Harrow Whole Systems Integrated Care Early Adopter Project presentation to

healthwatch Harrow

Friday 20 June 2014

Dylan Champion,
Harrow Whole Systems Integrated Care
Early Adopter Project Manager

Living ***longer*** and living ***well***

Introduction

- What is the Harrow Whole Systems Integrated Care Early Adopter Project?
- Who has been involved in developing Harrow plans?
- What is the proposal for improving services and how will it make a difference?
- What could it mean for a service user?
- What happens next?

What is the Harrow Whole Systems Integrated Care Early Adopter Project?

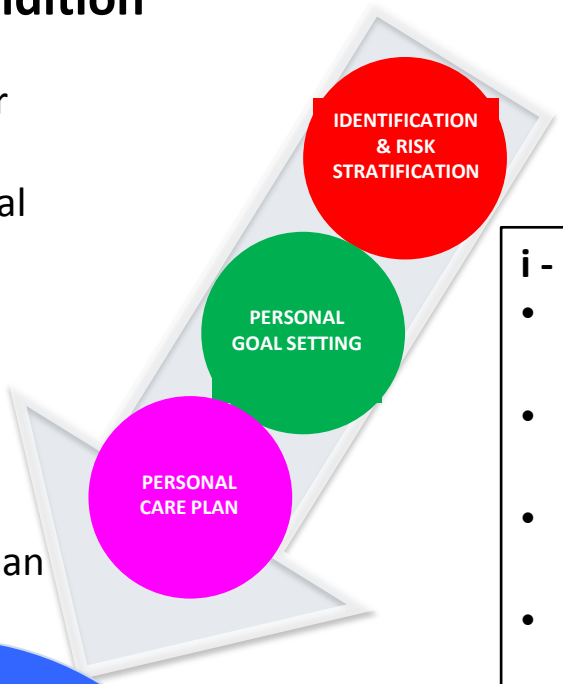
Project aimed at making life better for older people with at least one long term condition by providing more coordinated health and social care support

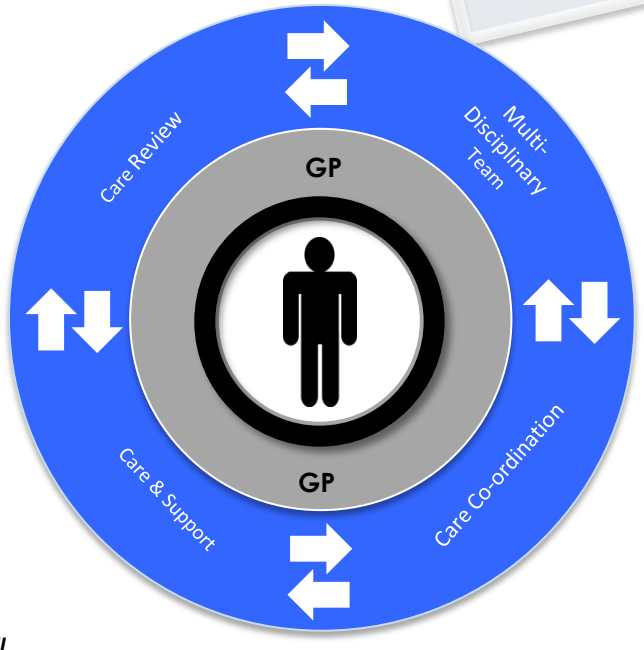
Part of a larger project taking place across North West London, which is funded by the Department of Health and is one of 14 national pioneer projects which are designed to transform the way that health and social care services are provided

Something that organisations, individuals and carers from across Harrow have worked together on over the last three months to develop the initial proposals

Early Adopter Project – Providing better long term care for older people with more than one long term condition

- Focus on self care and user empowerment
- GP identifying the individual using risk stratification
-Share understanding with patients and carers to agree care needs
-Understand personal goals
-Develop and deliver personalised care not just plan





i - statements

- All my needs as a person are assessed and taken into account.
- My carer/family have their needs looked at and are given support to care for me.
- I am supported to set and achieve my own goals.
- Taken together, my care and support help me live the life I want to the best of my ability.
- I am in control of planning my care and support.
- I decide the kind of support I needed and how to receive it.

Living ***longer*** and living ***well***

National Voices
People shaping health and social care

Meet Mary, an elderly patient with more than one Long Term Condition

- *Mary is 77 years old and suffers from multiple long-term conditions (Diabetes, COPD, CHD, hypertension, obesity). Her condition is at high risk of deterioration.*

Mary's story today

- *In the last year, Mary has had several emergency admissions via A&E, many GP visits (each with a different GP), multiple contacts with different people from community health services e.g. district nurses, and multiple visits from different social care staff. In some weeks, 2 or 3 different people come to her house to do different tasks.*
- *Mary feels anxious and unsupported, as she sees no coordination or continuity in her care. There is no single care plan for all her care, and information about her condition is held by different providers. A lack of coordination and planning mean that she accesses health and social care far more often than necessary or beneficial for her.*
- *In addition to the impact on Mary, the people who provide health and social care for Mary are frustrated by how her care is organised. When her condition deteriorates, they need to contact multiple providers several times; numerous phone calls and follow-ups to chase progress.*
- *No one person, even the GP, has clear visibility on everything that is being done for Mary, what the goals are, or, what the next steps are to improve Mary's health.*

Mary's story in a Whole System Model

- ***Mary now has a dedicated named GP and a Care Coordinator** who she can contact and trusts that this person understand her specific wellbeing needs. When she is unwell **she contacts her care coordinator rather than going to A&E**.*
- *Mary and her carer are now aware of her **care plan** as it has been **designed with her and her carers** and is happy with the level of community services visiting her as staff talk to each other and do things for each other where possible. **All professions that visit her are aware of her care plan**. The people who are providing care for her feel happy, confident and motivated.*
- ***Mary and her carer trust this service** and feels that she can contact this service when she needs it through the care coordinator or her named GP. Mary and her carer are **empowered to make informed decisions on her care plan**.*
- ***Increased training and communications** results in both Mary and the MDT team feeling happy, confident and motivated to achieve the best outcomes that Mary wants and needs. **The system is empowered through** better **alignment of skills and pathways** and through the use of **capitated budgets**.*

Over 120 service users, carers, lay partners, staff, , GPs, commissioners and providers have been involved in developing the Harrow proposals. Underpinning our Project are our Guiding Principles

Harrow COUNCIL LONDON

Ealing Hospital NHS Trust

Central and North West London NHS Foundation Trust

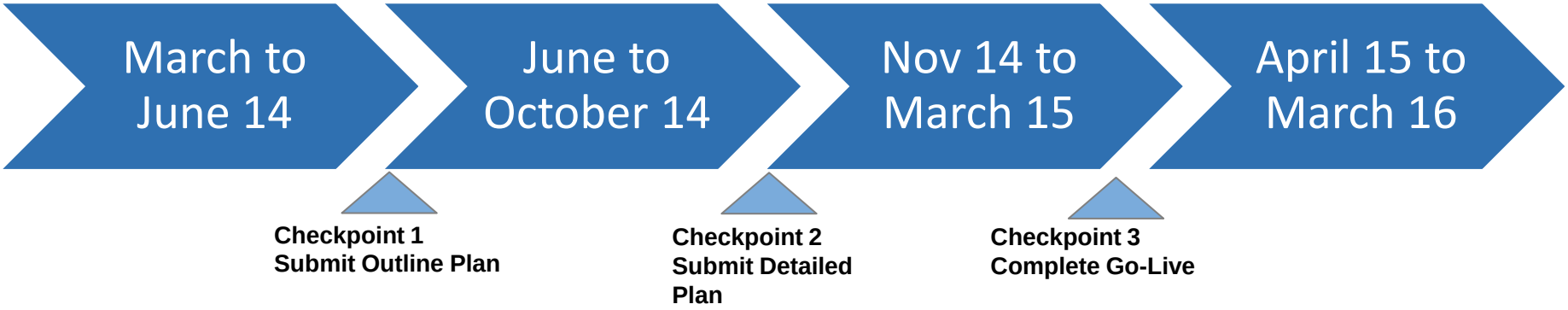
NHS Harrow Clinical Commissioning

healthwatch Harrow

The North West London Hospitals NHS Trust

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

We have committed to developing a single Integrated Health and Social Care Transformation Plan and a detailed Early Adopter Whole Systems Plan by Oct 2014



Outline Whole Systems Plan

- Vision & target population
- Model of Care

Go/No Go decision?

Joint Transformation Plan

- Agreed to develop joint transformation/ commissioning plan
- Agree governance/programme management arrangements
- Agree scope of programme

Final Detailed Whole Systems Plan

- **Agreed business case for whole systems approach**
- Commissioning intentions
- Implementation Plan inc. training and OD

October 2014

- **Period for seeking final approval from Partners prior to submission**

Joint Transformation Plan

- Joint strategic priorities
- Commissioning intentions & financial strategy
- Response to Care Act

Early Adopter Whole Systems Implementation

- **Complete implementation of ICP to support new arrangements**
- Complete benchmarking
- Set up of performance management arrangements
- Implement training and OD plan
- **Negotiate new contractual arrangements**
- **Establish shadow budget and contract management arrangements**

Joint Transformation Plan Implementation

- Ensure delivery of BCF & other strategic priorities

Early Adopter Whole Systems Implementation

- **Whole Systems go-live with capitated budgets**

Living ***longer*** and living ***well***

Next steps

Thurs 3 July

- **Health and Wellbeing Board update**

w/b 15 July

- **Working Group - Thank You event and next steps**

Produce detailed Plan

- How do users want to be supported?
- How will locality teams operate?
- Where will they be based?
- What type of expertise will need to be in each team
- Who will be responsible for each team
- How will the new approach make a difference to users?
- Is the new approach affordable?
- What preparations are required to implement the new plans?

30 October

- **Plans for 2015/16 to be agreed**

April 2015

- **Roll out of new arrangements begins (if detailed plans agreed)**

Thank You

dylan.champion@nhs.net 0774 878 6302

Living ***longer***
and living ***well***