# REPORT FOR: HEALTH AND WELLBEING BOARD

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| **Date of Meeting:** | **30 June 2016** |
| **Subject:** | Harrow and Brent System Resilience Group (SRG) |
| **Responsible Officer:** | Sue Whiting, Assistant Chief Operating Officer, Harrow CCG |
| **Public:** | Yes |
| **Wards affected:** | N/A |
| **Enclosures:** | None |

## Section 1 – Summary and Recommendations

This report gives an overview of the Brent and Harrow System Resilience Group (SRG), focused on Harrow. The SRG is an opportunity to work together collaboratively, bringing key organisations together to deliver timely access to care for the residents of Harrow Borough. The report summarises what an SRG is, and presents the work of the Brent and Harrow SRG in terms of key programmes and initiatives, and sets out the benefits of the SRG and other related programmes to the patients and population of Harrow.

**Recommendations:**
The Board is requested to:

(1) Note the report.

(2) Confirm the Harrow Council representative (and deputising arrangements) for the Brent & Harrow SRG

# Section 2 – Report

## 2.1 System Resilience Groups (SRGs)

Professor Sir Bruce Keogh outlined NHS England's vision for change in his *Review of Urgent and Emergency Care (the Review) End of Phase One Report*, published in November 2013[(1)].

Under this new care model outlined in the *NHS Five Year Forward View* [(2)], the urgent and emergency care system would be simplified to provide better integration between A&E departments and other services that provide and support urgent treatments.

Urgent and Emergency Care Networks (U&EC – see Figure 1) will be based on the geographies required to give strategic oversight of urgent and emergency care on a regional footprint, ensuring that patients with more serious or life threatening emergencies receive treatment in centres with the right facilities and expertise, whilst also assuring that individuals can have their urgent care needs met locally by services as close to home as possible.

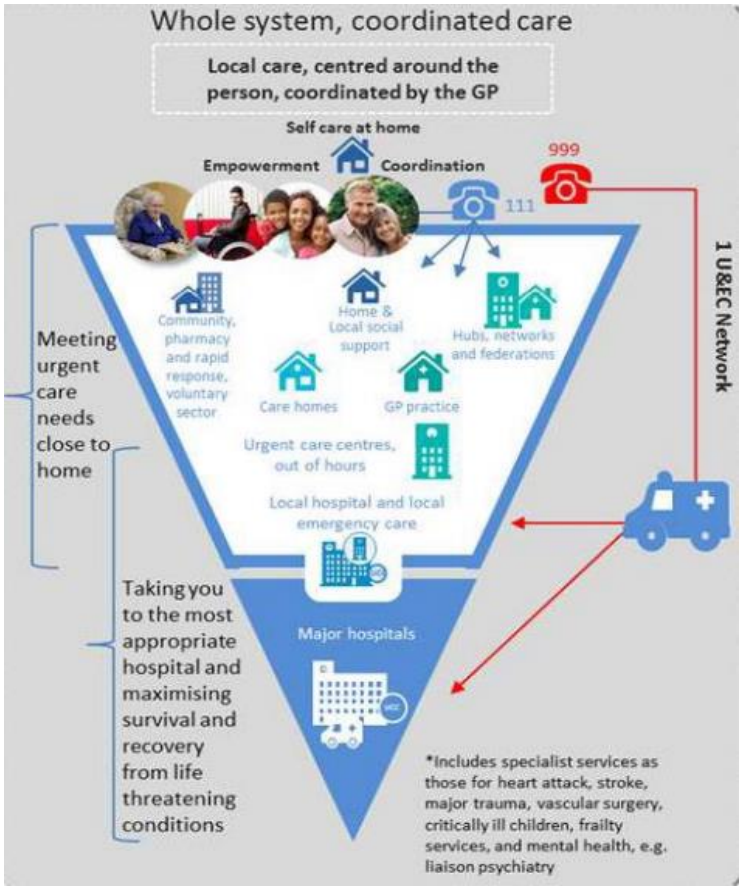



*Figure 1: North West London Strategy [(3),] based on Professor Sir Bruce Keogh NHS England's vision for change [(4)]*

System Resilience Groups (SRGs) have evolved to undertake the operational leadership of those local services fulfilling the role anticipated of the "operational networks" described in Sir Keogh's report.

SRGs retain responsibility for ensuring the effective delivery of urgent care in their area, in co-ordination with an overall urgent and emergency care strategy agreed through the regional Urgent and Emergency Care Network.

### 2.1.1 Important Operational Objectives for SRGs

For SRGs, important operational objectives include:

- The translation and delivery of network service designations and standards to match the local provision of services
- Ensuring a high level of clinical assessment for the patient, in or close to their home, and ready access to diagnostics where required
- The development and utilisation of "clinical decision-support hubs" to support the timely and effective delivery of community-based care
- Establishing effective communication, information technology and data sharing systems, including real-time access to an electronic patient record containing information relevant to the patient's urgent care needs
- The delivery of local mental health crisis care action plans to ensure early and effective intervention to prevent crisis and support people who experience mental health crisis
- Ensuring the effective development and configuration of primary and community care to underpin the provision of urgent care outside hospital settings 24/7 and
- Achieving accurate data capture and performance monitoring

## 2.2 Brent and Harrow SRG

SRGs are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. SRGs plan for the capacity required to ensure delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers.

SRGs offer a powerful opportunity to improve care for patients by, for example, fully integrating emergency healthcare development with primary care (where most unscheduled care takes place). SRGs have helped to establish more patient-centred care and are encouraging shared learning across health and social care communities by working in partnership.

Appendix 1 shows the membership of the Brent and Harrow SRG.

One of the principle purposes of the SRG is to drive the delivery of the Operational Resilience Plan by:

- Ensuring determination of need across the Harrow and Brent geographical footprint
- Initiating local change as identified
- Eliminating barriers to whole system improvement

- Ensuring all relevant perspectives as to both unplanned and planned care within the local health and social care system are adequately considered
- Enabling the management of Accident & Emergency 4-hour performance and referral to treatment times, including all of the contributing factors to achieving these targets
- Improving patient experience
- Assurance that appropriate systems and structures are in place and managed on a day-to-day basis
- Taking community pressures into consideration
- Monitoring progress against the required metrics of the Better Care Fund

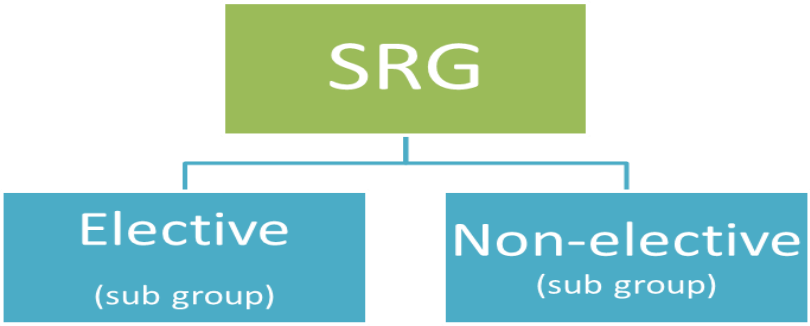
Key roles and functions of the SRG

- Provide an opportunity for all parts of the local health and social care system to co-develop strategy
- Collaboratively plan safe and efficient services for patients
- Provide the forum for system wide planning of service delivery

The SRG will measure its progress mainly through:

- Its ability to meet nationally prescribed planning requirements
- Working together to ensure that the Operational Resilience Plans and updates are supported and assured
- Demonstrable ability to flex or otherwise vary the ORP to incorporate actions required to meet specific identified challenges, including periods of likely heightened demand (e.g. over Winter)
- Ensure adequate testing of system wide escalation planning occurs
- Oversee monitoring of application of resilience funding to optimise outcomes

## 2.2.1 Composition of the Brent and Harrow SRG Sub-Groups




### *2.2.1.1 Elective Sub-Group*

This sub-group facilitates the delivery of elective (an admission to hospital that has been arranged in advance: it is not an emergency admission, nor a maternity admission nor a transfer from a hospital bed to another health care provider) projects that have been clinically agreed by members of the SRG.

The sub-group also oversees the performance management and quality assurance of elective schemes. In doing so, the elective sub-group identifies gaps in the delivery of target outcomes and initiates collaborative Task and Finish Groups. Risks are managed collaboratively through an agreed risk mitigation plan, and significant risks are escalated to the SRG.

Current work streams include:

- Referral to treatment initiatives (RTT)
- Cancer
- Diagnostics

### *2.2.1.2 Non-Elective Sub-Group*

This Sub-Group facilitates the delivery of non-elective (for unplanned, frequently urgent hospital admissions via A&E in most cases) projects that have been clinically agreed by members of the SRG.

Workstreams include:

- Winter Plan
- Better Care Fund

## 2.3 Benefits of the SRG to the Harrow Population

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.

By working in this way through the BCF and the SRG, the benefits for the patients and population of Harrow will be:

- Improvements in the quality of life for everybody in our Borough by providing proactive, joined-up services
- Stakeholder organisations working together, sharing information, expertise and experience better
- Delivering co-ordinated seamless care, in particular to those with the most complex health needs, including those with multiple long-term conditions
- Improving the efficiency of the existing system by reducing inter-agency referrals
- Reducing the utilisation of acute care resources to support our residents
- Making it easier for everybody, however sick or frail, to continue to live happily and safely at home.

## 2.4 Progress and Update Against 2015/16 Objectives

### 2.4.1 Elective Sub-Group

#### *2.4.1.1 RTT*

The London North West Hospital Healthcare (LNWHT) Trust's RTT position is currently not achieving the target for incomplete pathways. Most specialities are under pressure as all urgent requests are being prioritised. The focus is on driving efficiency, and a plan is in place to improve performance which will take time to embed.

#### *2.4.1.2 Cancer*

Cancer performance with regards to the 62 Day Cancer Waits has been challenging for the Trust to achieve in previous months. New for 2016/17 is the Cancer Remedial Action Plan (RAP) agreed between the LNWHT and Commissioners, and measures are being put in place to make improvements.

#### *2.4.1.3 Diagnostics*

Diagnostic performance has dipped since September 2015 in regards to the 6 week diagnostic wait. An improvement trajectory is in place along with an improvement plan focusing on patient booking, imaging, physiological measurement and endoscopy.

### 2.4.2 Non-Elective Sub-Group

#### *2.4.2.1 A&E performance*

Achievement of the A&E 4-hour wait target continues to be challenging. Work has been on-going throughout 2015/16 with London North West Healthcare NHS Trust (LNWHT) to improve patient flow and reduce delayed transfers of care. 43 new modular beds were opened in January 2016 to meet additional demand. LNWHT has submitted a revised action plan and trajectory to commissioners which has been agreed. Additional staffing has been brought into A&E and Surgical capacity continues to be utilised to ensure that bed breaches are minimised.

#### *2.4.2.2 Emergency Care Improvement (ECIP)*

Brent & Harrow SRG are working closely with ECIP (previously called Emergency Care Intensive Support Team - ECIST) to review and improve emergency care processes at LNWHT and support improvements to patient flow through the trust. This will improve both the 4 hour wait A&E target achievement and discharges from ED and Inpatients.

#### *2.4.2.3 Delayed Transfers of Care (DToC)*

The non-elective sub group actively reviews DToC numbers including the number of DToC patients and the number of Days lost due to DToCs. The top breach reasons across providers is also reviewed. Bottlenecks across the system are then removed to enable patient flow to be improved.

### *2.4.2.4 Discharge pathway*

As well as the ECIP discharge work, Brent & Harrow is working with partners across North West London to review and implement a universal discharge protocol. This work involves discussions with key stakeholders to review and compare current discharge policies for gaps and best practice and develop a unified protocol accepted across agencies.

### *2.4.2.1 Winter Planning*

Harrow CCG Winter Schemes for 2015/16 are shown in the table below.

*Table 1: Winter Schemes – Harrow CCG 2015/16*

| Harrow CCG Local Winter Schemes 2015/16 |
|---|
| Winter / Emergency Planning (Willow Ward) |
| Mount Vernon Beds – Edmund Ward (Step Down bed reserve) / CLCH |
| NH W16 Additional Beds in Willesden (Furness) |
| 3 Neuro Beds |
| 10 Nursing Beds |
| NH W7 Acute Psychiatric Unit – Co-located (transit Lounge) |
| Winter Resilience – Continuing Health Care Assessment (Staff Cost) |
| 3 Occupational Therapists (Band 5) |
| STARRS Social Worker |
| Social Care Harrow |
| Reablement |
| Care UK Green Ambulance (111 Resilience Scheme) |
| Winter Pressure campaign advertising cost |
| Additional Winter Pressure |
| 111 Pharmacy Hub |

### *2.4.2.2 Better Care Fund*

The Better Care Fund [5] (BCF) is a Programme spanning both the NHS and Local Government in each footprint area. It has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wrap-around' fully integrated health and social care, resulting in an improved experience and better quality of life.

Working with Harrow Local Authority, the agreed BCF schemes for 2016/17 will be Protection of Social Care Services (provided by the Local Authority) and Whole Systems & Transformation of Community Services (provided by Harrow CCG).

The funding will be supported by a Section 75 agreement between the CCG and the Local Authority (such a S75 agreement allows the two bodies to enter into partnership agreements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised).

### *2.4.2.1 Protection of Social Care*

In 2015/16, the Protection of Social Care Programme focused on the implementation of the Health and Social Care Act (2012) to support people with eligible levels of need, and to deliver high quality reablement and rehabilitation.

In 2015/16, the work looked at delivering:

a) Swift access and assessment, either from the acute sector or from a community setting, fully aligned with integrated teams wrapped around GP services
b) Reablement at the 'front of house' when people present to social care
c) A diverse range of available services for those eligible, purchasable through 'personal budgets'
d) 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 will be to ensure that the social care provision essential to the delivery of a safe, effective, supportive whole system of care is sustained and the same level and quality of service.

### *2.4.2.2 Whole Systems Integrated Care and Transformation of Community Services*

In 2015/16, 2 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 GPs with Special Interest (GPwSI) and supported by a multi-disciplinary team (MDT), which also incorporates a Virtual Ward Case Manager.

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

A key innovation in 2015/16 was the development of the Anticipatory Care Plan element of the Care Plan which pro-actively sets out future goals and actions for each patient.

Another key area of work in 2015/16 was the measurements of benefits achieved through the delivery of the Whole Systems (WS) Programme.

This focused on the avoidance of non-elective, elective, and accident and emergency admissions.
Monthly monitoring indicated 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 WS Programme is to demonstrate the sustainability of a multi-disciplinary and collaborative approach for 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 years of age, and have one or more long-term conditions. In total, there are 28,400 patients within the Borough that are over 65, with one or more long-term conditions and these currently account for 5,960 unplanned hospital admissions each year at an average cost of £2,628 each, and a total cost of £16 million per year.

### *2.4.2.2 BCF Future Plans for 2016/17*

In 2016/17, the WS Programme will focus on providing anticipatory, multi-disciplinary care for those 5,000 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 3 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 conditions, and an EMIS IQ Risk Score of 40 or over
- People over 65, with one or more long-term conditions, 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 conditions, currently living in a residential or nursing care home in the Borough

By focusing support on a proportion (approximately 20%) of the over 65s with one or more long-term conditions 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 5,000 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. 7 further outcome measures have also been developed for the WS Programme in 2016/17 and performance against each will be measured throughout the year. These measures are:

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

## 2.5 New Developments / Models for Brent and Harrow SRG - The High Impact 8 Change Model

Brent and Harrow CCG are working towards using the High Impact 8 Change Model as a framework for delivering health and social care improvements to Brent and Harrow patients (see Figure 2).

The Model was produced by several organisations: the Department of Health, the Local Government Association; NHS England; Monitor; Trust Development Agency (TDA); and ADASS, the Association of Directors of Adult Social Services.

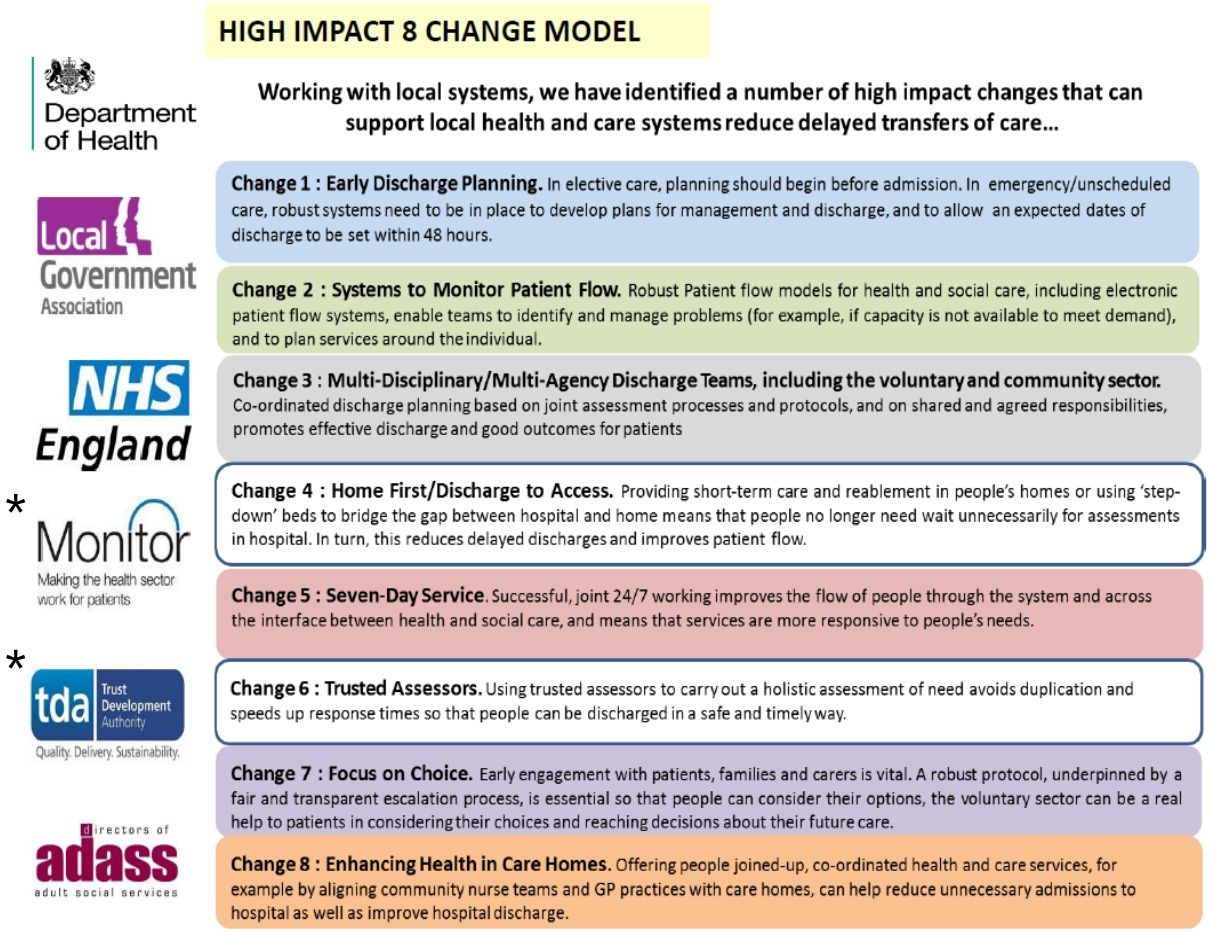



*Figure 2: High 8 Impact and Change Model*

* Note: The TDA and Monitor are now part of NHS Improvement.

At present, the Brent and Harrow SRG is undertaking a gap analysis and working towards incorporating the NHS Constitution and Outcomes Framework targets with the recently released *"CCG Improvement and Assessment Framework 2016/17"* [6] into a revised suit of indicators for the Brent and Harrow SRG.

These indicators will help drive performance improvement of the High Impact 8.

## 2.5.1 Current self-assessment against the High Impact Change Model

Ensuring people do not stay in hospital for longer than they need to is an important issue – maintaining patient flow, having access to responsive health and care services and supporting families are essential.

Valuable lessons were learnt from the health and social care system across the country last winter about what works well, and these lessons have been built into the High Impact Change model.

We have reviewed Brent and Harrow SRG's current maturity against the High Impact Changes assessment criteria which supports each change in the model. The evidence used is a base position of what is currently available to the Brent Harrow and Hillingdon CCGs Delivery and Performance Team.

Current assessment position.

| | Not yet Established | Plans in place | Established | Mature | Exemplary |
|---|---|---|---|---|---|
| RAG RATING | Rating 1/5 | Rating 2/5 | Rating 3/5 | Rating 4/5 | Rating 5/5 |

| Impact Change | Current assessment Position | Evidence link |
|---|---|---|
| Early discharge planning | Rating 2 - Plans in Place | One version of the truth. ED Action Plan. BCF |
| Systems to monitor patient flow | Rating 2 - Plans in Place | One version of the truth. ED Action Plan. BCF |
| Multi disciplinary / multi agency discharge teams | Rating 2 - Plans in Place | Brent & Harrow BCF plans |
| Home first / Discharge to Access | Rating 2 - Plans in Place | Brent & Harrow BCF plans |
| Seven Day Service | Rating 2/3 - Plans in Place / Established | Brent & Harrow BCF plans |
| Trusted Assessors | Rating 2 - Plans in Place | Brent & Harrow BCF plans |
| Focus on Choice | Rating 2 - Plans in Place | Brent & Harrow BCF plans |
| Enhancing Health in Care Homes | Rating 2 - Plans in Place | Brent & Harrow BCF plans |

*Figure 3: High 8 Impact and Change Model – Brent and Harrow SRG self-assessment rating*

## 2.5.2 Conclusion of assessment

The first run of the self-assessment found that Brent and Harrow SRG is currently rated as 'Plans in Place' (Figure 3) for the High Impact Change Model.

A prudent view has been taken in making the assessment due to the materials at hand. For this reason, we could anticipate that assessment of each change could in effect move up one position.

It is also expected that the assessment position will move up in ratings once leads have been identified to give comprehensive updates - specifically against the

assessment criteria, and once further documents and evidence are interrogated further.

### 2.5.3 Next steps

Further work will be done to progress the self-assessment of Brent and Harrow SRG against the High Impact Change model, which will result in a firm baseline position of rating for each change on, which to build and improve towards higher ratings and plug gaps in assessment assurance.

Gaps in assurance of assessment will be targeted and filled, while actions will be addressed to increase rating standards.

It is suggested that a position of 'Established' (see Figure 3) is aimed for in the first instance for each module in the High Impact Change Model.

A performance dashboard will be developed with robust metrics which will monitor both the High Impact Changes and their progress to moving up to the next rating step, and system improvement to delivering patient care.

The ultimate conclusion of this work will see SRG meetings using the High Impact Change model to assess, interrogate and improve key workstreams.

This would be conducted under the guidance and with the assistance of a comprehensive virtual PMO from the newly configured BHH Delivery and Performance team.

## 2.6 Summary

The Brent and Harrow SRG is a senior leaders' group that is tasked with ensuring that the different organisations and stakeholders – including the voluntary sector – all work together to ensure that, operationally, patients with more serious or life threatening emergencies receive treatment in centres with the right facilities and expertise, whilst also assuring that individuals can have their urgent care needs met locally by services as close to home as possible.

**APPENDIX 1**

## Membership of Brent and Harrow SRG

| Name | Title/Role | Organisation |
|---|---|---|
| Dame Jacqueline Docherty | Chief Executive | London North West Hospital Trust (LNWHT) |
| Dr Charles Cayley | Medical Director | LNWHT |
| Lee Martin | Chief Operating Officer | LNWHT |
| Yvonne Leese | Director of Community Services | LNWHT |
| Maeve O'Callaghan-Harrington | Deputy Director of Operations | LNWHT |
| Vince Baxter | General Manager – Adult Services | LNWHT |
| Jason Antrobus | Head of Performance | LNWHT |
| Jo Ohlson | Director of Commissioning Operations NWL | NHS England |
| Matthew Bailey | Deputy Head of Assurance NWL | NHS England |
| Pauline Cranmer | Assistant Director of Operations | London Ambulance Service (LAS) |
| Dr Etheldreda Kong | Clinical Chair | Brent CCG |
| Dr Sami Ansari | Clinical Lead for Acute & Urgent Care | Brent CCG |
| Sarah Mansuralli | Chief Operating Officer | Brent CCG |
| Isha Coombes | Assistant Director - Out of Hospital Services | Brent CCG |
| Dr Amol Kelshiker | Clinical Chair | Harrow CCG |
| Javina Sehgal | Chief Operating Officer | Harrow CCG |
| Sue Whiting | Assistant Chief Operating Officer | Harrow CCG |
| Phil Porter | Strategic Director – Community Wellbeing | Brent Local Authority |
| Yolanda Dennehy | Adult Social Care Lead | Brent Local Authority |
| Bernie Flaherty | Director of Adult Social Services | Harrow Local Authority |
| Sean Riley | Social Care Service Manager | Harrow Local Authority |
| Rob Larkman | Accountable Officer | Brent Harrow and Hillingdon CCGs |
| Jan Norman | Director of Quality & Strategy | Brent Harrow and Hillingdon CCGs |
| Alex Faulkes | Director of Delivery & Performance | Brent Harrow and Hillingdon CCGs |
| Jeff Boateng | Deputy Director of Delivery & Performance | Brent Harrow and Hillingdon CCGs |

**REFERENCES:**


1. *"Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report";* NHS England; http://www.nhs.uk/nhsengland/keogh-review/documents/uecr.ph1report.fv.pdf
2. *"NHS Five Year Forward View";* NHS England; https://www.england.nhs.uk/ourwork/futurenhs/
3. *"NHS 111/GP Out of Hours Integrated Services - A key role in the redesign of urgent and emergency care";* North West London Collaboration of CCGs; https://www.harrow.gov.uk/www2/documents/s130336/151014%20NWL%20JHOSC%20-%20paper%202%20-%20Update%20on%20NHS%20111%20service.pdf
4. *"Role and Establishment of Urgent and Emergency Care Networks";* NHS England; http://www.nhs.uk/NHSEngland/keogh-review/Documents/Role-Networks-advice-RDs%201.1FV.pdf
5. *"Better Care Fund";* NHS England; https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
6. *"CCG Improvement and Assessment Framework 2016/17*", NHS England; https://www.england.nhs.uk/commissioning/ccg-auth/

**Financial Implications/Comments**

No direct implications.

**Legal Implications/Comments**

https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/

**Risk Management Implications**

Lack of collaboration may cause delays in access to care, and/or failure to utilize resources most appropriately.

**Equalities implications**

Was an Equality Impact Assessment carried out? EIAs are be carried out under each individual Programme of work

**Council Priorities**

The Council's vision:

**Working Together to Make a Difference for Harrow**

# Section 3 - Statutory Officer Clearance (Council and Joint Reports)

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|---|---|
| Ward Councillors notified: | **NO** |

# Section 4 - Contact Details and Background Papers

**Contact:** Sue Whiting,
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020 8966 1006

**Background Papers** None.