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

Harrow 2022/23 Better Care Fund

Health and Wellbeing Board

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1. Components of the 22/23 BCF Submission

The 2022/23 BCF Plan comprises 4 elements:

- Financial Schedules
- 22/23 BCF Outcome Metrics
- Supporting Narrative
- Intermediate Care Capacity and Demand Exercise

2. Financial Schedules

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

- The CCG Contribution to the local authority.
- The Local Authority schedule of allocations for LA commissioned schemes funded through the CCG Contribution.
- The value of the NHS Provided Schemes.

2. Financial Schedules

The table below summarises the funding provided through the Better Care Fund.

Funding Sources	Income	Expenditure
DFG	£1,721,553	£1,721,553
Minimum NHS Contribution	£18,055,813	£18,056,747
iBCF	£6,663,537	£6,663,537
Additional LA Contribution	£0	£0
Additional ICB Contribution	£40,000	£40,000
Total	**£26,480,903**	**£26,481,837**

2. Financial Schedules

The table below summarises the uses to which the funding is put locally.

Harrow BCF Funding 22/23	
Care Act Implementation Related Duties	£485,730
Carers Services	£1,710,574
Community Based Schemes	£4,853,112
DFG Related Schemes	£1,721,553
Enablers for Integration	£479,280
High Impact Change Model for Managing Transfer of Care	£5,102,828
Home Care or Domiciliary Care	£2,348,966
Integrated Care Planning and Navigation	£3,111,772
Reablement in a persons own home	£1,589,780
Prevention / Early Intervention	£1,723,219
Residential Placements	£3,315,022
Other	£40,000
Total	**£26,481,836**

3. BCF Outcome Metrics

Each HWB area is required to propose plans for the following Outcome Metrics for the remainder of 2022/23.

1. Unplanned hospitalisation for ACS conditions

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

3. Long Term Support Needs of Older People met by Admission to Residential and Nursing Care Homes

4. Proportion of Older People who Were Still at Home 91 Days After Discharge from Hospital into Re-ablement / Rehabilitation Services

3.1 Unplanned hospitalisation for ACS conditions

8.1 Avoidable admissions		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition wa	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Rate per 100,000	88.2	77.1	82.9	73.5	The Avoidable Admission 22/23 Q1-Q4 plan was calculated by reducing 21/22 Q1-Q4 Actual Observed values by 1% and recalulating the Indicator Value based on this reduced Observed value. Please note the 21/22 Q1-Q4 Actual Observed values and Indicator methdology was prodcued by the BCF Team.	We are continuing a 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. There are a number of programmes underway which will give us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could impact on admissions over the next six months is as follows: • The development of our virtual wards programme • Continued roll out of post covid syndrome clinics • Go live of respiratory hub-lets • Continued work roll out of virtual monitoring • 111/999 Push pilots with urgent community response continue
	Indicator value	222.6	194.6	209.2	185.5		
	Denominator	252,300	252,300	252,300	252,300		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value						
	Indicator value	220	193	207	184		
	Denominator						

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3.2 Discharge to Usual Place of Residence

8.3 Discharge to usual place of residence		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition wa	Local plan to meet ambition
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)	Quarter (%)	93.5%	94.2%	93.7%	94.4%	The Discharge to usual place of residence plan was calculated by creating a 22/23 forecast using the 21/22 quarterly values and then applying a 1% reduction to this forecast. Please note the 21/22 actuals were produced by the BCF team. Q1 22/23 plan was set to be the Q1 22/23 actuals (based on M1-M2 22/23 data).	We are continuing a 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. There are a number of programmes underway which will give us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could impact on admissions over the next six months is as follows: • The development of our virtual wards programme • Continued roll out of post covid syndrome clinics • Go live of respiratory hub-lets • Continued work roll out of virtual monitoring • 111/999 Push pilots with urgent community response continue
	Numerator	4,844	4,921	4,908	4,617		
	Denominator	5,178	5,226	5,236	4,891		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	94.1%	95.1%	94.7%	95.3%		
	Numerator	4,848	4,935	4,931	4,632		
	Denominator	5,151	5,192	5,210	4,862		

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3.3 Older People Admitted to Residential and Nursing Care Homes

8.4 Residential Admissions		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition wa	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	445.4	349.9	400.0	400.0	The target was set at the same rate as estimated in 2022/23.	Introduction of 'Three Conversations' (strengths-based approach) to hospital discharge has prevented some placements made from hospital becoming permanent.
	Numerator	181	146	167	170		
	Denominator	40,634	41,727	41,727	42,566		

3. Proportion of Older People who Were Still at Home 91 Days After Discharge from Hospital into Re-ablement / Rehabilitation Services

8.5 Reablement		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition wa	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	96.6%	90.0%	85.0%	85.0%	The target was set at the same rate as estimated in 2022/23.	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. rogramme of work in place around discharge, led my local authority DASS as SRO • Better joint working between local authorities and NHS • All trusts continually reviewing and improving discharge process, with standardisation and sharing of good practice in place
	Numerator	394	325	307	307		
	Denominator	408	361	361	361		

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4. Supporting Narrative

The draft Supporting Narrative, which was submitted for internal ICB assurance on 9th September, is attached as Appendix A.

The narrative describes the Harrow Partnership's approach to the following:

- Joint priorities for 2022-23.
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting integration.
- 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
- Plans for supporting people to remain independent at home for longer
- Plans for improving discharge
- Supporting unpaid carers.
- The use of the Disabled Facilities Grant (DFG) and wider services

5. Intermediate Care Demand and Capacity

Intermediate Care Demand and Capacity Exercise

The sign-off of the BCF by NHSE is not dependent on any evaluation of the IC D&C submission.

This is a data collection exercise that will be used nationally to inform analysis of the role of IC within health and care systems.

The return, which is based on discharge pathways, requires an assessment of the local demand for IC and the capacity of local services.

5. Intermediate Care Demand and Capacity

Intermediate Care Demand and Capacity Exercise

Demand- Discharges
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)
1: Reablement in a persons own home to support discharge (D2A Pathway 1)
2: Step down beds (D2A pathway 2)
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)

Demand - Intermediate Care
Service Type
Voluntary or Community Sector Services
Urgent community response
Reablement/support someone to remain at home
Bed based intermediate care (Step up)

5. Intermediate Care Demand and Capacity

Intermediate Care Demand and Capacity Exercise

Capacity - Hospital Discharge	
Service Area	Metric
VCS services to support discharge	Monthly capacity. Number of new clients.
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.

Capacity - Community	
Service Area	Metric
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.
Urgent Community Response	Monthly capacity. Number of new clients.
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.