards. Where Practices have insufficient patients (List size less than 10,000) to sustain a fortnightly meeting then it is proposed that they convene a joint meeting with a neighbouring or partner practice, sharing responsibility for providing a GP lead for the meeting.

4. Virtual Wards

The three Virtual Wards will continue to provide multi-disciplinary support for more complex patients within the cohort and these will continue to operate at a Peer Group level, led by a GPwSI – GP with Special Interest and supported by a Virtual Ward Case Manager, the model will be further developed by increased community nursing, Enhanced Practice Nurse and Social Care participation. The diagram below provides an overview of the proposed operational model.



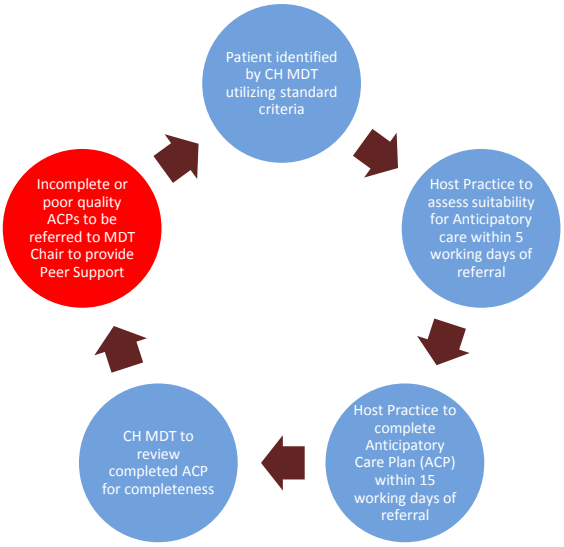
5. Anticipatory Care Plans

In 2016/17 the ICP Care Plan template will be simplified considerably and instead there will be increased focus on:

- Completing and agreeing with the patient an Anticipatory Care Plan

- Completing with the patient a Patient Activation Survey and agreeing with the patient following this a self-care action plan
- Agreeing and completing, where appropriate, with the Patient an Advanced Care Plan and inputting these details on the Coordinate My Care website
- Ensuring that those patients with an Anticipatory Care Plan receive the support that they require while part of the Whole Systems Cohort
- Undertaking a six month review

A key priority for 2016/17 will be improving the quality, usefulness and consistency of care plans. This will be achieved by adopting a systematic borough wide approach to their completion as set out in the diagram below:

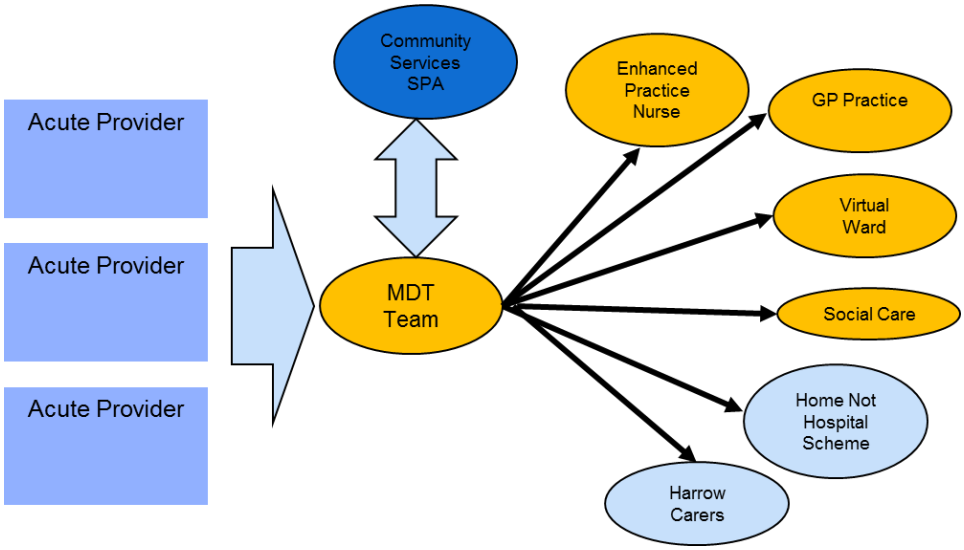


In 2016/17, GP Practices will be able to draw upon Enhanced Practice Nurses and other practice resources (but not Care Navigators) to complete Anticipatory Care Plans but at all time the patients named GP will remain accountable.

6. Improving Hospital Discharge Process

The Community Hub MDTs will take the lead in improving the hospital discharge process for people within the cohort. This will involve LNWHT proactively identifying those patients admitted to hospital and alerting the three WS Virtual teams so that preparations can be made prior to discharge to support the process. This new approach will build on the pilot project currently underway.

The diagram below provides an overview of how the Community Hub MDTs can improve the hospital discharge process by providing simpler contact for LNWHT Services and facilitate referral onto over 10 different services. It is anticipated that the Community Hub MDTs will work closely with the new Community Services Point Single of Access.



In addition, the Palliative Care Service will lead work with Whole Systems staff, Enhanced Practice Nurses and Community Nurses to increase the percentage of patients within the cohort who have been offered the opportunity to indicate a preferred place of death and to increase utilization of Coordinate My Care.

This will involve provision of a comprehensive and coordinated training programme and the employment of two Palliative Care Nurses to support the delivery of the WS Programme.

7. Promoting self-care through utilisation of Patient Activation Measure (PAM) toolkit

Harrow Council Public Health Team will lead on the promotion and roll out of the PAM Toolkit. PAM provides a simple, evidence-based mechanism for establishing the capacity of individuals to manage their health and then using that information to increase patients focus on self-care.

The aim for 2016/17 will be to facilitate a PAM assessment for all patients within the Whole Systems Cohort and then to undertake a further assessment upon discharge from the cohort or as part of a six month review and to demonstrate an improvement in patient activation. A

review of the effectiveness of the PAM toolkit will also be undertaken during the fourth quarter of 2016/17.

8. Using technology to provide integrated care

Harrow CCG will lead work with Harrow Health CIC and CLCH to develop an integrated computer system using EMIS Community which enables the effective and appropriate sharing of patient records amongst Team Members.

A first stage for this work will be the deployment of EMIS Enterprise Reporting to enable the collation and analysis of practice data. Once implemented a suite of standard reports will be developed in order that activity and outcomes can be monitored on a monthly basis.

Also key will be the creation of a single patient register, held on the Harrow Health CIC EMIS Community System, which will hold records of all patients being managed through a Virtual Ward and will be visible to Community Hub MDTs.

In 2016/17 Anticipatory Care Plan and activity undertaken by Enhanced Practice Nurses will be recorded on GP Practice EMIS Systems however this will be visible to Community Hub MDT members via the Harrow Health CIC EMIS Community System.

3.3 Outcomes and benefits

The aim of the WS Programme for 2016/17 is to demonstrate that by investing resources in multi-disciplinary teams in the community then the cost of that investment will be less than the expenditure on acute resources which would have resulted if the WS Programme did not exist.
To inform the quantification of benefits from the WS Programme the following outcome measures have been developed.

Priority Area	Outcome Measure	Method of Measurement	Rationale
Falls	• Reduction in recorded falls in 6 month period following referral	• EMIS to track no of recorded falls in 6 months prior to and six months following referral to WSIC Programme	• Significant prevalence amongst WSIC cohort
Dementia	• % of cohort receiving basic CIT memory assessment • % of cohort receiving comprehensive memory assessment (e.g. MMSE, Toronto assessment) • % of cohort referred to Memory Assessment Clinic • % of cohort diagnosed with dementia	• EMIS to track referral rates, outcome of referral	• Significant opportunity for improving outcomes for WSIC cohort
End of Life Care	• % of EoL cohort with Coordinate My Care record • % of EoL cohort dying in preferred place of death	• EMIS to track recorded DNAR forms, % of patients dying in preferred place of death	• Cashable benefit • Significant opportunity for improving outcomes for WSIC Cohort
Non Elective Admissions	• No of non elective admissions in previous 6 month period • No of A&E admissions in previous six month period	• Comparison of number of admissions pre and post referral to WSIC Programme • Comparison of WSIC Cohort with non WSIC Cohort	• Cashable benefit • Will maintain focus of WSIC Programme on delivery of out of hospital strategy

Hospital Discharge support	• No of WSIC Cohort readmitted to hospital with 28 days of discharge • No of WSIC Cohort experiencing delayed discharge from hospital		• Cashable benefits • Will shift focus of WSIC Programme towards improving hospital discharge
Patient Activation	• % of WSIC Cohort with positive improvement in PAM score within 6 months of referral	• NHS funded PAM Software Tool	• Will encourage focus on self care • Significant evidence to suggest cashable benefits
Patient Satisfaction	• % of patients rating support provided through WSIC programme as good or excellent	• Telephone Call back Survey following discharge/six month review	• Key priority for Programme

It is anticipated the WS Programme will deliver cashable efficiency savings of **£1,314,000** in 2016/17. For key milestones and budget details, see appendix 1.

3.4 Risk in the 16/17 plan

There are significant financial challenges for LBH in maintaining the level of social care services provided. This includes pressures relating to the demographic picture in Harrow as set out in section 2, where the number of vulnerable citizens are growing whilst complexity is also increasing.

Amidst the challenging financial environment it is essential that social care is protected so as to keep people safe and meet statutory obligations. In protecting social care we are also working innovatively with stakeholders, aiming to maximize the opportunity for co-production and empowering service users in the design of adult social care.

(Please see separate risk log and risk sharing template issued and submitted back on the 18/04/16). Risk sharing agreements and contingency plans for delivery of the Better Care Fund are outlined in section 4. Some key risks identified in the delivery plan are:

There is a risk that:	Mitigating Actions
The programme unable to demonstrate that investment in integrated community based approach can release more resources from acute services than invested	• Wider basket of outcome measures to be tracked than in 2016/17 • No direct QIPP savings attributable to WSIC Programme in 2016/17 • Consideration also to be given to tracking non cashable benefits
Partners unable to agree overall scope of Programme	• Programme built around existing projects, organizational priorities and analysis of healthcare priorities in Harrow • Significant national and international evidence to support priorities set within Programme
Delays in mobilizing resources required to deliver Programme result in outcomes not being achieved within timescale set	• All contracts and service agreements to be in place by Friday 27 May • IMG to consider benefits of contracts until 31 March 2018 for resources required
GP Practices do not effectively engage in	• New, simplified and integrated payment and reward

Programme	mechanism to be developed • Better joint working with other partners anticipated following roll out of integrated community services model
Shifting of resources may destabilise existing providers, particularly in the acute sector	• The development of plans will include facilitates whole system discussions and further work on co-design of, and transition to future service models
The implementation of the Care Act will result in an increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	• Ensure the use of the Care Act money is in line with allocation.

Section 4: Coordinated and Integrated Plan

Work is well on track to develop the BCF Plan 2016/17 with a clear consensus developed about scheme priorities, financial allocations and risk sharing arrangements.

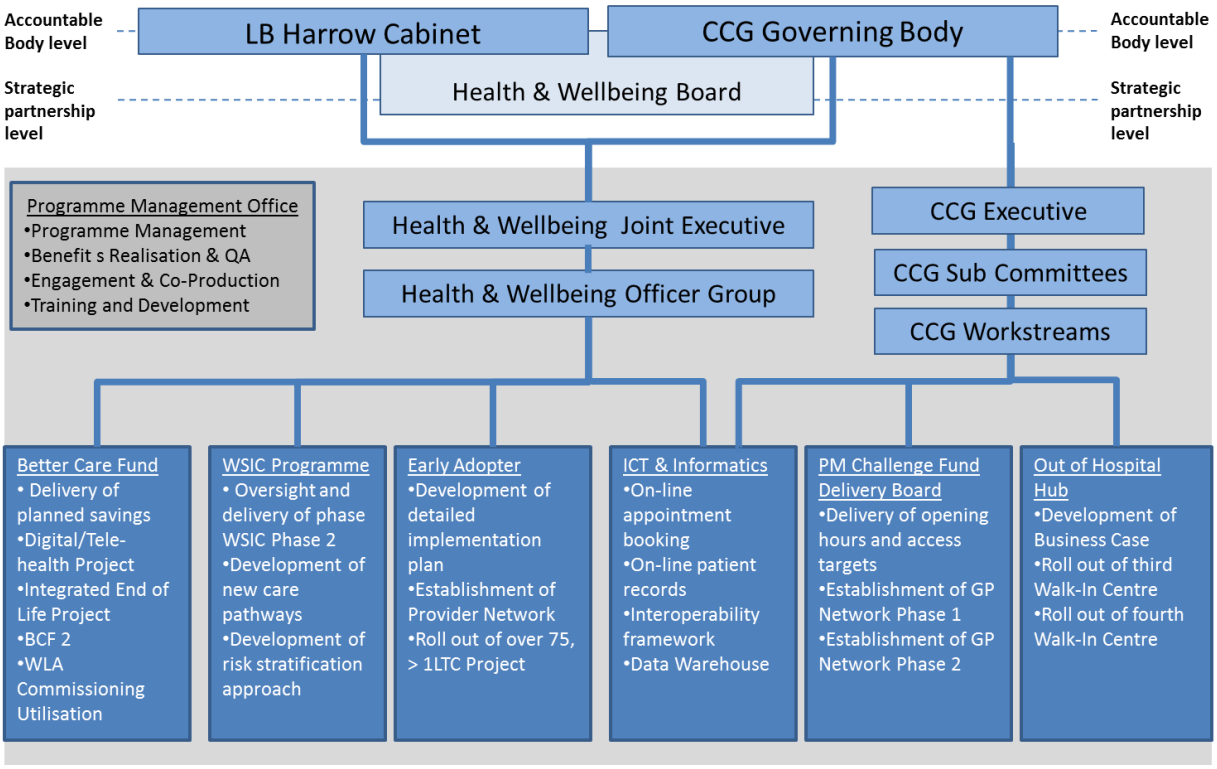
Coordination & Governance:

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 arrangement are:

- The Health and Wellbeing Board is the key forum for strategy development and agreement and continues to receive at each meeting a progress report on the delivery of the overall programme;
- The Health and Wellbeing Joint Executive operates 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;

Harrow Health and Social Care Transformation Programme - Governance Overview



- The Health and Wellbeing Executive operates as the Programme Board for all health and social care integration projects, including Better Care Fund projects;
- The CCG Executive oversees 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 meets fortnightly to provide direction and coordination to the programme.

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.

The existing Section 75 Agreement to support the management and distribution of Better Care Fund resources, associated with the achievement of the non-elected admissions targets will be revised to take account of changes within the revised plan and the additional CCG investment to the fund. 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.

Section 5: Approach to achieving National Priorities

Set out below is our outline approach to meeting each of the BCF National Priorities.

5.1 Plans to be jointly agreed – sign off process

Provider sign-up with plans

The Harrow Market Position Statement (MPS) sets out the direction of travel for providers of social care in the market place. The MPS for 2016/17 is drafted and includes representation from the independent sector providers and input from local people. It also addresses the demographic pressures and acuity of need so that providers and service users can work with the local authority in developing solutions.

The MPS reflects key areas of the BCF which have an impact on the delivery of social care and outcomes for local people. This approach enables us to engage providers in terms of market development in a way that links planning. An example of this can be seen in the development of reablement provision. Independent sector providers of reablement understand the capacity and service requirements for 2016-17 including the outputs and outcomes to be achieved.

These requirements are reflected in our service specifications and agreed with all providers on our approved framework. For 2016-17 we have extended our framework of reablement providers to ensure that demand continues to be successfully met, that there is stability in the market place and that the quality of service provision is maintained for local people. We are confident that through this engagement with providers we will continue to achieve the 80% success rate in terms of the number of people still living independently 91 days after discharge from hospital into reablement.

Housing authority engagement in developing the plan – DFG context

In developing and agreeing the plan the housing authority, in the context of Disabled Facilities Grant (DFG), has been involved. The housing authority has supported the strategic thinking about the use of adaptations and how a joined up approach can be taken to improving outcomes across health, social care and housing. In 2016-17 the housing element has been strengthened to reinforce the requirement for housing to be involved in the BCF plans.

Harrow's will allocate its funding, as appropriate, to the housing authority to enable it to continue to meet the statutory duty to provide adaptations to the homes of disabled people.
The Home Improvement Agency (HIA) in Harrow will continue to deliver advice, support, information, advocacy and practical help with designing and delivering repairs, adaptations to around 800 vulnerable people in 2016/17.

The services provided will be both cost-saving and preventive, aimed at prolonging older and disabled people's mobility, well-being, home safety, warmth and independence at home and preventing untimely or unnecessary admission to hospital or care.

5.2 Maintain provision of social care services (not spending)

There are a number of key elements to protecting social care in Harrow. The section below provides an indication of our successes and challenges.

There are significant financial challenges for LBH in maintaining the level of social care services provided. This includes pressures relating to the reduction in the financial envelope arising from the local government financial settlement as well as those from the demographic picture in Harrow, where the number of vulnerable citizens are growing whilst complexity is also increasing.

Amidst the challenging financial environment it is essential that social care is protected so as to keep people safe and meet our statutory obligations. In protecting social care we are also working innovatively with stakeholders, aiming to maximize the opportunity for co-production and empowering service users in the design of adult social care.

Summary of approach to support social care

Our approach to the maintenance of the provision of social care services is consistent with the 2012 department of health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14. Local adult social care services will continue to be supported within the plan in a manner that is consistent with 2015-16. In setting the level of protection for 2016-17 we have ensured that there is stability within social care, whereby we are able to continue to meet demand and deliver intended outcomes for local people.
The definition of social care support has been agreed and is as follows:

Safeguarding. Harrow Council is the lead for safeguarding across health and social care. Harrow has a well- developed joint approach to safeguarding and the planned joint working and allocation of resources ensures that this continues to be a focus. There is a growing year on year trend in alerts. There were 1,227 alerts last year, compared to 1003 in 2013/14, a growth of 22%. This year the projection is 1658 concerns at year end which will be an increase of 35%.
Deprivation of Liberty Safeguards. There has been a threefold increase in Deprivation of Liberty Safeguards cases on the previous year. The last reported figures indicated 800 (DoLs) referrals were made during the year, compared to year before of 385 therefore a threefold increase.

Personalisation and Choice. Harrow Council continues to offer its residents unparalleled choices in relation to arranging care to address their identified eligible social care needs. My Community e-Purse MCeP (our web-based support planning dynamic purchasing system) represents the direction of travel for Adult Social Care by offering some of the core philosophies of the Care Act 2014, choice and control over how care is delivered.

Supporting people with eligible need. It is estimated at year end that a significant number of people will have been assessed and new care placements made.

Responsive assessment and advice services. Figures indicate that a significant amount of new social care referrals will have been made in 2015-16 for short term support to maximise independence including requests being received from hospital discharges.

Reablement. A significant number of people will have been re-enabled, requiring no long term support. This includes supporting hospital discharge and a significant contribution to the whole system. Regular surveys are carried out to assess the quality of care and the experiences of those in receipt of the service. Harrow Council has developed a process for Reablement Carers assessment that mirrors the Reablement service for clients. Following a carers assessment, carers are referred to a third sector organisation including carers services for support that includes advocacy service, information and advice and counselling.

Carers Support. The carers strategy is currently being refreshed with the involvement of key stakeholders including the local authority, the CCG and the voluntary sector.

In addition to this performance we have also enhanced our approach to personalized coordinated care through the following:

- Improved pathway planning around reablement and hospital discharge planning
- Our commissioning approach is developing to be more ‘outcomes based’ and personalized reflected in the move toward more outcome focused service specifications
- We have strong engagement with the Health and Wellbeing board which supports the coordination of integrated thinking, commissioning and service offers.
-

The table below provides a comparison with 2015-16 and demonstrates that adult social care services will continue to be consistently supported.

Service Area	Social Care Activity	Data 15/16	Plan for 16/17
Reablement	The number of people who were still at home 91 days after discharge from hospital into reablement NOTE: this is based on ASCOF 2B	77.6%	80%
	Number of new reablement clients supported. NOTE: this is based on ASCOF 2D, home support services.	940	940
Hospital Discharge	Number of referrals made for social care support from hospital discharge	1470	1470
	Number of social care packages offered directly (without being referred to reablement).	380	380
Social Care	Approximate number of social care assessments carried out*	1600* approx	1600
	The number of reviews carried out on clients with long term support care packages	2650	2650
	The number of unscheduled reviews carried out	1050	1050
	The number of new residential and nursing care placements	220	220
	The number of clients in receipt of community services	2300	2300
	The number of safeguarding referrals made	650	650
	The number of Deprivation of Liberty Safeguards referrals made	800	800

*local data

5.3 Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

We will work towards delivering 7 days services across Health and Social Care as set out in the mandate. This is an aspiration within our out of hospital strategy and underpins the vision for integrated service in Harrow.

Current examples of 7-day social care services, which are being maintained include the following:

- Emergency Duty Team - this is a seven day service with social workers on site out of hours to take emergency referrals, conduct assessments and arrange provision.
- Community Alarm Services – this is a seven day service preventing unnecessary admission to hospital where people are living in their own homes.
- Hospital discharge into homecare and reablement – this is a seven day service available for people requiring the restart of social care support.

5.4 Better data sharing between health and social care, based on the NHS number

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 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.

Harrow has connection to NHS N3 network in particular those ASC teams operating FrameworkI, so there is now further interoperability within a safe and secure environment to source information through the Patient Demographics Service (PDS).

Currently all health services use the NHS number as the primary identifier for health and care services and appropriate agreements are in place.

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 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.

5.5 Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

A section 75 agreement between the Council and the Clinical Commissioning Group (CCG) is in place to underpin the agreement. Social care providers are specifically affected by changes of plans related to reablement. This includes the volume of people being referred by adult social care to approved providers of reablement services. Providers are clear as to the planned volume for 16/17 which is based on maintaining volume levels whilst achieving targets related to outcomes, particularly post reablement 91 day indicators.

In terms of social care services Harrow has restructured and created a People Directorate bringing together an all age disability approach to social care service provision and commissioning. The benefits of this approach include the following:

- A more streamlined system that is clearer and easier to understand
- Improved understanding and approach to need around the whole life pathway including mental and physical health.
- Consistency in service planning and delivery
- Less hand offs and referrals between services within the council.
- Improved use of resources to encourage business efficiency
- Improved strategic market development of services
- Reduce duplication of processes and disjointed information gathering
- Staff developing a wider range of skills

In terms of care for people with dementia, Harrow has identified a challenge being faced. Dementia diagnosis figures showed Harrow CCG reached 59.5% at the end of February 2016 which confirmed failure to meet the 67% target. In order to tackle this shortfall, there has been a joint approach developed to Dementia diagnosis, seeing the following changes:

- Increased local engagement and encouragement with the GPs and Practice Managers through Peer Group Meetings.
- Increased resource allocation to the MAS Service for 2 Consultant Psychiatrists (see table B, below)

- Weekly reports from CNWL (MAS) on activity and scrutiny of MAS performance around the Consultant teams (see table B, below)
- There has been an increase in diagnosis however delivery of the 67% target has not materialised despite additional funding
- Focus and prioritisation on waiting list over 250 and 19 weeks
- Harrow CCG engaged a EMIS data base specialist to train and support GP Practices with recording and ensuring accurate data recording on QOF
- Harrow CCG meet regularly with all practices through the Peer Groups to ensure, support and encourage higher levels of diagnosis and for Harrow patients
- Address issues around screening for scans and bloods as requested as part of the referral pathway depending on clinical presentation.
- Address cultural barriers stigma and concerns associated with Dementia diagnosis.
- The reconciliation exercise also unravelled a significant attrition rate of 35 patients which equates to 26% of the new patients added to the Dementia QOF Register. The key attrition factors are due to patients being deceased or moving to Care Homes in other boroughs.
- There has been weekly follow up contact with GP Practice Managers and GP's to ensure that Dementia QOF registers remains a priority

Harrow CCG has invested additional Funding of £155k. Initially £76k was given in August 2015 to increase the team by a consultant, a nurse and administration support for 3 months. This has been followed by further funding of £79k (total £155k) to finally clear the Memory Assessment Service waiting list and reach the 67% target by the end of April 2016.

5.6 Agreement to invest in NHS commissioned out-of-hospital services

This is a key element of the overall Shaping a Healthier Future Vision for a whole system, person-centred and outcome focused community service which provides care closer to home, reduces reliance on hospital based care and ensures that people have access to good quality, safe, locally delivered health care services.
There are specific plans to shift the setting of outpatient services from hospitals to the community in 2016/17 have been agreed with providers of hospital services.

Whole Systems Integrated Care

To support reducing our Non Elective Admissions; work continues on developing the Whole Systems Integrated Care programme (established 2012) in Harrow. Work is underway to ensure that 2016 is a year of transformation for the quality of care provided for people with Long Term Conditions in Harrow. This will include the establishment of an Accountable Care Partnership to deliver the work programme in the longer term.

In 2015/16 two new initiatives were launched and whilst at early stages of development are already delivering significant positive benefits to Harrow patients.

- Virtual Ward Project. In order to provide more intensive support in the community for patients at high risk of hospital admission but not requiring the short term crisis level support provided by the Rapid Response Team, network based Virtual Wards have been established. These are led by dedicated GPwSIs and supported by a multi-disciplinary team which also incorporates a Virtual Ward Case Manager. So far, over 60 patients have been supported through the establishment of the first Virtual Ward project and at full capacity it is expected that up to 150 patients will be supported through virtual wards at any one time.

- Enhanced Practice Nurse (EPN) Project. In partnership with the CCG, GP Practices across Harrow have employed Enhanced Practice Nurses to provide rapid and high level support for housebound patients at high risk of hospital admission. By 31 December 2015, over 724 patients had been supported, whose average age was 84 and all of whom were at risk of hospital admissions. Throughout the year there has also been a continued focus on utilising risk stratification.

Community Services: in 2015 the CCG re- tendered its community services contract to provide a more integrated care model with emphasis on high quality, responsive services able to manage a wider range of patients within the community, reducing the need for non-elective admissions. The new service commences on May 4th 2016.

In 2015/16 the CCG succeeded in reducing non-elective admissions by 1.4%, and A&E attendances were reduced by just under 3%. This was achieved through the expansion of the Ambulatory Emergency Care Unit and enhanced support in the community for patients with long term conditions.

In 2016/17 the following schemes will seek to reduce attendances at A&E and non-elective admissions to hospital through the CCG's Quality, Innovation, Productivity and Performance (QIPP) programme:

Adult Diabetes. This scheme will provide more services in community settings via the CCG funded Diabetes network nurses.

The aim is to reduce emergency attendances and admissions and the number of follow up attendances delivered in secondary care. This will be achieved by ensuring that the community nurses, primary care and secondary care work in a joined up seamless service to ensure optimum care delivery for patients. In addition there will be a programme of training and education and the promotion of self-care strategies for patients.

This is expected to achieve a reduction of in short term non-elective admissions with diabetes as primary diagnosis and a reduction of around 20% in outpatient activity.

Paediatrics. The paediatric project has two key components:

Activity Flow - During phase one of the paediatric programme, initial work will be undertaken to reduce the number of referrals through implementation of the Consultant Connect service and through a GP education and prevention programme. The implementation of Consultant Connect will provide direct access for GPs to paediatric consultants at Northwick Park Hospital which will reduce the number of referrals and improve the quality of referrals to secondary and potential tertiary centres as the consultants will be able to provide advice and guidance in relation to the most appropriate course of action without the requirement for an outpatient appointment. The overall impact will be a reduction in new and follow up appointments.

Acute Flow – A Paediatric Assessment Unit at Northwick Park Hospital is expected to reduce unnecessary A&E Attendances by 470 in 2016/17.

End of Life Care. The CCG has extended the 1 year pilot service that was commissioned to provide a co-ordination service for patients identified within the last year of life. Alongside a 24/7 single point of access telephone number for patients, carers and health care professionals, the service can also provide direct care to patients in their home. This is provided by a trained nurse or health care assistant depending on the need of the patient. The visiting service is available

between the hours of 7am-11pm, due to demand being very low over night, however the service can still be accessed for advice and support in these times.

Savings will be achieved through a reduction in admissions for patients identified in the last year of life. The current service across 15/16 is averaging 40 patient referrals a month and the full year forecast would be 480 patients referred to the service in the last year of life. The CCG is expecting that in year two of the pilot this will increase through knowledge of the service and caseload increasing and patients being referred earlier in the last year rather than later to make an impact. We are anticipating 800 patients will be referred into the service for 16/17. The CCG is enhancing the current service with an in-reach palliative care nurse within the acute Trust to assist with identification of patients, education of the service and delayed transfers of care.

Patients within the last year of life average 3.5 Non-elective admissions; it is assumed that the service will prevent in excess of 300 such admissions in 2016/17.

Non-Elective Hospital Pathways. There will be four elements to this scheme which will improve non-elective hospital pathways.

The first will focus on redirection to primary care in order to impact on the A&E flow. This will involve the development of a new A&E app specifically for Harrow CCG which shows real time waiting times at the Acute Trust and provides alternative pathways, i.e. WiCs, GP practices and urgent care centres (UCCs). In addition to this will be the use of Patient Champions at the front end of the service, who will work with patients in UCC and A&E and advise them on appropriate use of the hospital and alternative services, including how to register with a GP and facilitating appointments.
The second element will introduce some new pathways for ambulatory care sensitive conditions (ACS) as well as implementing the findings of the recent audit on the existing pathways within the Emergency Ambulatory Care Unit.

The above elements will ensure that the right cohort of patients are then being seen within A&E, this will in turn impact on the third element within this scheme which revolves around reducing the very short stay (0-4 hours) as well as the 0-1 day length of stay inpatient activity (in addition to the EACU admissions) where these patients are admitted for non-clinical reasons such as waiting for test results and transport delays. It has also been recognised that a high proportion of patients that fall into the cohort with a short length of stay go on to have no treatment.

The fourth and final element will be a review of UCC pathways to support the redirection work and reprocurement of UCCs. The expected reductions in activity are 1,100 A&E attendances and 110 non-elective admissions.

Community Beds. There are two elements to this scheme, the first is to reduce the length of time community rehabilitation patients spend in a rehabilitation bed at Edgware and Central Middlesex Hospital (Roundwood Ward), through focussing on rehabilitation need, rehabilitation potential, estimated dates of discharge (EDDs) and ensuring that the rehab and nursing teams plan for successful discharges within the patients planned pathway of care within these units. This links with the second element which is improvements in the discharge planning process with the Trust.

Together, these two elements are expected to reduce acute excess bed days by around 10%.

The CCG is also reviewing its bed base to consider options for maximum utilisation of the resource, option include the development of some 'Step Up' capacity to support avoidable admissions.

Admissions Avoidance. This scheme is made up of two elements, the first is improving nursing and care homes standards in order to stop inappropriate admissions into the acute trust. A recent review of Harrow nursing home data has demonstrated that savings can be made from a reduction of admissions through strengthening aspects of nursing home care to be equivalent to district nursing.

Harrow CCG has re-procured its community services and the new service specification, which commences on the 1st April 2016, includes provision of support to nursing homes. In addition to this the Enhanced Nurse Practitioners, which are aligned to Harrow GP practices, will work with nursing and care homes to ensure care plans are in place and understood by the staff. This will reduce admissions from care homes by around 5%.

The second element is around falls prevention. Firstly there will be a review of the current service to understand current provision and what enhancements may be required to the specification in order to reduce acute admissions resulting from falls. There is evidence to suggest that admissions can be reduced by as much as 50-60%, however we have taken a more conservative approach and assumed a reduction of 20%.

Risk Sharing

There are no contingency funds held as part of a local risk share arrangement. The financial position of the both the CCG and the LA is challenging and our shared challenge is whether the Council and CCG strategies are able to absorb any further reductions in funding and all other challenges through increasingly efficient ways of working.

The committed funds within the BCF are intended to protect, to maintain services and to maintain current performance levels through continued joint working between the organisations and their partners. As part of the BCF submission both organisations have signalled their on-going commitment to further developing their joint and integrated working arrangements.

This will include a systematic review of the existing out of hospital pathways to identify potential improvements in performance and to release much needed capacity across the whole system.

Section 4 of the 2016/17 BCF Plan demonstrates that adult social care service levels will continue to be consistently maintained based on 2015/16 outturn. We have assessed local pressures in terms of volume and demand and are confident that funded capacity will meet local need and deliver agreed outcomes for service users. Alongside this we intend to proactively monitor a number of areas including:

- Joint monitoring of planned BCF performance outputs including trends and forecasted pressures.
- Joint monitoring between the local authority and CCG of hospital pathways, processes and systems effectiveness.
- Effective management of social care market suppliers to support capacity and performance e.g. capacity maintenance with providers of reablement.
- Joint monitoring of discharge pathways and alternatives to residential care.
- Joint monitoring of DFG to support levels of independence within people's own homes and supporting discharge from hospital.

5.7 Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan

We will continue to take a whole systems approach to DTOC. The Local Authority continues to attend the local systems resilience group. Also, the DTOC is helped by Local Authority care management team who will continue to support the push to bring this measure down.

The plan is to continue to maintain DTOC levels as those of 15/16. With an aim of reducing further the number of delayed transfers and length of days delayed in the longer term. Some progress has been made to bring down DTOCs in 15/16 LNWHT through:

- ECIST Audit of MFD patients to identify root causes of delays to discharge
- RED-Green & SAFER Pilot wards
- Continuing Health Care process training for ward staff with clear timeline for completion
- CCA nurses in place to support process and timely discharge
- Additional staff for sourcing beds and an additional social worker to speed up joint assessment logistics. Brent Local Authority determining funding for additional social workers for weekend, appointing at risk
- Directory of Community Services assisting clinical decision making and support
- Reviewing Choice Policy so consistent across the 3 boroughs
- Social workers now on acute sites from all 3 main LAs
- Driving in-reaching of community hospitals to pull patients out when MFD

This DTOC reduction plan has successfully been able to bring DTOCs down from a high of 62 to 20. See appendix 3 for details of the work to date in achieving this and performance chart.

6. Performance Metrics

Indicator	2016/17 Target and Target Basis	Notes & Key Drivers
Non-elective Admissions (General and Acute) *(Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population.)*	***2016/17 Target:*** No additional reduction in NEA activity over CCG operating plan assumptions planned through BCF. ***Target Basis:*** Achieved target in 2015/16. Work continues on developing Whole Systems Integrated Care programme, including establishing an Accountable Care Partnership	• Current whole systems scheme to develop further to evidence outcomes • New national condition on NHS commissioned out of hospital services
Admissions to Residential and Care Homes *(Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population.)*	***2016/17 Target:*** 552.3 ***Target Basis:*** Target remains as per 2015/16. Planning for demand to remain consistent with the forecast 15/16.	• Rising demand from growing and aging population • Social care initiatives and housing support delivering advice/ support/ practical help with adaptations for vulnerable people - cost-saving & preventive measures to prolong people's independence at home & avoiding untimely or unnecessary admission to care

Effectiveness of Reablement *(Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.)*	***2016/17 Target:*** 80.0% ***Target Basis:*** Target remains as per 2015/16. Anticipate volume of referrals made into the reablement service will remain stable over the year, including demands as a result of winter pressures.	• Ensuring there are effective out of hospital services • Supporting people in their own homes
Delayed Transfers of Care *(Delayed transfers of care from hospital per 100,000 population.)*	***2016/17 Target:*** In development as part of local action plan to reduce DTOC. ***Target Basis:*** We will continue to maintain DTOC levels as those of 2015/16. Aim to reduce further the number and length of days delayed.	• Whole systems approach to DTOC. • LA continues to attend the local systems resilience group
Overall GP Experience	***2016/17 Target:*** 78.0% ***Target Basis:*** To improve on the current GP experience survey performance of 78%.	• Improving access to primary care in order to increase patient satisfaction • Whole Systems Integrated Care programme will increase access to primary care services
Social Care User Experience *(Local performance metric, measured annually.)*	**2016/17 Target:** 58.0% ***Target Basis:*** Target remains as per 2015/16.	• Patient engagement and improving patient experience.

7. Appendices

7.1 Appendix 1

Whole Systems Plan and Milestones

The table below sets out the proposed key milestones for Whole Systems Programme in the first half of 2016/17, as in 'Harrow WS Business Case 2016-17'.

Milestone	Deliverable
Friday 29 April 2016	• Draft Business Plan presented to IMG (27 April)
Friday 13 May 2016	• EMIS Enterprise Reporting Solution in place • Transfer of Care Navigators to HH CIC complete
Friday 27 May 2016	• WS Business Plan agreed by all WS Partners • Contracts and payment arrangements for all stakeholders including GPs to be in place • Integrated management structure for Whole Systems to be agreed by IMG

Friday 10 June 2016	• Systematic Case Identification Process underway • New Community Services operating arrangements to be fully aligned with Whole Systems (Virtual Wards, Practice Case Meetings, EPNs)
Friday 24 June 2016	• Operating Protocol for Whole Systems and Virtual Wards to be agreed by IMG • Methodology for calculating cashable benefits delivered through WS Programme to be agreed.
Friday 8 July 2016	• Service Manager for Whole Systems to be appointed • All VW cases to be on EMIS Community
Friday 22 July 2016	• First Monthly Performance Report to IMG • *1000 Anticipatory Care Plans to be completed* • *All Virtual Wards to have active case load of 25 patients or more*
Friday 12 August 2016	• PAM Tool to be fully operational
Friday 26 August 2016	• Whole Systems dashboard to be rolled out to all Practices • Whole Systems Specification for 2017/18 to be drafted
Friday 9 September 2016	• Service Manager for Whole Systems to be in post
Friday 23 September 2016	• Advance Care Plan Training Programme to be complete • *2500 Anticipatory Care Plans to be completed*

Proposed budget arrangements

The table below provides an overview of the proposed expenditure on Whole Systems Integrated care in 2016/17. Indicated in brackets is the extent of the provision to be contracted and also the proposed provider. For each programme scheme a specification, payment scheme and contract will be put in place between the CCG and the identified provider to ensure the effective delivery of the programme.

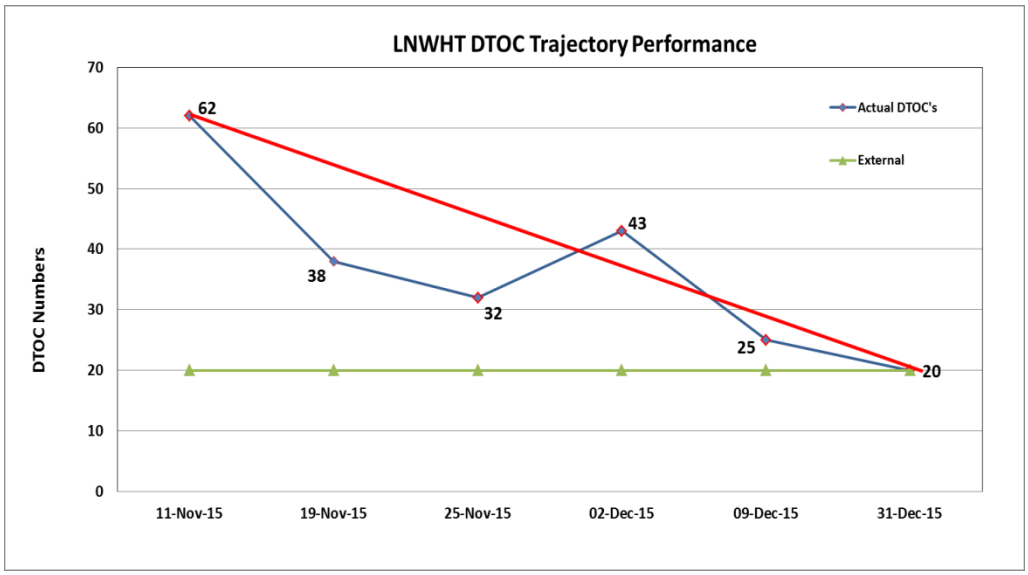
Programme Scheme	Value (£)
Care Navigator Contract (Harrow Health CIC)	250,000
Virtual Wards – Employment of GPwSIs (Various GP Practices & Harrow Health CIC)	600,000
Virtual Wards – Case Managers Contract (Soar Beyond)	250,000
Virtual Wards - Mental Health Consultant (9 Sessions)(CNWL)	140,400
Virtual Wards - Palliative Care Consultant (2 Palliative Care Nurses + .2 Palliative Care Consultant)(LNWHT)	116,000
Virtual Wards - (1.5 Social Care Workers)(LB Harrow)	66,000
Virtual Wards – GP Attendance and MDG Chair Supervision	56,000

Anticipatory Care Payment Scheme (5,000 @ £120 per patient)(GP Practices)	600,000
Home Not Hospital Scheme (Age UK)	75,000
WS Programme Team Resource	264,650
Anticipated under delivery due to slippage	-200,000
Total	**2,218,050**

Expenditure and value for money will be scrutinized by the CCG Finance and QIPP Committee and Governing Body or by the Non Conflicted Procurement Panel prior to approval and contract signature. This will be complete by 31 May 2016. In 2016/17 the budget will be managed and monitored by Harrow CCG on behalf of the WS Programme.

7.2 Appendix 2

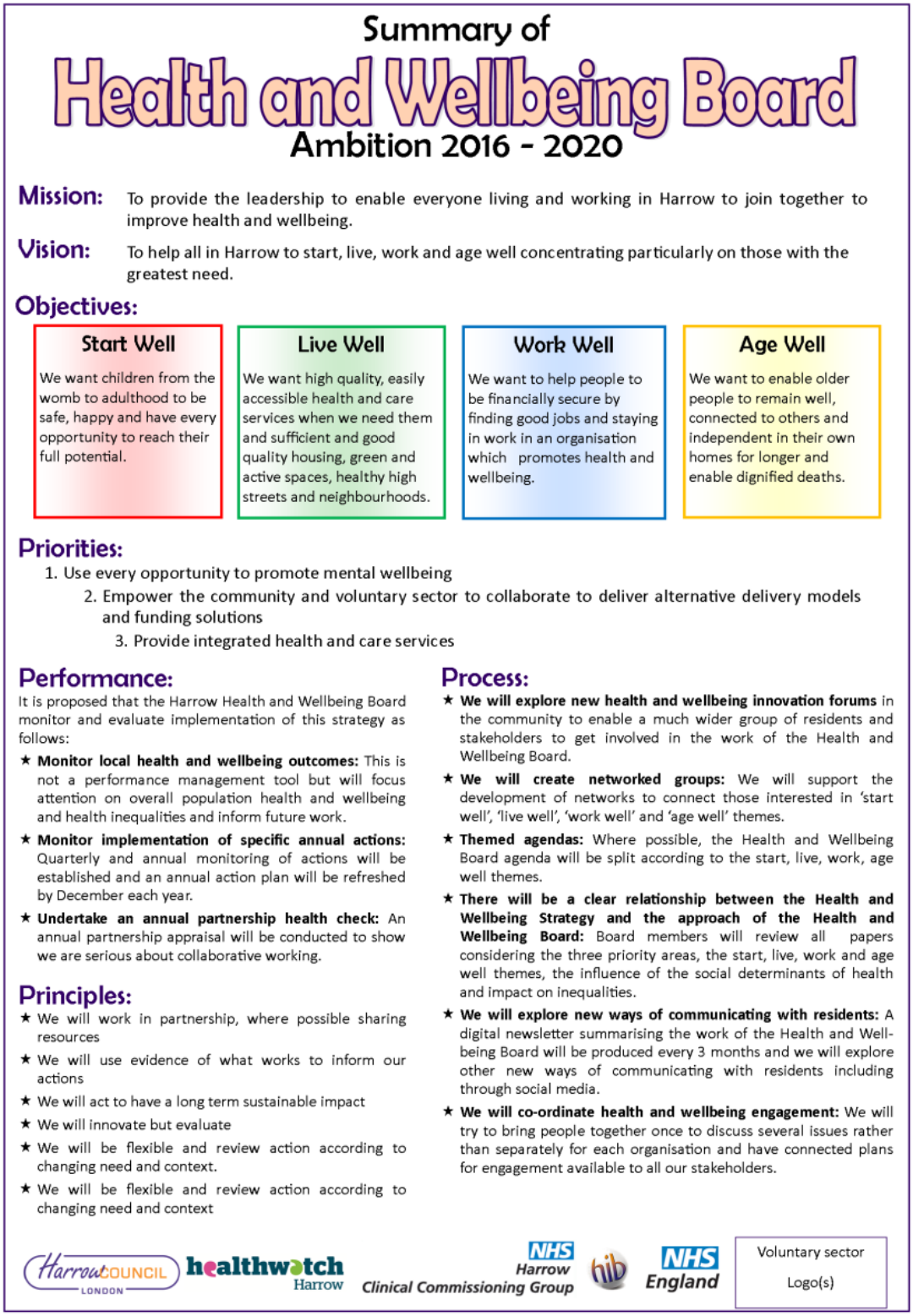
LNWHT DTOCs Progress and Reduction Plan in 2015/16



DTOC Reduction Plan		
No	**Name**	**Date**
1	Daily DTOC calls	Done
2	Daily Dashboard of DTOC performance	Done
3	Daily update on community bed capacity	Done
4	Nursing Home restrictions	Done
5	Nursing home assessment delays	Done
6	Patient Choice Policy - single policy to apply across all LNWHT sites	In Progress
7	Interim beds - Brent	Done
8	Interim beds - Harrow	Done
9	Staff Training	18-Dec
10	Bi-weekly Strategic telecon (Monday & Thursday)	Done
11	Review SRG membership	Done
12	Review Housing protocols & processes	Done
13	Improve Out of Area DTOC processes	Done
14	Clinical leadership for long stay meetings	Done
15	ECIST DTOC redisign process	31-Jan

7.3 Appendix 3

Health and Wellbeing Board Ambition



Summary of

Health and Wellbeing Board

Ambition 2016 - 2020

Mission: To provide the leadership to enable everyone living and working in Harrow to join together to improve health and wellbeing.

Vision: To help all in Harrow to start, live, work and age well concentrating particularly on those with the greatest need.

Objectives:

Start Well

We want children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential.

Live Well

We want high quality, easily accessible health and care services when we need them and sufficient and good quality housing, green and active spaces, healthy high streets and neighbourhoods.

Work Well

We want to help people to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing.

Age Well

We want to enable older people to remain well, connected to others and independent in their own homes for longer and enable dignified deaths.

Priorities:

1. Use every opportunity to promote mental wellbeing
2. Empower the community and voluntary sector to collaborate to deliver alternative delivery models and funding solutions
3. Provide integrated health and care services

Performance:

It is proposed that the Harrow Health and Wellbeing Board monitor and evaluate implementation of this strategy as follows:

- ★ **Monitor local health and wellbeing outcomes:** This is not a performance management tool but will focus attention on overall population health and wellbeing and health inequalities and inform future work.
- ★ **Monitor implementation of specific annual actions:** Quarterly and annual monitoring of actions will be established and an annual action plan will be refreshed by December each year.
- ★ **Undertake an annual partnership health check:** An annual partnership appraisal will be conducted to show we are serious about collaborative working.

Principles:

- ★ We will work in partnership, where possible sharing resources
- ★ We will use evidence of what works to inform our actions
- ★ We will act to have a long term sustainable impact
- ★ We will innovate but evaluate
- ★ We will be flexible and review action according to changing need and context.
- ★ We will be flexible and review action according to changing need and context

Process:

- ★ **We will explore new health and wellbeing innovation forums** in the community to enable a much wider group of residents and stakeholders to get involved in the work of the Health and Wellbeing Board.
- ★ **We will create networked groups:** We will support the development of networks to connect those interested in 'start well', 'live well', 'work well' and 'age well' themes.
- ★ **Themed agendas:** Where possible, the Health and Wellbeing Board agenda will be split according to the start, live, work, age well themes.
- ★ **There will be a clear relationship between the Health and Wellbeing Strategy and the approach of the Health and Wellbeing Board:** Board members will review all papers considering the three priority areas, the start, live, work and age well themes, the influence of the social determinants of health and impact on inequalities.
- ★ **We will explore new ways of communicating with residents:** A digital newsletter summarising the work of the Health and Wellbeing Board will be produced every 3 months and we will explore other new ways of communicating with residents including through social media.
- ★ **We will co-ordinate health and wellbeing engagement:** We will try to bring people together once to discuss several issues rather than separately for each organisation and have connected plans for engagement available to all our stakeholders.

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7.4 Appendix 4

Documents used in developing the narrative plan.

1. Harrow BCF Plan January 2015
2. Harrow CCG Community Services Specification Overview – 5th August 2015
3. Harrow Market Position Statement 16/17 (not published yet)
4. Health and Wellbeing Strategy
5. JSNA
6. Adult Social Care Outcomes Framework 2015/16
7. Harrow Council Mid Term Financial Strategy 2016/17 (part of Cabinet Report available online)
8. Harrow CCG Commissioning Intentions 2015/16
9. LNWHT – DtoC/MFFD, part of stocktake slide pack.
10. BHH Rightcare plan 2016.
11. NWL STP draft 2016 – final version for completion June 2016.
12. Harrow CCG Operational plan 2016/17 – draft March 2016.
13. Harrow CCG, WSIC – Whole Systems Integrated Care, business case April 2016.
14. BHH SRG plan.