Appendix 1 Draft BCF Supporting Narrative

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Harrow Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

The Harrow Partnership, which, through the Harrow Health and Care Executive oversees the development and implementation of th BCF, includes:

London Borough of Harrow

North West London ICB

Harrow Together – VSC Alliance

London North West University Hospitals Trust

Central London Community Health Trust

Central and North West London Mental Health Trust

Harrow Health CIC

How have you gone about involving these stakeholders?

Through presentation of BCF requirements and review of plans, prior to sign-off and reporting to the Harrow Health and Wellbeing Board.

The service integration and development plans described below are contained in the Harrow Borough Plan, which has been the subject of extensive engagement with partner agencies, patients, their carers and the citizens of Harrow

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The BCF plan is developed by staff from all of the health and care agencies that form the Harrow Partnership, including statutory health and care bodies and the voluntary sector.

Progress towards finalisation of the plan is overseen by the Harrow Heath and Care Executive (HHaCE), which endorses the plan prior to its submission for approval by the Harrow Health and Wellbeing Board.

Collaborative commissioning decisions are agreed by the HHaCE prior to submission to the Harrow Joint Management Board, a multi-agency group of senior staff from partner organisations and, if necessary, to partner agencies' governance processes

Implementation of the Borough Plan, which contains the Partnership's priorities for service development, are monitored through multi-agency workstreams and the HHaCE

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- **Joint priorities for 2022-23**
- **Approaches to joint/collaborative commissioning**
- **How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23**

Joint priorities for 2022-23 HC

The mission of the Harrow Partnership is to work with children, families, and communities in Harrow to support better care and healthier lives.

The three key priorities are:

- To reduce health inequalities through embedding a robust population health management approach at a borough and neighbourhood level
- To develop truly integrated out of hospital teams at a neighbourhood level to improve our citizens' experience of care and reduce unplanned acute care and intensive social care packages
- To deliver transformational change in care pathways to deliver high quality integrated care, improving outcomes and addressing variation

Key priorities for the development of services include:

- Delivery of core 20 plus 5 programme
- Strengthening our support to carers
- Supporting the development of Harrow's Primary Care Networks
- Frailty through implementation of the integrated frailty model for Harrow
- Long term conditions care, with specific focus on diabetes care and hypertension
- Mental Health and learning disability services transformation
- End of life care: strengthening integration and ensuring a choice of where to die for Harrow citizens

Approaches to joint/collaborative commissioning – HC

The Harrow Health and Care Partnership has, through its Borough Plan, set a longer-term view for the partnership, defining what it is seeking to achieve through a strategic planning process and how through a one-year delivery plan.

As a partnership our attention also now is increasingly focusing on system financial controls, managing demand and addressing workforce challenges across all providers.

Key enablers of integrated care delivery include:

- Setting our Harrow Population Health Management methodology and implementing at borough and neighbourhood level
- Aligning data and intelligence across partnership organisations
- Digital integration
- Estates development as an enabler for integration
- Integrating our training and education offer across the partnership

How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.
BCF funded services have remained stable in Harrow from 2021/22 to 2022/23.

The services are focused on:

- Maintaining the health and wellbeing of people with long term conditions in the community ie Integrated services using Population Health Management to ensure equitable access for people with complex needs ie Frailty Service.
- Using the PHM approach the Borough Partnership is implementing integrated services for the care of people with diabetes and for those who are frail.
- A project is also underway to integrate Rehabilitation and Reablement services across the borough.

The implementation of these schemes will serve as a model for a further programme of service integration to which the Borough Partnership is fully committed.

Implementing the BCF Policy Objectives (national condition four)
National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- **Enable people to stay well, safe and independent at home for longer**
- **Provide the right care in the right place at the right time**

Please use this section to outline, for each objective:

- **The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care**
- **How BCF funded services will support delivery of the objective**

Plans for supporting people to remain independent at home for longer should reference

- **steps to personalise care and deliver asset-based approaches**
- **implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches**
- **multidisciplinary teams at place or neighbourhood level.**

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- **Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.**
- **Carry out collaborative commissioning of discharge services to support this.**

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.
The Borough Partnership is reviewing all of the services it provides with the aim of integrating care and support.

A key example of integrating care within the borough is a project to integrate the Rehabilitation and Reablement services delivered by various providers.

The offer of reablement to either avoid an admission to hospital or support a person to return home following an admission to hospital is key in maximising independence.

The support that will be integrated into a seamless service includes:

- A Flexible, person-centred package of support, including therapy, reablement support, equipment
- Delivered at home or an intermediate care bed with the focus on the person returning home
- Outcomes based short-term planning
- Regular review of outcomes and agreeing new goals
- Start planning for longer term including appropriate housing
- Offering Information and advice

Other examples of integration include:

- Frailty through implementation of the integrated frailty model for Harrow
- Long term conditions care, with specific focus on diabetes care and hypertension
- Mental Health and learning disability services transformation
- End of life care: strengthening integration and ensuring a choice of where to die for Harrow citizens

The means through which the plan will delivered are:

- Setting our Harrow Population Health Management methodology and implementing at borough and neighbourhood level
- Aligning data and intelligence across partnership organisations
- Delivery of core 20 plus 5 programme
- Digital integration
- Estates development as an enabler for integration
- Integrating our training and education offer across the partnership
- Strengthening our support to carers
- Supporting the development of Harrow's Primary Care Networks

How BCF funded services will enable people to stay well, safe and independent at home for longer / Provide the right care in the right place at the right time

BCF funded services focused on maintaining independence include:

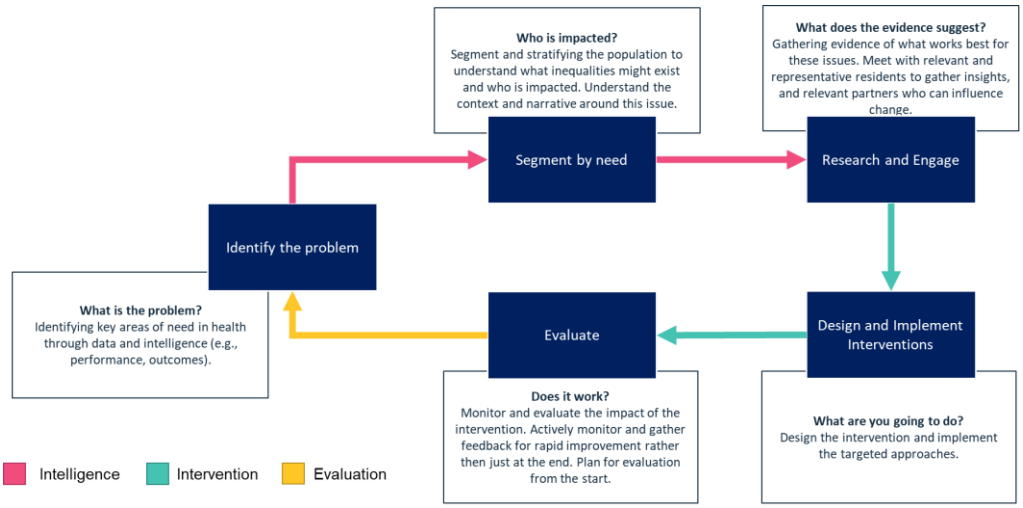
- Preventative / Early Intervention service ie Falls; diabetes prevention
- Reablement / Facilitation of safe discharges from hospital ie Short-term Rehabilitation Team; Bed based Intermediate Care
- Prevention of admission ie Rapid Response team
- Supporting appropriate residential placements ie Care Home Support Team; Complex Care placements

P*lans for supporting people to remain independent at home for longer*

- ***Steps to personalise care and deliver asset-based approaches***
- ***Implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches***

The Harrow Borough-based Partnership (health and care) are co-producing a new model of integrated intermediate care which includes bed-based services, community-based services, crisis response and reablement services. The new model will include a single point of access and a single team coordinating the discharge and intermediate care of all patients discharged from hospital in Harrow until they become as independent as is possible in their normal places of residence.

We have adopted a population health management framework (illustrated below) to deliver applicable elements our partnership transformation programmes, such as our integrated falls prevention and support programme and the integration of our intermediate care services.



Using the population health management facility on the North-west London ICB's Whole Systems Integrated Care dashboard, we are interrogating community, acute, social care and primary care data to understand our population's needs and implement preventative interventions to avoid admissions and re-admissions into hospital. We are tracking the pre- and post-discharge health and care journeys of citizens who have received reablement in the last year to better understand what led to their admissions and the need for reablement, and to identify areas where prevention would have prevented decline. We are also identifying the population who are at high risk of falls and proactively contacting them to support with falls prevention, such as referring them for strength and balance classes and multi-factorial falls risk assessments.

Multidisciplinary teams at place or neighbourhood level

The Frailty service model described above is based on the integration of services provided by health and care staff into a single multi-disciplinary team to support patients with complex needs in the community.

The partnership has taken a similar multi-disciplinary approach in the integration of diabetes services based around multi-agency, multi-disciplinary teams operating at PCN level.

Personalised Care and Asset-based Approaches

Harrow offers personalised care and an asset based focus to supporting individuals through a 3 conversation approach. This approach is about having open and meaningful conversations with people and families who need support. It's also about the conversations that people working in the sector have with colleagues and partners – working out how to collaborate to make things happen so that we can support people and help them remain as independent as possible, connected to their communities and participating in activities they enjoy.

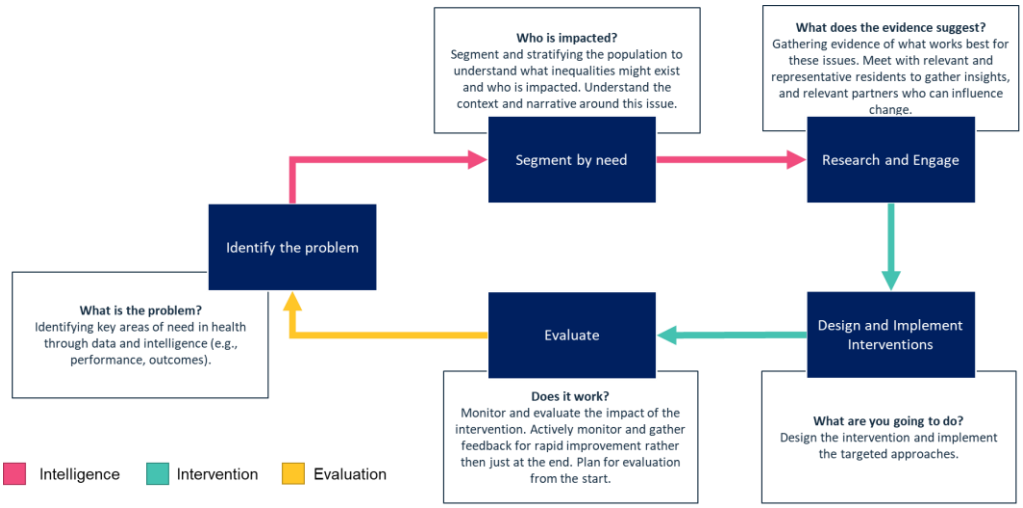
This approach recognises that people and families are the experts in their own lives, so as social and health care workers we are actively listening to them and use the resources and skills we have to build on their wishes and strengths, and to connect them to the right people, communities, and organisations to make their lives better.

We have seen that the strength-based approach has challenged how we offer support more affectively. Reducing the number of handoffs and ensuring that the teams work in a more joined up way has created a seamless transition for the citizen.

As we come out of COVID, we have seen a 30% increase in the volume of new referrals. Through working with the Managers and Social Work staff, it has become evident that it is time for Social Workers to be back in the Community working closely with GP's and other partners having earlier, preventative conversations.

Earlier conversations through an asset based approach will ensure that residents and their families have easy access to appropriate information and advice, have access to an integrated health and social care system , have an improved experience and quality of life

Population Health Management / Preparing for Anticipatory Care
We have adopted a population health management framework (illustrated below) to deliver applicable elements our partnership transformation programmes, such as our integrated falls prevention and support programme and the integration of our intermediate care services.



Using the population health management facility on the North-west London ICB's Whole Systems Integrated Care dashboard, we are interrogating community, acute, social care and primary care data to understand our population's needs and implement preventative interventions to avoid admissions and re-admissions into hospital. We are tracking the pre- and post-discharge health and care journeys of citizens who have received reablement in the last year to better understand what led to their admissions and the need for reablement, and to identify areas where prevention would have prevented decline. We are also identifying the population who are at high risk of falls and proactively contacting them to support with falls prevention, such as referring them for strength and balance classes and multi-factorial falls risk assessments.

Plans for improving discharge

Ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- **Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.**
- **Carry out collaborative commissioning of discharge services to support this.**
- **Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.**

- At the start of the pandemic, the pressing need to improve the coordination and effectiveness of the through-put of hospital discharges was identified. An important variable to this was the need to have more vacant hospital beds to be able to absorb the impact of Covid-19 on patients. As a result, all partners across the Acute, Health Community Services and Adult Social Care developed **Independent Discharge Hubs** (IDH) staffed by all partners. The shared aim was to work in an integrated style regardless of the type partner agency and its funding source, with the sole ambition to transition the citizen back to the community in the most efficient pathway. This method drastically improved the discharged flow and partnership working. It also created an integrated seamless approach to discharges for the citizen. As a result of its success, the IDH has now become business as usual.

- We are continuing to focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and internal improvements within trusts and our integrated care hubs. Whilst we expect some improvements, we are not making significant changes in terms capacity in out of hospital immediately, though this remains our longer term plan.
- A local programme of work is in place around discharge, led as SRO by Harrow's Director of Adult Social Services to strengthen joint working between local authorities and the NHS
- An integrated service model for rehabilitation and reablement services is uin development and will be implemented in 2022/23
- Community teams have managed increasingly complex acuity patients within their caseloads

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Carers are at the core of the health and care system in Harrow. Without the service they provide to our most vulnerable citizens, our system could not function. The Harrow Borough Based Partnership brings together the Local Authority, NHS Services, the voluntary and community sector and local citizens. As a Borough Partnership in Harrow we recognise that we must do all that we can across every organisation to identify people with caring responsibilities, support those people both in their caring role and their wider quality of life, as well as their own health and wellbeing. A Carers strategy has been co-produced with Carers in Harrow sets out how we will seek to do this.

Our overall aim is to improve the wellbeing and resilience of carers of all ages and backgrounds, so that they can continue to provide support for the people they care for without compromising their own health, social networks and ability to contribute to society.

Our services help to prevent problems for carers and they are responsive in meeting carers' needs. Carers are directly involved in shaping, planning and delivering the services which we offer.

Services offered at the Carers Centre include:

- Information and advice
- Benefit application support including form filling
- Home visits
- Advocacy
- Carer' support including drop-ins and experienced staff who will listen and understand your situation
- Activities, including yoga, Zumba, Pilates and Qigong with new activities introduced regularly
- Training and events including computer classes, first aid and back care
- Complementary Therapies including massage
- Wellbeing sessions, including positive psychology and mindfulness – including access to CNWL Recovery and wellbeing college courses
- Understanding mental health
- Specialist MacMillan cancer carer support
- Counselling
- Support for young carers (see below)
- Respite care
- Grants for carers
- Breaks and holidays
- Homeshare
- Carer emergency card

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

ASC Officers and Housing are ambitious about improving the options for citizens to remain at home living independently. There are close working relationships with Housing colleagues and work together on a range of housing matters including, discharge from hospital, adaptations to support independence at home, development of new schemes, planning move-on from supported living for people recovering from Mental Health.

Health trusts and the CCG are also involved in some strategic local authority projects, for example, reducing homelessness.

DFG adaptations are used to help to meet the changing needs of older people and those with long term conditions.

In Harrow older people can also access sheltered housing for older and extra care housing (with on-site care services), provided either by the Council and by registered providers (housing associations) as their needs become more complex, as well as residential and nursing placements.

Aids & Adaptations
Different schemes are available to help people in all housing tenures who require aids, adaptations and home improvements to stay in their own home and continue to live independently.

Harrow Council supports eligible residents through promoting and delivering major adaptations (funded through the Housing Revenue Account for council tenants and Disabled Facilities Grants in other tenures), the handyperson scheme and the 'Staying Put' scheme.

The Disabled Facilities Grant (DFG) programme provides funding for properties to be adapted to meet the needs of disabled people (non-council tenants) to live independently in their own homes.

Adults applying for the grants are means tested to assess whether they are able to contribute to the cost of works, however children do not have to undergo the means test.

Examples include level access showers, through-floor lifts or the construction of extensions to provide additional bedrooms allows households to continue living independently in their own homes and reduces the need for costly residential care.

Social Housing- Transfer applications
Social housing tenants whose current home is no longer suitable for their needs due to health, disability or mobility are given priority to move and can bid for alternative general needs social housing or sheltered housing for older people.

Move on from Supported Housing
Access to social housing continues to be facilitated for some vulnerable groups through move on quotas to support moving from care or supported housing to independent housing.

New Supply of Affordable Housing
The Council is building new homes for the first time in decades and is making use of other opportunities to increase the supply of affordable housing in the borough, such as through the Council's regeneration programme.

The Council works with registered providers (housing associations) to develop new general needs and supported housing and to explore options for existing housing where the accommodation falls below current standards or is not being used to its optimum benefit.

Housing for Older People
Older people are a diverse group of people with a range of different housing needs and preferences, and may choose to live in mainstream housing or in specialist housing.

Mainstream housing is usually general needs housing in the social or private sectors, either rented or purchased. Aids and adaptations can help to meet the changing needs of older people in this type of housing.

Specialist housing for older people, other than residential and nursing care homes, enables an older person to live independently in their own living space with varying levels of support. In Harrow older people can access sheltered housing for older and extra care housing, provided either by the Council and by registered providers (housing associations). A new extra care scheme will open in Spring 2023 as part of the Extra Care Strategy. The strategy will be reviewed to inform the next phases.

Assistive Technology

Harrow recognise that the Disabled Facilities Grant should more consistently be used to help people take advantage of technology to live independently.

The local authority is developing its Assistive Technology Strategy that will include a continuum of AT. Initially the focus is on digital solutions to maintain independence eg My Meds. The ambition overtime is to enhance the use of AT to continue activities of daily living within Citizen's own home. For example removing physical barriers eg automated door openers to improve access, adjustable height kitchen surfaces and appliances, using AT to monitor patterns of behaviour to enable early interventions where appropriate and the further development of AT to prompt daily life activities eg improve hydration.

Building on existing Council projects to increase fibre connections and connectivity to vulnerable citizens within Harrow.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- **Changes from previous BCF plan**
- **How these inequalities are being addressed through the BCF plan and BCF funded services**
- **Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered**
- **Any actions moving forward that can contribute to reducing these differences in outcomes**

One of the Harrow Partnership's three main priorities is to reduce health inequalities through embedding a robust population health management approach at a borough and neighbourhood level.

The pandemic has particularly shone a light on the health inequalities that exist in the borough. Working as a multi-agency partnership we have explored some of these in more depth to come up with solutions that reduce inequalities and improve outcomes for Harrow's communities.

Sophisticated data analysis on long term conditions, such as diabetes, hypertension and obesity, in different cohorts of residents (for example based on ethnicity, gender, age) has revealed disproportionate health outcomes. These health conditions affect the lives of so many on the borough and we have used this intelligence to inform our plans for engaging communities in health issues, designing suitable interventions and commissioning culturally appropriate services. For example, we have established a new 'Good Weight Pathway' for patients, allowing them to self-refer for the first time.

We have established a pilot in the Harrow East Primary Care Network and rolled out initiatives such as the 15-step NHS toolkit in accessing primary care, vaccine outreach in the Romanian community, focusing on childhood immunisations and antenatal care in predominantly the Romanian community as we know they currently access these services less than other communities in Harrow.

Working as a partnership we have developed a population health management approach to identifying health and wellbeing needs and inequalities, making sure that data is shared appropriately to inform the development of plans across health and social care pathways and a collaborative approach. This will help us to develop a mutual understanding of causes of ill health and coordinating care.

We need to address the large gap in health inequalities between our residents from the least to the most deprived wards and as highlighted by Covid, increasing the healthy life expectancy for all, particularly those in disadvantage, improve physical activity and ensure children experience a healthy start to life with good diet and appropriate exercise, as well as supporting families to access early support where required, enabling them to be more self-sufficient and rely less on public services.

Following our engagement in 2021 with community leaders in Harrow's Black communities on initially Covid and then more broadly health inequalities, we have recently commissioned Voluntary Action Harrow to run an Engagement Commission as the next step to our conversations about wider health issues. This will follow up some of the concerns and insight shared by the community leaders and build on the what the data has shown us around health inequalities, for example on weight management, hypertension and diabetes.