North West London Integrated Care System
Working together for better health and care

Harrow Borough Based Partnership

2020/21 Better Care Fund End of Year Submission

Harrow Health and Wellbeing Board
28th July 2022

BCF Submission Process

The BCF Plan was endorsed by the Harrow Health and Care Executive.

A draft submission was made on 16th November and approved by the Health and Wellbeing Board on 23rd November.

NHSE considered the submissions from each HWB area and provided feedback in January 2022.

The Year End Submission was made in May and is now being presented to the HWB for retrospective endorsement to meet one of the National Conditions.

Elements of the Plan

The BCF Plan comprises 3 elements:

1) **Financial Schedules**: Funding arrangements between the LA and CCG and scheme schedules have been agreed.

2) **BCF Outcome Metrics**: Plans for 2021/22 outcome measures and Year End position.

3) **Supporting Narrative**: A summary is provided in the slides below.

1. Financial Schedules

The value of the schemes pooled within the BCF in 2021-22 totaled £25,317,782, with health schemes totaling £10,329,723 and local authority schemes £14,988,509.

The local authority schemes comprise the following:

a. Disabled Facilities Grants - £1,721,553 (paid directly to the Council)

b. Improved Better Care Fund Grant - £6,467,630 (paid directly to the Council)

c. Better Care Fund (Protection of Social Care Services) £6,799,326 (contribution from CCG)

2. BCF Outcome Metrics

Each HWB area was required to propose plans for the following Outcome Metrics for the remainder of 2021/22:

1a. Percentage of Patients who have been in hospital for longer than 14 days
1b. Percentage of Patients who have been in hospital for longer than 21 days
2. Percentage of Hospital Inpatients who have been discharged to usual place of residence
3. Unplanned hospitalisation for ACS conditions
4. Long Term Support Needs of Older People met by Admission to Residential and Nursing Care Homes
5. Proportion of Older People who Were Still at Home 91 Days After Discharge from Hospital into Re-ablement / Rehabilitation Services

Setting and Delivering Outcome Metrics: Percentage of Patients who have been in hospital for longer than 14 / 21 days

Reverting to 19/20 performance would imply a substantial deterioration in current performance, even allowing for increased levels of delays during the winter period.

Harrow has produced a revised forecast that excludes 20/21 activity and has used this to set a target.

		21-22 Q3 Plan	21-22 Q4 Plan	Actual to End Feb
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	10.3%	11.1%	10.9% / 10.3% On Track
	Proportion of inpatients resident for 21 days or more	4.9%	5.9%	5.6% / 4.9% On track

	NHSE Forecast: All HWBs		NHSE Forecast: London (sum of 33)		Actual 19/20 Harrow		NHSE Forecast: Harrow		Harrow Proposed Forecast		Actual to End Feb	
	14+	**21+**	**14+**	**21+**	**14+**	**21+**	**14+**	**21+**	**14+**	**21+**	**14+**	**21+**
21/22 Q3 Forecast Average	11.9%	5.4%	11.0%	5.1%	11.6%	6.2%	9.9%	4.8%	10.5%	4.9%	10.9%	5.6%
21/22 Q4 Forecast Average	12.2%	5.3%	11.8%	5.0%	12.4%	7.6%	9.8%	4.6%	11.3%	5.9%	10.3%	4.9%
Total	**24.1%**	**10.8%**	**22.7%**	**10.1%**	**24.0%**	**13.8%**	**19.7%**	**9.3%**	**21.8%**	**10.8%**		

Setting and Delivering Outcome Metrics : Percentage of Hospital Inpatients who have been discharged to usual place of residence

2. Percentage of Hospital Inpatients who have been discharged to usual place of residence

	21-22 Plan	Actual to end Feb
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.0%	93.8%

Supported Discharge Services including Home First continue to support discharge from hospital, with the priority being to support patients to live at their home.

Setting and Delivering Outcome Metrics : Unplanned hospitalisation for ACS conditions

8.1 Avoidable admissions	19-20 Actual	20-21 Actual	21-22 Plan to End Feb	21-22 Achieved
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	2,030	1,250	1,837	1,728

The guidance describes the purpose of the metric as a measure of, '*Progress in preventing chronic ambulatory care sensitive conditions (e.g. diabetes, hypertension) from becoming more serious will be measured using this indicator. Ambulatory Care Sensitive (ACS) conditions are those where effective community care and case-management can help prevent the need for hospital admission'*.

- This represents a sub-set of the NWL Operating Plan indicator for Non-Elective Admissions (NEL), which requires a return to 19/20 activity levels ie a return to pre-Covid levels without growth.
- The proposed plan was equal to the total number of ACS admissions in 19/20: 2,030.
- The performance achieved was significantly better than the plan, with 109 fewer avoidable admissions than the target. .

Setting and Delivering Outcome Metrics : Long Term Support Needs of Older People met by Admission to Residential and Nursing Care Homes

Ambition:	No more than 146 actual placements made or intended
Performance Aim :	Equivalent to 350 placements per 100,000 population

Data source: Adult Social Care Outcomes Framework

Comments:

- This target was not met
- The number of admissions were higher (197 vs 181 last year) - approx. 400 per 100,000
- Limited availability of alternatives in the local care market (e.g. supported living, extra care)
- Presenting needs were higher than prior years

Plans for the Future

- The introduction of 'Three Conversations' (strengths-based approach) to hospital discharge has prevented some placements made from hospital becoming permanent. This approach will continue to be developed and embedded.
- Increasing availability of alternative placements eg Extra Care
- Developing the Integrated Intermediate Care operating model through the Harrow Borough Based Partnership

Setting and Delivering Outcome Metrics : Proportion of Older People who Were Still at Home 91 Days After Discharge from Hospital into Reablement / Rehabilitation Services

Ambition:	To retain current performance as a minimum
Performance aim:	90%

Comments:

- This target was not achieved.
- 40% more people were discharged into rehab/reablement than last year from an already high rate, but the proportion of people remaining at home has dropped.
- Harrow already had one of the highest rates of discharge into rehab/reablement (7th of 32 in London) and this has grown significantly while still achieving reasonable outcomes.

Plans for the Future:

- Integrated Intermediate Care Project has been agreed by the Harrow Borough Based Partnership. The vision is '*to empower the citizens of Harrow to gain or regain their confidence and skills to achieve their individual health and wellbeing goals, and maximise their functional ability, choice, control and independence.' A Partnership Steering Group has been established and work is on-going to develop a system operating model working with the hospital, community health providers, the VCS, social care and GPs.*
- Developing the use of the Disabled Facilities Grant (DFG) to make adaptions to support people living in their own homes.

Delivery of the BCF Plan

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	The BCF is aligned with the local system's collaborative approach to the delivery of outcomes. Local commissioning and provider organisations assess and agree improvements to delivery through the Harrow Health and Care Executive, which provides operational leadership to the Borough Based Partnership.
2. Our BCF schemes were implemented as planned in 2021-22	Agree	Local focus on system working has been maintained to manage operational issues arising from Covid that have affected service delivery, including: - High levels of staff sickness; - Redeployment of staff to vaccination programmes; - Reductions in services' capaiity resulting from impact on patient flow of enhanced infection prevention and control measures.
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Agree	The planning process and joint agreement of outcome metrics focused discussion of system pressures and measures to mitigate them.

Challenges and Successes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges
Challenge 1	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	Short term financial settlements and additional funding streams becoming available in Q3 for use by the end of the financial year is a relatively ineffective approach to meeting system pressures and does not allow for sustainable investment eg: - Reduction in Ageing Well Funding in 22/23; - Planning the use of Winter Access Funding in November 22 for use by April 23.
Challenge 2	Other	National NHS initiatives to incentivise additional secondary care activity that do not include additional resources for social, community and voluntary sector provided care create imbalances in local systems that are hard to mitigate in the short term.

Challenges and **Successes**

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes
Success 1	2. Strong, system-wide governance and systems leadership	The Harrow Health and Care Executive meets weekly to assess pressures on the local health and care system, plan mitigations and review the progress of collaborative working in the borough. All local agencies are represented at a senior level, attendance os very good and discussions are invariably constructive and result in agreed action.
Success 2	8. Pooled or aligned resources	Service developments and resource allocation (eg Ageing Well; Winter Access Funding) are discussed and planned through the HHaCE to ensure alignment of resources to integration plans and the pressures on all parts of the system.

Next Steps and Recommendations

Next Steps:

- For the preparation of the BCF 2022-23 Plan, an integrated BCF Working Group will develop plans and present reports to HWB as required.
- The BCF Working Group will be incorporated into the Harrow Place Based Partnership transformation priority on Frailty which includes the Integrated Intermediate Care programme.
- The Guidance for 2022-23 has yet to be published

Recommendations:

1. Note the details of the presentation
2. Endorse the End of Year Submission