Integration and Better Care Fund

Narrative Plan Template 2017/19

Area	North West London
Constituent Health and Wellbeing Boards	Harrow
Constituent CCGs	Harrow

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- Integrated Personal Commissioning & Personal Health Budgets Project
- BAF Report 1a, 1b, 2
- ACS Development Programme Plan
- Jointly Agreed DToC Trajectory
- Mental Health Escalation Process
- Harrow STP Chapter and Timeline
- CCG ACS MOU
- Harrow CCG and London Borough of Harrow Joint Carers Strategy DRAFT

1. Signatories

Harrow Health and Wellbeing Board

XX, **Chair** : ....

Date : ....

For and on behalf of Harrow Clinical Commissioning Group

Paul Jenkins, **Chief Operating Officer** : ....

Date : ....

For and on behalf of London Borough of Harrow

XX : ....

Date : ....

2. Foreword

The 2017 – 19 Harrow Integration and Better Care Fund Plan builds directly on the 2016/17 plan submitted June 2016.

Overseen by the Harrow Health and Well Being Board the 17/19 plan sets out a number of steps aimed at underpinning and further developing the existing vision for Whole Systems Integrated Care in the wider context of the aspirations of the North West London NWL STP – Sustainability Transformation Plan (Partnership).

The end of year report 16/17 concluded that significant progress had been made in a number of areas not least in helping to mature the collaborative working relationship between the partners, Harrow Council, Harrow CCG and the wider stakeholder group.

This was achieved within the context of unprecedented financial challenge facing the lead partners at a time of increasing demand for services from all areas of the resident population of Harrow. Whilst all partners acknowledge the success of the plan it is fully acknowledged that there is further work to be done to deliver and build on the planned outcomes whilst supporting financial recovery and achieving longer term sustainability - system wide over the next two years.

The national picture for the finances of the public sector continues to remain very challenging. Projections by London councils based on the government spending plans are for additional reductions of over 30% over the next two years.

This plan re-iterates the commitment of all partners to meeting the national conditions of:

- A jointly agreed plan.
- NHS contribution to social care is protected.
- Agreement to invest in NHS – commissioned out of hospital services.
- Implementation of the High Impact Change Model for Managing Transfers of Care.

In addition the plan aims to develop further our work on the enablers that support our approach to integrated working:

- Delivery of 7 days services across health and social care
- Improving data sharing between health and social care
- Developing a joint approach to assessments and care planning.

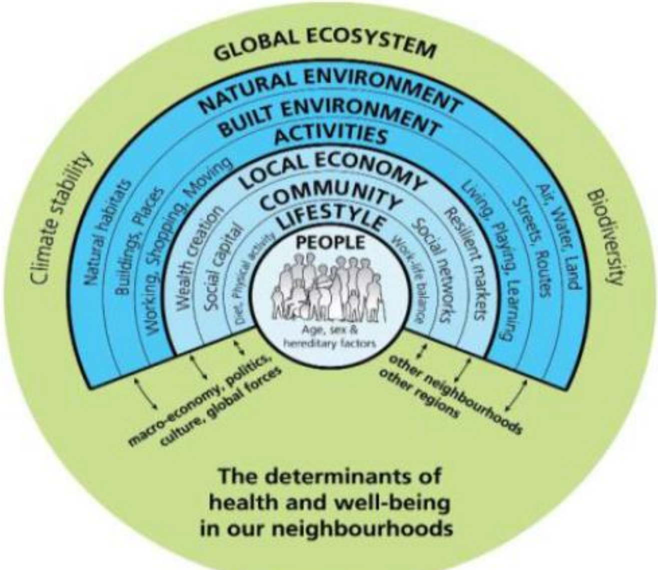
Ultimately the plan aims to deliver our shared goal of improving access to services in the:

'Right place at the Right time'.

3. Introduction

3.1. The Population of Harrow and Their Health & Social Care Needs

Reductions in local authority budgets and increasing pressure on both health and local authority budgets due to an increasingly aged population mean that over the next few years, some difficult decisions will have to be made to respond to these challenges.



Population

Around 243,500 people live in Harrow; just over half of them are female.

- 7% of the population are children under 5 years old, and
- 7% are aged over 75.

Compared to London, the population of Harrow has a greater proportion of older people (over 60) and a lower proportion of people in their 20s and 30s.

The age structure of the population varies across the borough with more children living in the south and central corridor, and more people aged over 65 living in the north of the borough.

Life Expectancy

Life expectancy for both men and women is higher than the England and London averages. For men in Harrow life expectancy in 2011-13 was 82.4 years and for women, 85.9 years. Over the past 13 years life expectancy has increased year on year and the gap between Harrow and London and England has been maintained in women and slightly widened in men.

Ethnicity

In 2011, 43% of the Harrow population were from an Asian/ Asian British background, the percentage from a white ethnic background was almost equal; 42%. A further 8% were from Black/ African/ Caribbean/ Black British ethnic background. Over the next 10 years it is predicted that the local Black, Asian and minority ethnic (BAME) population in Harrow will increase from almost 54% to 68%. Every year Harrow welcomes over 2,000 people new British citizens through citizenship ceremonies.

As with the age structure of the population, the ethnic mix also varies across the borough. In Pinner and Pinner South wards BAME groups make up around 40% of the population while in Queensbury, Kenton West and Kenton East, BAME groups make up over 70% of the population (data from Census 2011). With the increase in BAME population, there may be different patterns of health and illness. For

example, higher rates of diabetes and heart disease in BAME groups may require a different and culturally appropriate approach to prevention and treatment services.

Deprivation

The impact of deprivation on health and wellbeing is well documented. Deprivation is most commonly measured using the Index of Multiple Deprivation (IMD) which incorporates a number of factors and includes a number of dimensions such as housing, employment and income to give a single score. Harrow is ranked 203rd out of 354 Districts in England where 1st is the most deprived. Most deprivation is in the centre of the borough, with pockets in the south and east. Harrow's least deprived areas are found in the west of the borough. Not all disadvantaged people live in deprived areas and conversely, not everyone living in a deprived area is disadvantaged.

Children in Need

Harrow's children 'in need' (CiN) rate has increased recently following a revision of thresholds for eligibility of social care services. Harrow now has a similar proportion (rate per 10,000 children aged 0 - 17) of children 'in need' (CiN) compared to statistical neighbours; the rate has been increasing since 2012 in Harrow. This is likely to result in additional demand on both universal and specialist services.

3.2 Key issues and challenges

Nearly two-thirds of Harrow's under-18 CiN population are from BME groups and this reflects the population of the borough. The proportion of children in need from Asian or Asian British origin is over one quarter; higher than for statistical neighbours (19.8%), London (13.1%) and England (6.2%).

As at 31 March 2014, approximately 54.8 (male) children were children in need compared to 43.7% (female) children in Harrow. This remains consistent with London, England and Harrow's statistical neighbours.

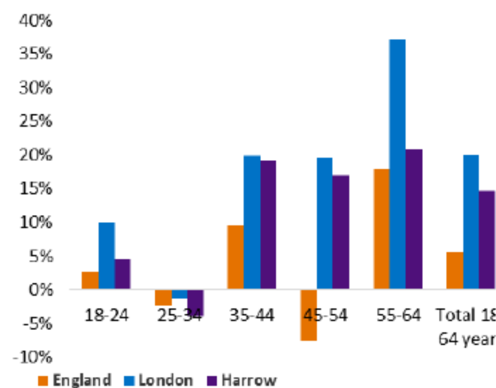
The number and rate of referrals per 10,000 children in Harrow had historically been low compared to national averages, but 2013 -14 saw a rise due to revised thresholds & the changing demography.
There were 2,305 referrals made to children's social care services during 2013-14 compared to 1,529 in the previous year. Nationally there has been a rise in referrals by approximately 11%.

Physical Disability

Of people with long term health problems or disability living in the borough, 15% reported that day to day activities are limited either a lot or a little compared to 17.6% in England and 14.1% in London.

There are approximately 15,000 people aged 16 to 64 with moderate or serious physical disability living in Harrow and this number is predicted to increase to 16,000 by 2020 (a 15% overall increase). These trends are similar to those predicted for London with the largest increases being in the 55 to 64 age group. In London and Harrow, the number of people receiving disability allowance is highest in the 45 to 69 age group. The amount of weekly benefit claimed is below the London and England average.

Figure 9: Predicted change in percentage of people with a moderate physical disability from 2014-2030



The average amount of weekly disability living allowance in Harrow is 12th lowest in London and is below the England average.

Key issues and challenges

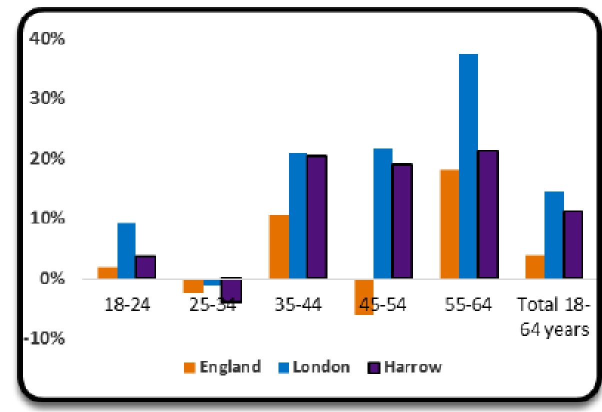
Across the borough, 75% of all claimants have been receiving benefits for five years or more. Long term reliance on benefits is likely to be associated with poorer health and wellbeing.

Learning disability

There are around 3,800 adults with a learning disability in Harrow, with the largest number in the 25 to 34 year old age band, and these numbers are projected to increase over the next 15 years by 11%.

The largest increase being among those aged 55 to 64 years (21.3% increase), and those with Autistic Spectrum Disorders (13.6% increase).

Figure 27: Projected increase in people with a learning disability 2015-30



These increases are likely to be due to improved survival rates and increased birth rates which are likely to have an impact on service provision.

Of the estimated 3,782 people with a learning disability living in Harrow only 435, just over 1 in 10, are known to the Harrow Council Adult and Social Care Services.

This places Harrow in the 2% of local authorities in England with the lowest rate of people with learning disabilities accessing services. Planning based on these numbers is likely to be an under estimate of actual need. The number of people known to local authorities has been decreasing over time, suggesting possible barriers to accessing social provision.

Self-reported health, long term illness and disability

Health status is also affected by socio-economic group. Almost 90% of people employed report that their health is very good or good, compared to only 60% of those who have never worked and the long term unemployed.

Health topics

Cancer

Cancer incidence for all cancers is lower in Harrow than the England average, with rates for specific cancers such as lung, cervical and prostate being similar or lower. The same is true for mortality, where Harrow has the lowest premature cancer death rate of all boroughs in England.

Early diagnosis is important for improving survival rates. Harrow does better than the national average in almost all aspects of early diagnosis. Emergency presentations through A&E which can be indicative of late diagnosis and waiting time for diagnostic tests are low. However, treatment within 31 days of decision to treat is lower than the English average (96.7% compared with 98.2%).

Survival is indicative of early diagnosis and access to optimal treatment. For one year survival, Harrow is in the top 5% of boroughs in England, at five years the proportion is equal to England; about 1 in 2 people.

National data show that survival rates are lower for people living in deprived areas. The largest observed deprivation gap at one-year survival is for bladder cancer in females and oesophageal cancer in men. Breast cancer is the only one of the top 10 cancers in which incidence rates are higher among women in higher socio-economic groups but survival rates still lower among women in lower socio economic groups. There is also increased risk of certain cancers in Asian and Black ethnic groups and women from these groups have a lower under-65 survival rate for breast cancer and higher risk of cervical cancer in those over 65 years.

Lung cancer deaths have been increasing in Harrow since 2007-09 and national data show they are the most common cause of cancer deaths in men accounting for almost one in four (235). Since smoking causes 90% of all lung cancer; these deaths will also disproportionately affect those from lower socioeconomic backgrounds.

Bowel and breast screening rates are lower than the England average and breast screening rates do not meet the national minimum target of 70%. Cervical screening, rates among younger women (25 to 49 years) for whom the uptake is approximately 11% lower than the national average (60.6% compared with 71.5%). This is almost 20% short of the national minimum target (80%). In addition, vaccination against Human Papilloma Virus (HPV) – which causes almost all cervical cancer – is lower than the England average (83.2% compared with 86.7%) and decreased by about 2% between 2012/13 and 2013/14.

High deprivation and an ethnically diverse population have been linked with low levels of screening. South Asians in particular are significantly less likely to respond to routine invitations for breast screening. However health promotion work has been shown to make a substantial improvement in some London boroughs such as Tower Hamlets. Interventions and support for people with disabilities for screening should also be an integrated part of screening programmes.

Liver disease

Deaths from liver disease remain a persistent problem. Much liver disease is preventable and is caused by lifestyle factors such as obesity and excess alcohol consumption. Rates of preventable liver-disease have remained lower than the national and London average in Harrow. However, after an apparent decrease in 2009-11, rates appear to be increasing again particularly among females. As well as this, the difference in rates between males and females remains smaller in Harrow than in London and may be decreasing. Inequalities persist and there is evidence at the national level that rates of premature mortality from liver disease (considered preventable) among those in the most deprived areas is twice that of rates in the least deprived areas. Hepatitis B and C are risk factors for liver disease. Hepatitis C is more prevalence in South Asian populations and so the number of expected infections in Harrow may be an under estimate. Hepatitis B is also a risk factor for liver disease and is vaccine preventable however no data are available for Harrow

Tuberculosis (TB)

Tuberculosis is an important health issue in Harrow. The borough has the fifth highest incidence of TB in London; 61 per 100,000 in 2013 compared with 36 in London overall. Trends over time are similar to those seen in Newham where incidence is the highest in London. New infections in Harrow have been increasing since 2008 and exceed the level at which vaccination of infants aged 0 to 12 months is recommended1. Incidence varies within the borough and hotspots are located in central and south eastern LSOAs.

Mental Health

Mental health is an important public health priority as flagged by the publication of "*No health without mental health*", the mental health strategy for England. Tackling mental health is important because of the stigma still attached to seeking help, its link with physical health and subsequent social exclusion, discrimination and wider inequalities.

Adult Mental Health

In Harrow in 2012-13, the prevalence and rate of new cases (incidence) is lower than the England average. Prevalence (recorded in adults aged 18 and over) was 3.4% of the total 191,072 GP registered population (aged 18+) compared with 5.8% for England. In the same time period, there were 1,019 new

recorded cases of depression; incidence rate 0.5% compared with 1% in England. This does not necessarily mean incidence and prevalence are lower; it could mean poorer identification and recording of cases. For mental health problems including schizophrenia, bipolar affective disorder and other psychoses, prevalence is slightly higher than the England average; 0.93%, compared with 0.84%.

The average rate of people with a mental illness in residential or nursing care per 100,000 population in Harrow 16.4, lower than the England average (32.7). Harrow has a higher percentage of mental health service users who were inpatients in a psychiatric hospital 3.6% compared to the national average (2.4%).

In addition, Harrow rates for attendances at A&E for a psychiatric disorder (361.8 per 100,000 population) and number of bed days (6,227 per 100,000 population) are higher than the average national rates (243.5 and 4,686 per 100,000 population, respectively). Both are costly. However, the rate of detentions under the National Mental Health Act per 100,000 population in Harrow (23.3) is similar to the average for England (15.5).

The rates of emergency admissions for self-harm (84.1 per 100,000 population) and hospital admissions for unintentional and deliberate injuries in aged 0-24 years (96.9 per 10,000 population) in Harrow are lower than the average for England (191 and 116 respectively). The suicide rate in Harrow 4.8 per 100,000 population is also lower than the average national rate; 4.8 compared with 8.5 per 100,000 population.

In summary, many mental health related indicators show Harrow does better than the national average.

Local Service User Concerns

National research has shown that people with mental health problems have a lower life expectancy than average. There are a number of contributing factors including higher rates of smoking, drinking and substance misuse and lower likelihood of attending for preventative health care such as cancer screening tests or health checks. Concerns have been raised by people with mental health problems and their carers about the lack of emphasis on their physical health by health professionals. Harrows *Stop Smoking Service* has worked closely with CNWL (Central and North West London Mental Health Trust) to support people with mental health problems to access services.

Mind in Harrow has undertaken a number of projects to identify the needs of people from black and minority ethnic (BAME) groups and of refugees. Common findings from the research undertaken over the past 10 years are:

- Poor awareness of mental health services and how to access them, which often leads to only seeking help in a crisis
- Cultural stigma of mental health problems
- Lack of culturally appropriate support within the services
- Need to consider mental health treatment within a religious context

- Need to raise awareness and reduce stigma within different communities; and
- A desire for a more holistic approach that addresses underlying problems affecting mental health

Diabetes

Diabetes remains a major health issue in Harrow and prevalence is predicted to increase by 45% in the next 20 years. There is a 3-fold increased risk of diabetes among people of South Asian origin compared with white people and risk increases at a younger age and lower BMI.
Prevalence in Harrow is the highest of any London borough, over 16,000 (8.5% of the adult population) are recorded on practice disease registers, an increase of about 3% since 2010/11. Modelled estimates, incorporating undiagnosed diabetes, predict prevalence is actually about 10% of the adult population in Harrow; a further 2,800 people. Both diagnosed and undiagnosed prevalence is significantly higher than the London (6%) and England (6.2%) average.

Cardiovascular disease

Cardiovascular disease is the leading cause of death in Harrow when all ages are considered and is the second largest cause of death after cancer in people aged under 75 years. During 2011-13, the premature mortality rate from all cardiovascular diseases in Harrow was 70.3 per 100,000, significantly better than the national average (78.2 per 100,000). The premature mortality rate consider preventable from all CVD among men under 75 years of age during the same time period was 74.3 per 100,000 while in women it was 20.9 per 100,000, these rates did not differ significantly from the national average (76.7 per 100,000 and 26.5 per 100,000 respectively).In 2014, the early CVD mortality rate in Harrow for persons under 75 years is predicted to be reduced by one third compared to 10 years ago. The percentage of CVD deaths as a proportion of all deaths was 23.% for people aged under 75 years and 40% for people aged 75 and above.

Falls in Older People

Older people, particularly women, are at greatest risk of falling and the morbidity associated with falls. Women experience a higher rate of associated injury including hip fractures; have less timely surgery for hip fractures and are more likely to be readmitted after hip replacement. Health and social care costs associated with falls are high and set to increase as the population ages; falls per year in Harrow are predicted to rise from 12,650 per year to 23,800 in the next 20 years. Currently NHS costs for hip fracture alone are estimated to be almost £3 million in Harrow, and this does not include any associated social care costs.

We are aiming to maintain and to build on the performance levels of 2016/17 BCF Plan, however this is done within the context of an increasingly challenging financial position that requires continued and strengthened joint working between partners to ensure capacity and throughput across the whole health and social care system. The planning template contains our local agreement on a DToC trajectory that reflects our current position.

4. What is the local vision and approach for health and social care integration

4.1. The Harrow Vision

The Integration and Better Care Fund Plan is the principle vehicle in Harrow to deliver Whole Systems Integrated Care with partners to support the local health and care economy to define and deliver its Accountable Care model that will enable longer term system wide capacity to meet increasing need and demand for services.

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 to 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. Well before 2019/20, our shared vision for health and social services is to deliver an integrated system approach built around the needs of our local population.

By working in this way we believe we will:

- Improve the quality of life for everybody in Harrow by providing proactive, joined up services.
- Work together, share information, expertise and experience better.
- Deliver co-ordinated seamless care, in particular to those with the most complex health needs, including those with multiple long-term conditions.
- Improve the efficiency of the existing system by reducing inter agency referrals.
- Reduce the utilisation of acute care resources to support our residents.
- Make it easier for everybody, however sick or frail, to continue to live happily and safely at home.

4.2. Whole System Integrated Care Programme

The Better Care Fund Plan will support the delivery of the Whole Systems Integrated Care (WSIC) and the transformation of services working in Harrow in 2017/19, supported by Harrow CCG and Harrow Council signalling their on-going commitment to further develop their joint and integrated working arrangements e.g. Hospital Discharge, Discharge 2 Assess, Personal Health Budgets. In the period 2017/19, the WSIC Programme will focus on providing anticipatory, multi-disciplinary care for people over 65, with one or more long term condition and high risk of admission to hospital.

*WSIC can be located in appendices.

4.3. ASC - Transformation of Community Services – developing the 'Local Service' model for Harrow

The aim for 2017/19 is to further reduce hospital admissions and overall cost of delivery by shifting investment in resource and provision of services into the community rather than acute settings in line with the CCG's 'Out of Hospital' strategy and emerging 'Local Service' model. We are aiming to have our local ASC – Accountable Care System Organisation operating in shadow form by April 2018.

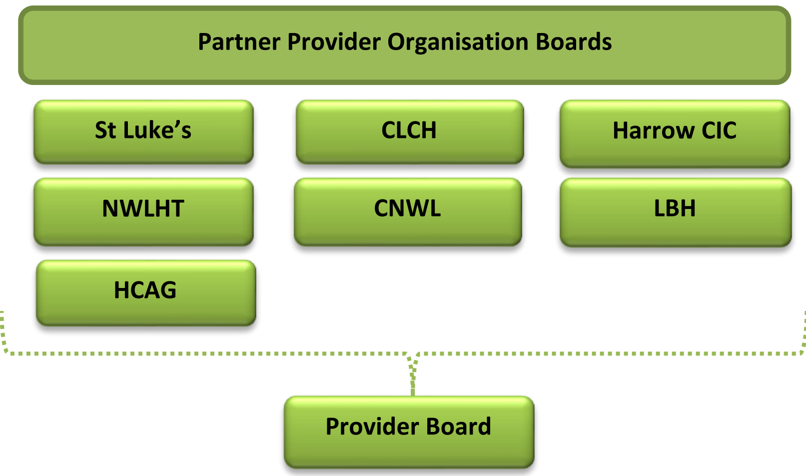
This will be founded on the maturing of their integrated ways of delivering health and social care, building on the foundations of what has to date been achieved through the Better Care Fund programme, and aligning these achievements with the Whole System Integrated Care transformation.

ACS is:

An evolved version of an STP in which commissioners, providers in partnership with Local Authorities, the 3rd and voluntary sectors take collective responsibility for the total health and care needs of their population.

The Transforming Community Services Programme will focus on sustaining the single point of access 'Hub' model for community services, expanding on the work undertaken in 2016/17. Community Hub multi-disciplinary teams (MDTs) will work closely with the established Community Services Single Point of Access and GP practices to improve the hospital discharge process and further reduce delayed transfers of care by providing simpler contact for London North West Healthcare Trust (LNWHT) Services using local intelligence to facilitate referral in order to deliver the best care for Harrow patients.

This will see the creation of a provider conglomerate which come together and take responsibility for the whole continuum of health and care support provision. Below is the expected organisational architecture:



The proposed provider partner structure for the ACS governance structure can be found in the appendices: CCG ACS MOU.

5. Background and context to the plan, including evidence base and local priorities

5.1. Case for Change:

The Health and Wellbeing Strategy and our Better Care Fund Plan have been informed by our **Joint Strategic Needs Assessment (JSNA)**, which has been refreshed since the last BCF submission. The assessment highlights some key issues, as set out below:

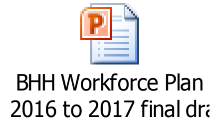
http://www.harrow.gov.uk/download/downloads/id/7745/jsna_2015-2020

An Older and Aging Population and Some Challenging Circumstances

Around 243,500 people live in Harrow, 7% of the population are children under 5 years old and 7% are aged over 75. Compared to London, the population of Harrow has a greater proportion of older people and a lower proportion of people in their 20s and 30s. One third of over 65s have at least one long term health problem or disability and people are living longer with ill health (approximately 20 year gap in healthy life expectancy and life expectancy).

Over the next ten years, the population of Harrow is expected to grow over all. The proportion of people who are of working age (16-64) will decrease by 4% and the proportion of those over 65 will increase by 4%, increasing the ratio of dependency. This also has an impact of the workforce and the need to recruit, train and retain a range of health and social care staff. We continue to work with our provider services to support the recruitment and retention of appropriately qualified staff.

Large scale regeneration is planned and initial assessments suggest significant impact on primary care and education as a result of increased population in new housing developments – adverse impact needs to be mitigated.



Harrow is one of most ethnically and religiously diverse boroughs in country, which has implications for rates of e.g. diabetes and heart disease in BAME groups and cultural sensitivity. In addition, there are financial challenges across the system which will have an impact on future provision of services (health checks, weight management, and smoking). This presents a potential opportunity to collaborate with shared funding to improve outcomes.

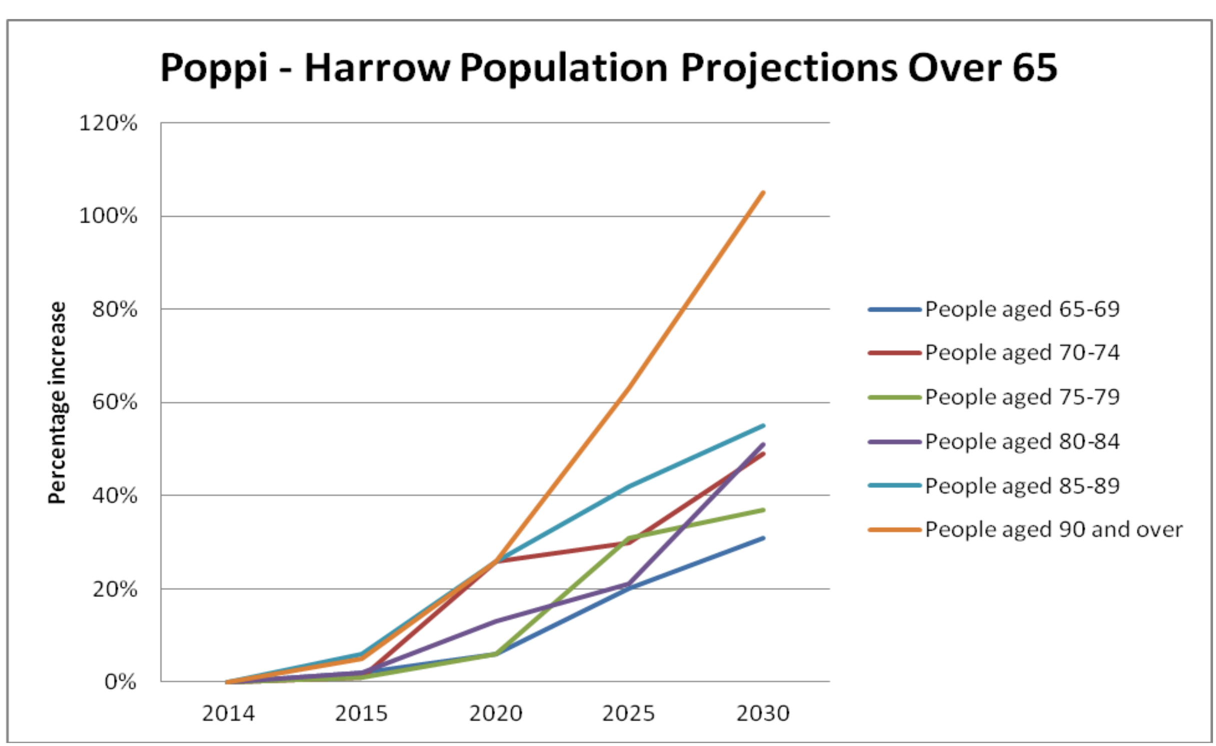


Figure 1 Population projections, from POPPI database

As shown in Figure 1, the projected significant increase in the number of residents of the borough over the age of 65 over the next 15 years suggests that demand on services and the complexity of needs is anticipated to increase. This points to the need to invest more to maintain an even level and quality of service to counteract this projected growth in demand, however the financial challenges mean that this is unlikely. This requires enhancing the integrated approach to maintain services to an increasing population. Both the CCG and LB Harrow have made 'Prevention' a key activity area alongside promoting a local model of self-care, supporting local residents to live full and active lives, to maintain independence and to avoid admission into acute care.

As part of our Whole Systems Integrated Care model we continue to develop PAM's –Patient Activation Model and envisage this to be part of the currency for commissioning the Accountable Care Organisation in the longer term.

Uneven distribution of need and cost

To inform our wider health and social care transformation programme, Harrow has undertaken a risk stratification analysis of the population using the BIRT 2 risk assessment tool and CCY performance and financial data.

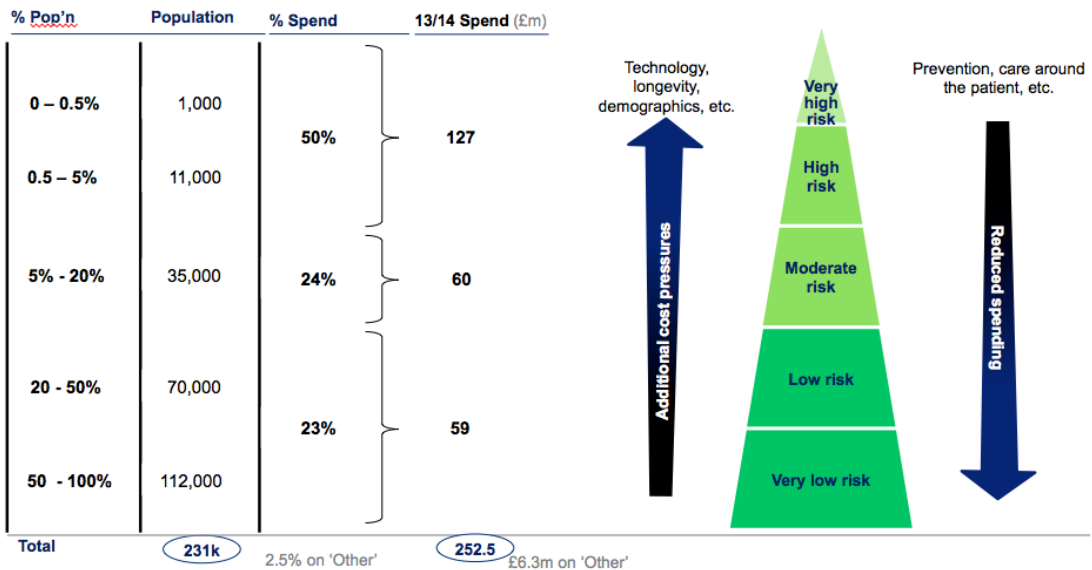


Figure 2 Risk stratification analysis

The stratification exercise found that 50% of available resources are utilised by only 5% of the population and this proportion of resource use is growing. Further analysis indicates that high-risk patients are most likely to utilise acute services and are very likely to have more than one long term condition. This increases the cost to serve for that patient segment and severely diminishes the ability to provide for other segments.

Therefore the emphasis for Harrow should be on providing anticipatory and preventative care for these most at risk patients; those aged 65 and over with multiple long term conditions.

The risk stratification exercise will be repeated autumn 2017 to support us in targeting our resources as we develop further our Whole Systems Integrated Service and our Accountable Care Model.

5.2. Shaping a Healthier Future

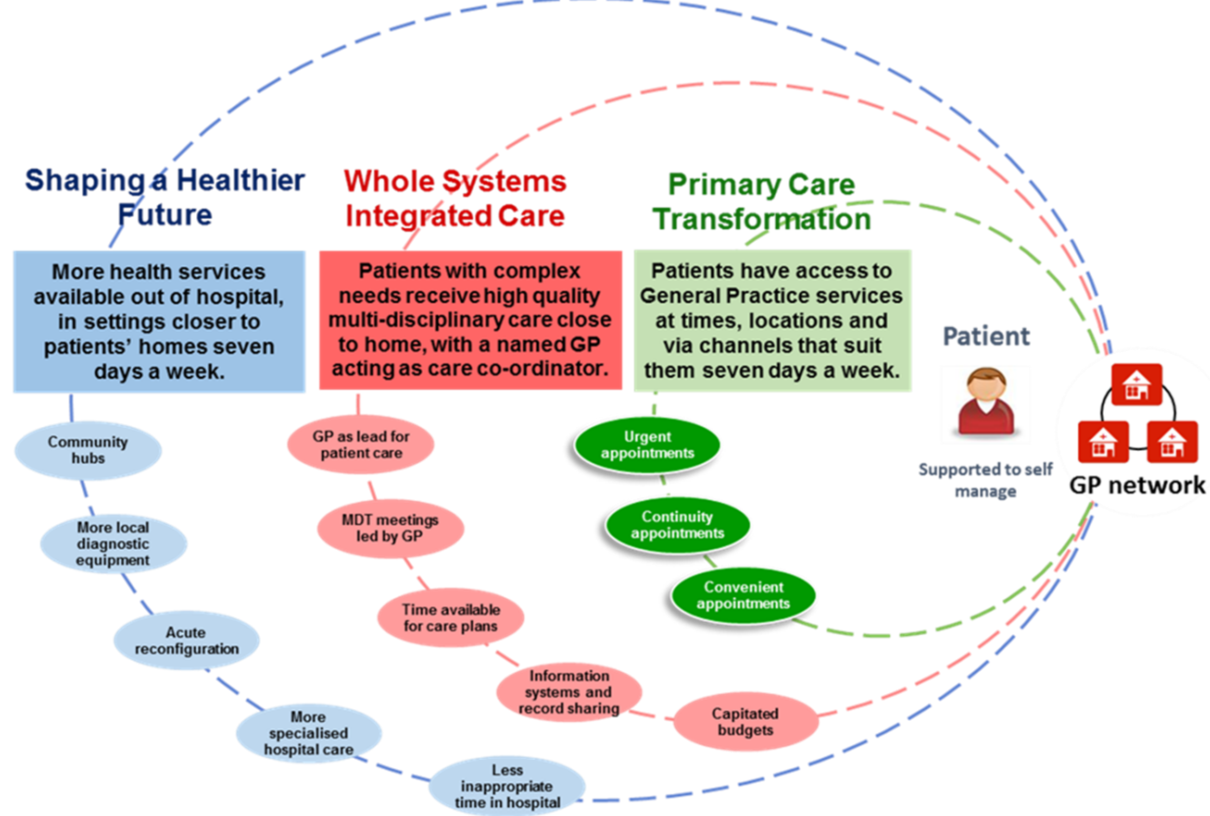
Shaping a Healthier Future (SaHF) is a clinically led programme being delivered across the eight Clinical Commissioning Groups (CCGs) in North West London (NWL) which will create a future healthcare system in NWL to meet the changing demands of the population, improve standards, and provide a sustainable financial future.

The vision for care in NWL is underpinned by four overarching principles detailed below:

- Personalised – Enabling people to manage their own care themselves and to offer the best treatment to them. This ensures care is unique.
- Localised – Localising services where possible, allowing for a wider variety of services closer to home. This ensures care is convenient.
- Integrated – Delivering care that considers all the aspects of a person's health and is coordinated across all the services involved. This ensures care is timely, efficient and appropriate.
- Specialised – Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures care is better.

Delivery of SaHF is directly supported by the North West London Five Year Strategy and a series of transformation programmes have been initiated to deliver SaHF. All of these programmes are relevant to the delivery of the Integrated Urgent Care Service. These transformation programmes are:

- Primary Care Transformation (including out-of-hospital): Placing Primary Care at the heart of whole system working, and improving access to GP services.
- Whole Systems Integrated Care: Coordinating care across commissioning bodies and providers, centred on the patient.
- Acute Reconfiguration: Improving hospitals to deliver better care 7 days a week, and ensuring there are more services accessible and closer to home.
- Mental Health Transformation: Improving mental and physical health through integrated services.



5.3. Opportunities currently under consideration in the STP

Harrow is working as part of a wider collaborative of 8 CCGs across North West London, many of the mature change programmes already underway impact across all boroughs and have aligned visions to develop improve and sustain the very interconnected nature of the system.

The North West London (NWL) area will be the footprint for a Sustainability and Transformation Plan (STP) (June 2016). Each borough will develop a local plan which will be combined with the others to produce the overall North West London STP.

Harrow-CCG-Local-Input-Into-NWLSTP.pdf

Various opportunities to improve outcomes for people in Harrow and deliver more cost effective services, principally around prevention, partnering and highlighting the importance of self-care, including:

- Older people – Falls prevention and social isolation (particularly important given people in touch with social care report less social contact than they would like).
- Primary prevention - Wide scale provision of information and brief advice on alcohol, physical activity, diet, smoking and mental health and signposting to appropriate services (MECC – Making Every Contact Count).
- As part of MECC, exploration of models with voluntary and community sector to explore how health champions could support provision and signposting.
- Child health – related to poverty and mental health (evidence strong around Conduct Disorder), A&E attendances.
- Diabetes – NWL approach to roll out and evaluation of NDPP- National Diabetes Prevention Programme, increase detection, reduce between practice variation in terms of detection/management (and link to action on hypertension).
- Mental health – Align with Like Minded programme, opportunity for transformation through joint working, early intervention, sign up to Time to Change campaigns to tackle stigma and particular attention to child mental health. (This raises the profile of MH in a number of local strategies and is a Harrow Health and Wellbeing Board strategy priority acknowledging local need and aspiration to highlight).
- Self-care – mapping and integrating services/facilities which support self-care with widespread use of Patient Activation Measure to segment the population according to ability to self-care, to tailor approaches and evaluate behaviour change. Also in this improved signposting for patients – opportunities to integrate public health, council, NHS (e.g. 111) mechanisms to ensure people find

the same high quality information no matter where there first point of contact (as opposed to a single point of access).

- Integrated approaches to health and social issues – social prescribing acknowledging the significant impact that debt, housing, employment, income, etc. issues have in health and wellbeing.
- Mental health – through prevention and earlier intervention as well as psychological therapies and (reducing spend on primary prescribing and improving outcomes against quality standards such as IAPT-Improving Access to Psychological Therapies impact, people with mental illness in settled accommodation, dementia diagnosis, assessment of depression severity at outset). This builds on our commitment with regards to NHS England business rules requiring CCGs to ensure that they continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. In 2016/17 Harrow CCG are planning to meet this requirement and increase investment in mental health services by 6%.

The further development of the Harrow plan will be informed by the discussions held within a stakeholder group, formed of representatives of patient and the public engagement groups, the CCG, local authority, health and social care providers and the 3rd sector.

6. Progress to date and Better Care Plan 17/19

6.1. The evolution of BCF 16/17 Plan

In 2016/17, two new initiatives were developed, both of which, though at an early stage of development, are already delivering significant positive benefits to Harrow patients:

1. **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 GP's with Special Interest (GPwSI's) and supported by a multi-disciplinary team which also incorporates a Virtual Ward Case Manager.

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

A key innovation for 2016/17 has been the development of the Anticipatory Care Plan element of the Care Plan which proactively sets out future goals and actions for each patient.

Another key area of work in 2016/17 has been measuring the benefits achieved through the delivery of the Whole Systems Programme (WSIC). 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 Whole Systems Programme was to demonstrate the sustainability of a multi-disciplinary and collaborative approach to 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 and have one or more long term condition. In total, there are 28,400 patients within the borough that are over 65 with one or more long term condition and these currently account for 5,960 unplanned hospital admissions each year at an average cost of £2,628 and a total cost of £16 million per year.

Harrows 2017 – 19 BCF Plan was informed by themes identified in 2016/17:

Harrow Better Care Fund Plan Themes	
	Make life better for the people of Harrow.
	Prioritise home and community-based support to keep people well, and to reduce the overuse of the emergency care system.
	Joined up, cost-effective services, making the most of the available resources.
	Planned in partnership between those that use them, stakeholders, providers and commissioners to ensure that they best meet the needs of Harrow.

Figure 3 BCF themes

Since the last BCF Submission we have up-dated our Health and Wellbeing Strategy (2016 -2020).
http://www.harrow.gov.uk/download/downloads/id/8376/joint_health_and_wellbeing_strategy_for_harrow_2016-2020

This means:

- Start well – we want children from conception to adulthood to be safe, happy and have every opportunity to reach their full potential.
- Live well – we want high quality, easily accessible health and care services when we need them, sufficient and good quality housing, green and active spaces, healthy high streets and neighbourhoods.
- Work well – we want to help people to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing.
- Age well – we want to enable older people to remain well, connected to others and independent in their own homes for longer and enable dignified deaths.

The key priorities are:

- Use every opportunity to promote mental wellbeing.
- Empower the community and voluntary sector to collaborate to deliver alternate delivery models and funding solutions.
- Provide integrated health and care services.

The focus of Health and Wellbeing partners in the future will be an emphasis on how they can contribute to making Harrow a better place to live and reduce the differences in life expectancy and healthy life expectancy between communities.

What is planned to change?

By 2019/20, we anticipate change in six substantive areas through the better configuration of services:

1. Agreed joint and integrated working arrangements on a number of health and care services between Harrow CCG and Council – full roll out of the 8 high impact changes.
2. Multi-disciplinary care for people over 65.
3. Deliver a single point of access ‘Hub’ model.
4. Improve hospital discharge and reduce DToC levels
5. Deliver high quality re-ablement and rehabilitation services.
6. Commission care from a locally established Accountable Care Organisation*

*model in development for April 2018 launch.

6.2 BCF Plans for 2017/18

In 2017/18, the WS Programme will focus on providing anticipatory, multi-disciplinary care for those 6,000 people within the cohort, who through a systematic approach to case identification are identified as most likely to benefit from the support available, also extended to ensure that services across providers work together to deliver improvements in patient care and quality that also support a reduction in their attendances and admissions to hospital

In particular, the following patient groups have been identified as those that will be supported through the WS Programme in 2017/18:

- Over 65 years old with
- Palliative care/end of life patients
- A diagnosis of dementia
- In nursing/residential homes
- 2 or more admissions in the previous 12 months
- Q admission score >50%
- And any patient over 65 where GP intelligence/frailty index suggests high risk of admission

- Any patient in an intermediate care bed
- An ICD10 diagnosis of drug and alcohol dependency and frequent attenders to services
- Patients with Mental health diagnosis and health complications.

Key Workstreams

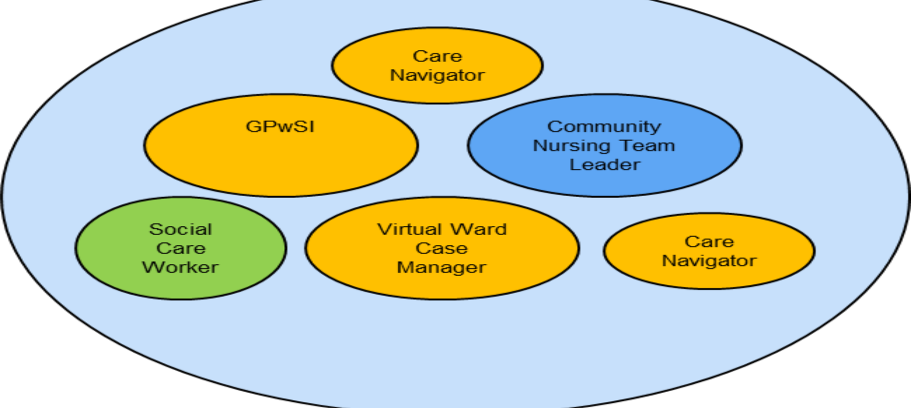
In order to deliver the proposed Programme Benefits, eight workstreams have been developed for and these are set out below:

1. Community Hub-Based Multi-Disciplinary Teams.
2. Systematic Case Identification.
3. Proactive Case Coordination.
4. Virtual Wards.
5. Anticipatory Care Plans.
6. Improving Hospital Discharge Process.
7. Use of Patient Activation Measure toolkit.
8. Using technology to provide integrated care.

Establishment of Community Hub Based Multi-Disciplinary-Teams

A key priority for 2017/19 will be to ensure coordinated and effective joint working at a CCG Peer Group level. For the delivery of community nursing, social care and virtual wards resources have been identified to work across the Peer Groups. In addition, Care Navigators are in place to support individual Peer Groups.

The diagram below provides an overview of the resources available to support the Community Hub model.



These teams are physically co located and consideration is given to who is best placed to lead each of the three teams. In addition, it is proposed that they agree a shared work programme to ensure the most efficient attendance and participation in Practice Case Reviews and Virtual Ward Meetings and that the team work collaboratively to deliver the best outcomes for the patients within the cohort.

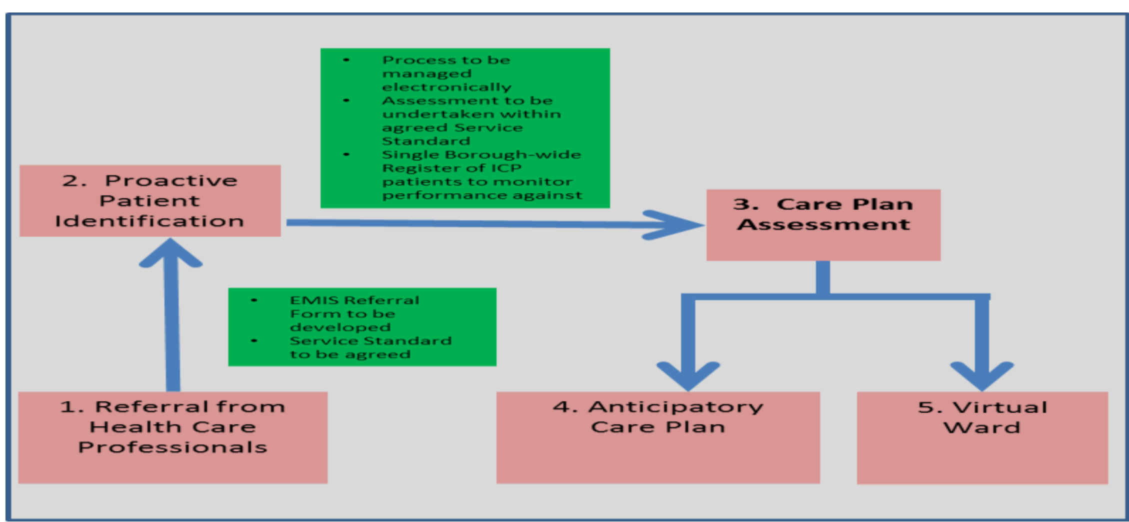
This work stream will be led by CLCH – Central Community Healthcare NHS Trust and Harrow Health CIC. Success will be measured using the Health and Social Care Professional Satisfaction outcome measure.

Systematic Case Identification

In 2017/18, Care Navigators work with Enhanced Practice Nurses and Virtual Ward Case Managers to proactively screen patients who have been discharged from hospital with three or more admissions in the last six months or who have an EMIS IQ Score of 50 or more.

Part of the process of completing an Anticipatory Care Plan should include undertaking a Patient Activation Assessment and where appropriate utilising the 'Coordinate My Care' computer system to enable other care professionals to be aware of patient wishes in the event of deterioration in the patient's condition.

The diagram below provides an overview of the revised case identification process:



Proactive Case Coordination

In 2016/17, new arrangements come into place to deliver community nursing in Harrow. These new arrangements align with the existing Virtual Wards model, the work of Enhanced Practice Nurses and arrangements for providing GP Led Anticipatory Care (Care Planning).

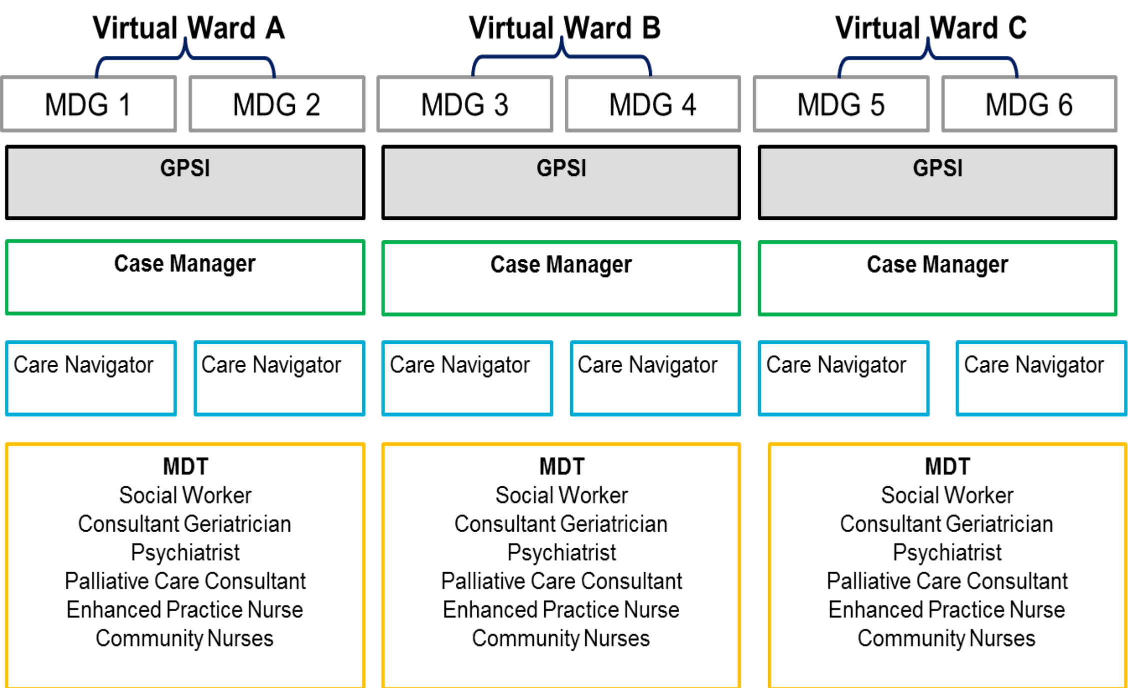
Four principal activities will be supported through the WS Programme:

- The WS Programme Team will be responsible for ensuring a consistent approach for each and providing quality assurance for the work undertaken.
- Fortnightly Case Review meetings.
- GP Practices will undertake fortnightly Case Review Meetings to review new cases and ensure effective and on-going support for existing cases. These meetings will be led by a Practice GP and will be supported by a Care Navigator. Also in attendance will be appropriate clinical members of the Community Hub MDT Team and the Enhanced Practice Nurse.
- A standard format will be agreed for Case Review Meetings which will build at a practice level on the good practice developed within Virtual Wards. Where Practices have insufficient patients (list size less than 10,000) to sustain a fortnightly meeting, then it is proposed that they convene a

joint meeting with a neighbouring or partner practice, sharing responsibility for providing a GP lead for the meeting.

Virtual Wards

The three Virtual Wards will continue to provide multi-disciplinary support for more complex patients within the cohort and these will continue to operate at a Peer Group level, led by a GPwSI – GP with Special Interest and supported by a Virtual Ward Case Manager, the model will be further developed by increased community nursing, Enhanced Practice Nurse and Social Care participation. The diagram below provides an overview of the proposed operational model.

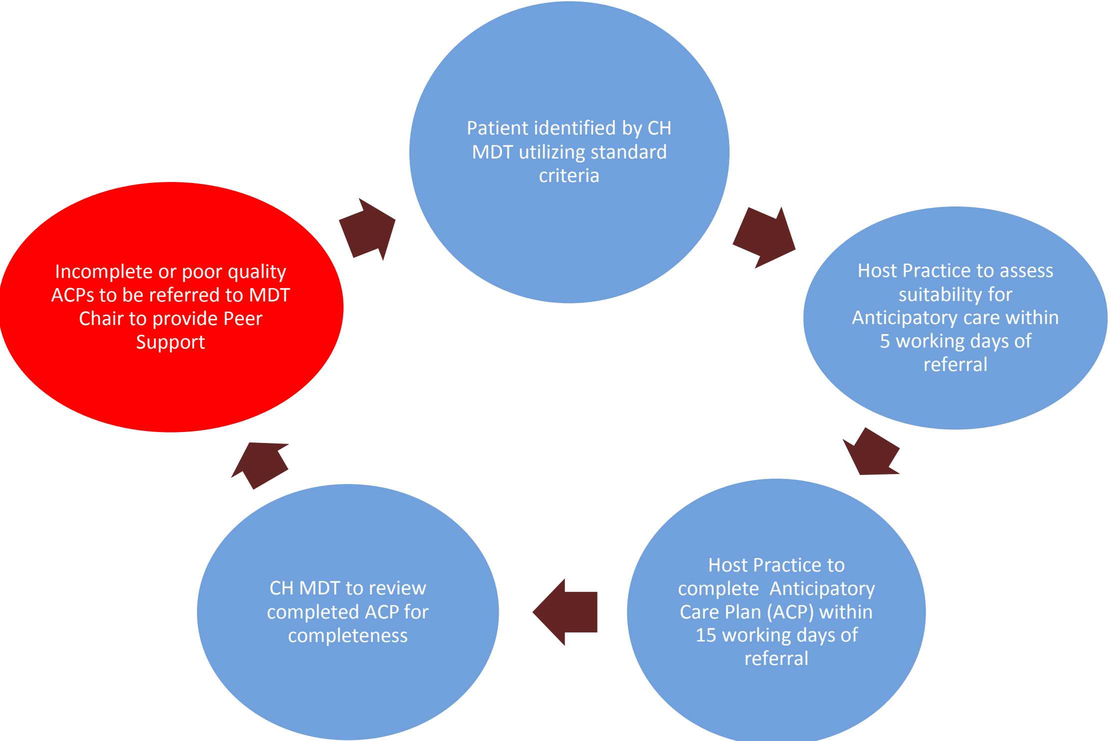


Anticipatory Care Plans

In 2017 the Care Plan template was simplified considerably and there has been increased focus on:

- Completing and agreeing with the patient an Anticipatory Care Plan.
- Completing the Patient Activation Survey and agreeing with the patient a self-care action plan, following this.
- Agreeing and completing, where appropriate, with the Patient an Advanced Care Plan and inputting these details on the Coordinate My Care website.
- Ensuring that those patients with an Anticipatory Care Plan receive the support that they require while part of the Whole Systems Cohort.
- Undertaking a six-month review.

A key priority for 2017/18 is improving the quality, usefulness and consistency of care plans. This will be achieved by adopting a systematic borough wide approach to their completion as set out in the diagram below:

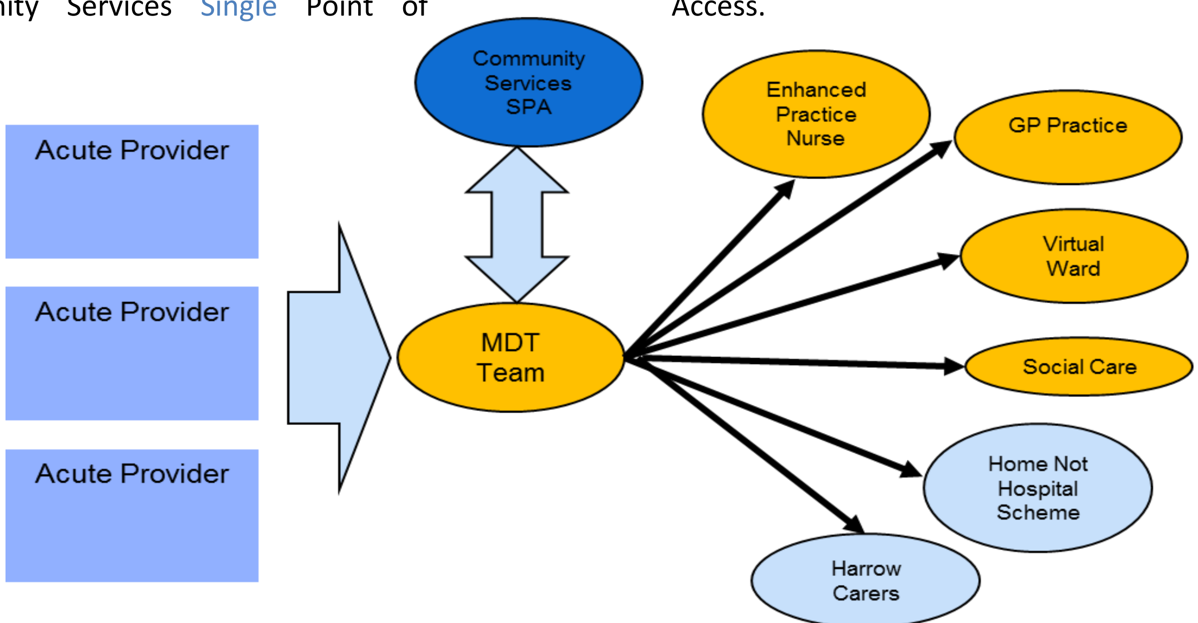


In 2017/18, GP Practices will be able to draw upon Enhanced Practice Nurses and other practice resources (but not Care Navigators) to complete Anticipatory Care Plans but at all time the patients named GP will remain accountable.

Improving Hospital Discharge Process

The Community Hub MDTs will take the lead in improving the hospital discharge process for people within the cohort. This will involve LNWHT proactively identifying those patients admitted to hospital and alerting the three WS Virtual teams so that preparations can be made prior to discharge to support the process. The discharge pathway aims to support local health and social care systems to reduce the time people spend in hospital. This new approach will build on the pilot project currently underway – Harrow Home First (D2A).

The diagram below provides an overview of how the Community Hub MDTs can improve the hospital discharge process by providing simpler contact for LNWHT Services and facilitate referral onto over 10 different services. It is anticipated that the Community Hub MDTs will work closely with the new Community Services Single Point of Access.



In addition, the Palliative Care Service will lead work with Whole Systems staff, Enhanced Practice Nurses and Community Nurses to increase the percentage of patients within the cohort who have been offered the opportunity to indicate a preferred place of death and to increase utilization of Coordinate My Care.

This will involve provision of a comprehensive and coordinated training programme and the employment of two Palliative Care Nurses to support the delivery of the WS Programme.

Promoting self-care through utilisation of Patient Activation Measure (PAM) toolkit

Harrow CCG in partnership with the Council Public Health Team will lead on the promotion and roll out of the PAM Toolkit. PAM provides a simple, evidence-based mechanism for establishing the capacity of individuals to manage their health and then using that information to increase patients focus on self-care.

The aim for 2017/19 will be to roll out PAM assessments for all patients within the Whole Systems Cohort and then to undertake a further assessment upon discharge from the cohort or as part of a six month review and to demonstrate an improvement in patient activation. The results of the review of the effectiveness of the PAM toolkit undertaken during the fourth quarter of 2016/17 are awaited.

Using technology to provide integrated care

Harrow CCG will lead work with Harrow Health CIC and CLCH who are now operating an integrated computer system using EMIS Community which enables the effective and appropriate sharing of patient records amongst Team Members. This system went live in November 2016 but requires some further assurance to ensure information governance compliance. We aim to provide access to the social care department longer term however we are yet to determine the actual operating process and platform that meets governance compliance standards.

We are also awaiting the first publication of the North West London Community Dashboard which enables the collation and analysis of practice data. Once fully functioning this will provide a suite of standard reports in order that activity and outcomes can be monitored on a monthly basis.

Also key will be the creation of a single patient register, held on the Harrow Health CIC EMIS Community System, which will hold records of all patients being managed through a Virtual Ward and will be visible to Community Hub MDTs.

In 2017/18 Anticipatory Care Plan and activity undertaken by Enhanced Practice Nurses will be recorded on GP Practice EMIS Systems however this will be visible to Community Hub MDT members via the Harrow Health CIC EMIS Community System.

The CCG and the Local Authority are working collaboratively to increase the roll out of PHB's – personal health budgets. This work is being supported with funds from NHSE and aims to increase the numbers of PHB's delivered locally using Harrow Councils personal budget tool – 'Infinity'. The online tool gives eligible individuals the ability to manage their budgets independently and is intended to help both the CCG and Council to administer PHB's and personal budgets more efficiently reducing administration costs to the organisations.

Outcomes and benefits

The aim of the WS Programme is to demonstrate that by investing resources in multi-disciplinary teams in the community then the cost of that investment will be less than the expenditure on acute resources which would have resulted if the WS Programme did not exist.

To inform the quantification of benefits from the WS Programme the outcome measures outlined in Figure 4 below have been developed.

Priority Area	Outcome Measure	Method of Measurement	Rationale
Falls	• Reduction in recorded falls in 6 month period following	• EMIS to track no of recorded falls in 6 months prior to and	• Significant prevalence amongst WSIC cohort

	referral	six months following referral to WSIC Programme	
Dementia	• % of cohort receiving basicmemory assessment • % of cohort receiving comprehensive memory assessment (e.g. MMSE, Toronto assessment) • % of cohort referred to Memory Assessment Clinic • % of cohort diagnosed with dementia	• EMIS to track referral rates, outcome of referral	• Significant opportunity for improving outcomes for WSIC cohort
End of Life Care	• % of EoL cohort with Coordinate My Care record • % of EoL cohort dying in preferred place of death	• EMIS to track recorded DNAR forms, % of patients dying in preferred place of death	• Cashable benefit • Significant opportunity for improving outcomes for WSIC Cohort
Non Elective Admissions	• No of non-elective admissions in previous 6 month period • No of A&E admissions in previous six month period	• Comparison of number of admissions pre and post referral to WSIC Programme • Comparison of WSIC Cohort with non WSIC Cohort	• Cashable benefit • Will maintain focus of WSIC Programme on delivery of out of hospital strategy
Hospital Discharge support	• No of WSIC Cohort readmitted to hospital with 28 days of discharge • No of WSIC Cohort experiencing delayed discharge from hospital		• Cashable benefits • Will shift focus of WSIC Programme towards improving hospital discharge
Patient Activation	• % of WSIC Cohort with positive improvement in PAM score within 6 months of referral	• NHS funded PAM Software Tool	• Will encourage focus on self-care • Significant evidence to suggest cashable benefits
Patient Satisfaction	• % of patients rating support provided through WSIC programme as good or excellent	• Telephone Call back Survey following discharge/six month review	• Key priority for Programme

Figure 4 Priorities and outcome measures of WS workstream

It is anticipated the WS Programme will deliver cashable efficiency savings of £1,314,000 in 2018/19.

6.3. Better Care Programme Funding 2017 - 19

	2017/18	2018/19
Transformation of Community Services		

CLCH Contract	8,695,530	8,925,201
Rapid Response Team	-1,282,249	-1,320.716
Sub Total	**7,413,281**	**7,604,485**
Whole Systems Integrated Care		
Rapid Response Team	1,282,249	1,320,716
WSIC budget	1,181,300	1,216,770
Sub Total	**2,463,579**	**2,537,486**
Protecting Social Care		
Protecting Social Care	4,603,000	4,690,000
Care Act	435,000	358,000
Carers Contribution	515,000	423,000
Reablement Contribution	349,000	287,000
Non-recurrent Funding	204,000	130,000
Sub Total	**6,106,000**	**5,888,000**
iBCF Schemes		
Increased ASC needs	1,652,827	3,294,246
Market Management & Stability	675,000	500,000
Protection of social care funding	400,000	510,000
Acquisition of residential provision (increase in residential bed capacity)	900,000	375,000
Sub Total	**3,627,827**	**4,679,246**
Disabled Facilities Grants	**1,293,294**	**1,406,085**
TOTAL BCF Pooled Budget	**20,903,980**	**22,115,302**
CCG Minimum Contribution	14,323,118	14,595,257
CCG Additional Contribution	1,659,742	1,434,714
Local Authority Contribution	1,293,294	1,406,085
iBCF Contribution	3,627,827	4,679,246
Total Funding Sources	**20,903,980**	**22,115,302**

6.4. Protection of Social Care

In 2016/17, the Protection of Social Care Programme continued its focus on implementation of the Care Act, to support people with eligible levels of need, and to deliver high quality re-ablement. In 2016/17, the work delivered:

- Swift access and assessment, either from the acute sector or from a community setting, fully aligned with integrated teams wrapped around GP services.
- Re-ablement at the 'front of house' when people present to social care.
- A diverse range of available services for those eligible, purchasable through 'personal budgets'.
- Comprehensive and effective safeguarding of vulnerable adults and diligent quality assurance to ensure services are of a good standard.

Towards the end of 2016/17 social care saw an increasing number of people accessing social care, in particular from the acute hospitals as a result of discharges. The needs of service users presenting to social care were also more complex. In addition, the costs of providing care in the local care market increased and supply for Harrow residents was limited given the diminishing purchasing power. This has continued into 2017/18, and the unprecedented financial challenges of the local authority exacerbate these challenges, which add further pressure to the social care system. The iBCF and funding for the protection of social care will not eliminate all of the significant funding pressures anticipated in 2017/19.

In 2017/19, the aim of this programme of work is to ensure that the social care provision essential to the delivery of a safe, effective, whole system of care is maintained where possible within the available (and reducing) financial envelope.

Council and CCG officers have agreed a contribution of to enable the national condition for the protection of social care funding to be for 2017/19 and will be supported by a section s75 agreement.

Social Care minimum	5,651,628	5,759,009	CCG.

6.5. Meeting the National Conditions in 2017 – 19

6.5.1. Agreement on a local action plan to reduce delayed transfers of care

Patients registered with Harrow GPs account for 77% of accident and emergency hospital activity at North West London (NWL) Hospital NHS Trust; over 30,000 attendances in 2014-15. Emergency care for Harrow GP patients is also provided by:

- Barnet and Chase Farm Hospitals Trust 5% of their total attendances,
- West Hertfordshire Hospitals NHS Trust 4%,
- Royal Free Hampstead NHS Trust 2%,
- The Hillingdon Hospital NHS Trust 2%, and
- a variety of other hospitals combined total 11%.

Not all Harrow Residents are registered with Harrow based GPs and not all GP patients live within the borough, it is not possible to directly compare hospital admissions data with the resident population data.

41% of people registered with Harrow GPs who attended NWL hospital trust were classified as white and almost 32% were Asian or Asian British. This latter group appear to be under represented, however, more than 3,300 attendances did not have an ethnic classification (11%) which may explain some of the discrepancy.

The most common conditions for presentation recorded were:

- gastrointestinal 8.5%,
- respiratory 6.1%, and
- cardiac 5.8%.

This varies according to ethnic group. Cardiac conditions were the most common in the Caribbean community (9%); similarly for the Bangladeshi community along with respiratory conditions (both 8.1%). Respiratory conditions were more common amongst most mixed sub-groups; White and Black Caribbean (10%), White and Asian (12%) and White and Black African (9.4%) although numbers are small. For all other ethnic groups, the most common condition was gastrointestinal.

Tre are a number of schemes that are being developed and ramped up such as:

- Community provider reinvestment
- Enhanced care in care homes
- Discharge to Assess
- Home First
- Rapid Response/ Prevention

The aforementioned services changes are all intended to bring throughput and provide capacity system wide. On the basis of those working assumptions and positive impacts, we have calculated efficiencies within the system that will support reinvestment in community/ OoH services.

	17-18 plans								
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NHS attributed delayed days	273.6	273.6	264.8	273.6	243.2	255.2	255.2	230.5	255.2
NHS Barnet CCG	19.7	19.7	19.0	19.7	19.0	19.7	19.7	17.8	19.7
NHS Brent CCG	11.6	11.6	11.2	11.6	11.2	11.6	11.6	10.4	11.6
NHS Harrow CCG	242.4	242.4	234.6	242.4	213.0	224.0	224.0	202.3	224.0

Social Care attributed delayed days	145.0	145.0	142.0	143.0	142.0	143.0	143.0	129.1	143.0
Jointly attributed delayed days	52.1	51.8	49.9	51.5	49.9	51.5	51.5	46.5	51.5
Total Delayed Days	470.7	470.4	456.7	468.1	435.1	449.6	449.6	406.1	449.6
Population Projection (SNPP 2014)	195,784	195,784	195,784	195,784	195,784	195,784	197,714	197,714	197,714

Harrow CCG along with LB Harrow and CNWL (Central North West London MH Trust) have operated a joint weekly MH DToC panel weekly since April 2017. This works alongside work being done to address mental health admissions avoidance and delayed discharges, at a local level and as part of the wider STP footprint work:

Delivery Area 1

6	We are promoting the Time to Talk campaign to reduce mental health stigma	2017-18
7	We are providing an employment mental health service that is linked to existing talking therapies, which aims to support people with mental health conditions into employment	2017-18
8	We have signed the NHS Learning Disabilities Employment Pledge and are developing an action plan to increase employment for people with a Learning Disability.	2017-18
15	We will ensure that diagnostic, assessment and integrated care pathways are in place for people with a Learning Disability, autism and complex and challenging behaviour.	2017-18

Delivery Area 2

9	We are improving the mental health of people with diabetes by providing talking therapies to diabetics with depression and / or anxiety.	2017-18
10	We are increasing access to, and availability of, early intervention mental health services, such as psychosis services, psychological therapies and community perinatal services.	2017-18

Delivery Area 4

1	We will improve specialist community-based support through opening up Early Intervention in Psychosis team access to all age patients - specifically for patients who are over 35 – and embedding a link worker model for delivery of interventions to patients who are over 35	2017-18
2	We will embed physical health check assessments within inpatients and Early Intervention in Psychosis community teams, ensuring outcomes are factored into care plan management.	2017-18
3	We will improve pathways between the mental health Single Point of Access and Local Teams.	2017-18
4	We will provide different types of accommodation for mental health patients - moving towards independent living with floating support. We will also implement a Supported Housing Strategy, to improve access for people with mental health issues to access good quality, affordable housing with tenure options.	2019-20
5	We will implement Community Based Packages to provide mental health care closer to people's homes	2017-18
7	We are enhancing our investment in Primary Care Mental Health services, to improve access to mental health services	2017-18
8	We are providing mental health training to GPs (through an Advanced Diploma in MH Care), peer support, and other treatment types in line with proposed Like-Minded model.	2017-18

9	We are providing specialist perinatal mental health community services.	2017-18
10	We are promoting the 'Five ways to wellbeing' amongst older people to improve their mental health	
11	We are supporting the 'Work and Health Programme', which provides work placements for people with common mental health needs	2017-18
12	We are improving urgent/crisis care in the community so that patients can be treated at, or close to, home. We are doing this through providing a 24/7 single point of access, timely assessment, more crisis management, supporting recovery at home in the community and extending out-of-hours Children and Adolescent Mental Health Service (CAMHS) provision.	2017-18
13	We are also exploring alternatives to inpatient admissions, such as crisis houses/recovery houses.	2017-18
14	We are carrying out an options appraisal for 'tier free' CAMHS service transformation across North West London, including a review of workforce training needs	2017-18
16	We are providing a new community eating disorder service for children & young people	2017-18

*Can be referred to in appendices: Harrow STP Chapter and Timeline.

6.5.2 Maintaining Provision of Social Care Services

Harrow Council, agreed by full Council in February 2017, set the 2017/18 budget and Medium Term Financial Strategy (MTFS) to 2019-20. This required further savings of £8.043m to be developed during 2017/18 with a remaining gap of £8.998m to be identified for 2018/19.

In 2017-2018 the total controllable Council general revenue budget will be £147m, of which £58m (39%) will be spent on Adult Social Care (ASC). In 2017-2018 Adult Social Care savings total £2.7m and represents 24% of the total Council savings, with further savings of £7.3m expected to be delivered over the two years to 2019-20.

The budget planning process allocated growth of £4.6m (funded largely by the precept levied at 3% which generated additional funding of £3.2m) to the adult social care budget in 2017-18 to address social care pressures. The MTFS to 2019-20 does not assume any allocation for ongoing demographic pressures or assumptions that the precept will continue to be levied, however this is under review as part of the budget setting process for 2018-19.

The financial pressures are occurring in parallel to an increase in Adult social care needs, including complexity of care, and year on year increases in the number of older people being discharged from hospital (approx. 24%), which coupled with a fragile provider market, highlights the challenges being experienced across the health and social care economy in Harrow.

Given the overall financial challenges faced by the Council, inflationary pressures are no longer addressed through central funds. This has required funds to be earmarked within the iBCF to be set aside to provide support to providers to support market stability. The impact of the National Living wage has been reviewed, and will be factored into approved inflationary funding. Consistent with previous years, local providers are required to submit requests for fee uplifts and are managed through a standardised review process.

The Relative Needs Formula (RNF) allocation (uplifted in line with guidance) has been applied for the protection of adult social care in the Better Care Fund within the two year plan, however the financial challenges faced by the CCG have unfortunately resulted in a reduced contributions towards the nationally mandated amount for Care Act 2014 new burdens, contributions towards carers, re-ablement

and in the non-recurrent funding in relation to health facing posts supporting the health and social care interface.

Uplifted investment in Adult Social Care Commissioned Services in line with the guidance and the RNF amount for LB Harrow will enable:

- Joint work on the Discharge to Assess “Home First” scheme
- Continuation of joint work on the Virtual Ward scheme
- Continuation of joint work to manage delayed transfers of care through the social work team co-located at Northwick Park hospital, and reprovision of intermediate care beds to ensure timely discharge
- working towards intermediate housing options (potentially including adapted) and modern telecare solutions, to assist timely discharge and keep residents in their own homes, avoiding long term dependency on care
- support for young people with complex conditions in the community
- anticipated growth to manage population pressure and ensure that individuals are supported within social care and neighbourhood services as appropriate.

Prevention services in 2017/18 total £2.9m and are funded within the ASC budget.

The aim of the local health and care system is to continue to build on the schemes identified in 2017-18 in the second year of the plan. There is a joint commitment to meeting the CCG minimum and respective inflationary uplift to support this.

This will of course be based on the outcomes of scheduled scheme reviews and evaluations and local priorities, which will inform Harrows BCF mid-point BCF review.

6.5.3 Care Act and Carers Breaks

This biennial BCF Plan spending for Care Act duties and Carers break are as follows:

Protecting Social Care		
Care Act	435,000	358,000
Carers Contribution	515,000	423,000
Sub Total	**6,106,000**	**5,888,000**

The finding will be used to support the meeting or commitments set out in Harrows Joint Carers Strategy (DRAFT can be found in the appendices), which is currently seeking HWBB (Health and Wellbeing Board) sign off.

6.5.4 DFG

Disabled Facilities Grants	1,293,294	1,406,085

6.5.5 Improved Better Care Funding

The iBCF, agreed as part of the 2017 budget, allocated in March additional resources of £3.6m to support adult social care. This is largely being used to meet increased ASC needs, including the impact of inflation to support providers in the market, and also to support the protection of social care funding more at 2016-17 levels given the reduction in CCG funding due to the CCGs financial pressures.

iBCF Schemes		
Increased ASC needs	1,652,827	3,294,246
Market Management & Stability	675,000	500,000
Protection of social care funding	400,000	510,000
Acquisition of residential provision	900,000	375,000
(increase in residential bed capacity)		
Sub Total	**3,627,827**	**4,679,246**

6.6 Agreement to invest in NHS commissioned out-of-hospital services

Harrow retendered its community services contract in 2015. The new service aim to provide a more flexible response to clinicians and patients needs. The re-provided service operates flexible working including extended hours and weekend working patterns.

This is in line with Harrow CCGs vision for developing Out of hospital services under the ACS model.

6.7 Better Data Sharing between Health and Social Care

Information sharing has improved within Community and Primary Care level by the successful adoption and roll-out of EMIS Community.

There is some data sharing between other partners that are agreed through relevant authorities Information Governance tools.

The challenge going forward is to have a single operating platform across the whole of the health and care system. Scoping work is underway at STP level, but is very early on in the developmental stage.

Also please refer to *Using technology to provide integrated care* in chapter 6.1.

6.8 Plans to support seven day services across Health and Social Care

Both partners have committed to moving towards 7 day working but have yet to finalise agreement on this due to a number of issues including capacity and funding. We have however flexed a number of our existing services operating hours to provide increased capacity. Primary Care services in a number of areas are offering an 8 – 8 service, 7 days a week and our Rapid Response service operates 8 – 10 p.m. 365 days per year.

7 National Conditions

7.1. Jointly Agreed Plan (KLOE 1)

The Harrow Market Position Statement (MPS) sets out the direction of travel for providers of social care in the market place. The MPS for 2017/18 is drafted and includes representation from the independent sector providers and input from local people. It also addresses the demographic pressures and acuity of need so that providers and service users can work with the local authority in developing solutions. This is also reflected in Harrow CCG's commissioning intentions 2016/2018*

*Currently being refreshed.

The MPS reflects key areas of the BCF which have an impact on the delivery of social care and outcomes for local people. This approach enables us to engage providers in terms of market development in a way that links planning. An example of this can be seen in the development of reablement provision. Independent sector providers of reablement understand the capacity and service requirements for 2016-17 including the outputs and outcomes to be achieved.

These requirements are reflected in our service specifications and agreed with all providers on our approved framework. For 2016-17 we have extended our framework of reablement providers to ensure that demand continues to be successfully met, that there is stability in the market place and that the quality of service provision is maintained for local people. We are confident that through this engagement with providers we will continue to achieve the 80% success rate in terms of the number of people still living independently 91 days after discharge from hospital into reablement.

7.2. Evidence that Local Providers have been involved in the plan (KLOE 2)

In Harrow lead providers inform and shape strategic service transformation programmes, this includes the development of the WSIC operating model. Providers are also involved in development of the future out of hospital services work programme under the banner of ASC development.

Transformation Intelligence gathered from providers during quality and performance meetings and reviews, which informed the shaping of the plan.

7.3. Housing Authority engagement in developing the plan DFG (KLOE 3)

The BCF assumes that the full disabled facility grant allocation will be allocated to the housing authority to enable it to continue to meet the statutory duty to provide adaptations to the homes of disabled people.

The housing authority continues to support improving outcomes across health, social care and housing largely through the use of adaptations. Other schemes, such as the Home Improvement Agency (HIA) in Harrow deliver advice, support, information, advocacy and practical help with designing and delivering repairs, adaptations to vulnerable people. Fast track non-means tested adaptations may be considered for hospital patients to assist timely discharges, and falls prevention and social exclusion schemes work to prevent hospital admissions. During 2017/19 Harrow will pilot the use of telecare programmes aimed at those with early stage dementia or epilepsy (for example through the use of GPS tracking systems and relevant sensors), to enable service users to live in their own homes thereby delaying reliance on health and care systems.

The services provided will be closely monitored to ensure that the funding is targeted at both cost-saving and preventive measures, aimed at prolonging older and disabled people's mobility, well-being, home safety, warmth and independence at home and preventing untimely or unnecessary admission to hospital or care.

7.4. NHS Contribution to social care is maintained in line with inflation

The CCG is committed to meeting its mandated provision of 30% contribution and respective 1.79 % inflationary uplift, in order to maintain provision of social care services (not spending).

There are a number of key elements to protecting social care in Harrow, which are detailed as follows.

- Safeguarding.
- Deprivation of Liberty Safeguards.
- Personalisation and Choice
- Supporting people with eligible need
- Responsive assessment and advice services
- Reablement

Carers Support. The local authority will prioritise statutory resources within the available financial envelope.

There are significant financial challenges for LBH in maintaining the level of social care services provided. This includes pressures relating to the reduction in the financial envelope arising from the local government financial settlement as well as those from the demographic picture in Harrow, where the number of vulnerable citizens are growing whilst complexity is also increasing.

Amidst the challenging financial environment it is essential that social care is protected so as to keep people safe and meet our statutory obligations. In protecting social care we are also working innovatively with stakeholders, aiming to maximize the opportunity for co-production and empowering service users. Whilst the allocation of social care funding has been uplifted in line with the guidance for 2017/18 and our financial planning assumptions include an inflationary uplift for the 2nd year of the plan, the overall CCG funding levels have reduced.

7.5. Agreement to invest in NHS-commissioned out-of-hospital services

Harrow CCG has for many years invested in the development of 'out of hospital' services for its local residents. This is demonstrated in the investment in our WSIC – Whole Systems Integrated Care model and our plans for developing a local accountable care organization which is planned to operate in shadow form from April 2018.

The CCG also re- tendered its community services contract increasing its investment in these services to deliver more community based care. The new community service provider is been operational since May 2016 with full operation of its Rapid Response – hospital admission avoidance service since November 2017.

Locally we continuously look for opportunities to develop our local services model and to re-invest monies where possible. We are at present re providing our intermediate care bed capacity to deliver a more local option(s) alongside our recently piloted Discharge 2 Assess programme.

The challenge for the partners remains an increasing demand for services in a challenging financial climate.

7.6. Managing Transfers of Care

7.6.1. The Harrow Urgent & Emergency Care Transformation Plan

The following is based on a High Impact Change Model self-assessment of Harrows local position and actions associated:

7.6.2. Early discharge planning

Not yet established	Plans in place	Established	Mature	Exemplary
Early discharge planning in the community for elective admissions is not yet in place	Clinical commissioning group (CCG) and adult social care (ASC) commissioners are discussing how community and primary care coordinate early discharge planning	Joint pre-admission discharge planning is in place in primary care	GPs and District Nurses lead the discussions about early discharge planning for elective admissions	Early discharge planning occurs for all planned admissions by an integrated community health and social care team
Discharge planning does not start in A&E	Plans are in place to develop discharge planning in A&E for emergency admissions	Emergency admissions have a provisional discharge date set in within 48 hours	Emergency admissions have discharge dates set which whole hospital are committed to delivering	Evidence shows X per cent patients go home on date agreed on admission

Work is underway to support early discharge planning and to improve the discharge pathway. The CCG and the local authority are supporting early discharge planning for elective admissions though the development of the whole systems pathway. Discharge planning for non-elective admissions starts at the point attendance at A&E via the STARRs complex discharge team (including an A&E social worker), Rapid Response service and a soon to be introduced Frailty Pathway model– OPALs (October 2017) . Harrow CCG is reviewing its Rapid Response pathways to support admission avoidance and facilitate early discharge planning – November 2017 – PDR attached in appendices.

7.6.3. Implement Systems to Monitor Patient Flows

Not yet established	Plans in place	Established	Mature	Exemplary
No relationship between demand and capacity in care pathways	Analysis of demand underway to calculate capacity needed for each care pathway	Policy agreed and plan in place to match capacity to care pathway demand	Capacity usually matches demand along the care pathway	Capacity always matches demand along the whole care pathway
Capacity available not related to current demand	Analysis of demand variations underway to identify current variations	Analysis completed and practice change rolled out across trust and in community	Capacity usually matches demand 24/7 to match real variation	Capacity always matches demand 24/7 reflecting real variations
Bottlenecks occur regularly in the trust and in the community	Analysis of causes of bottlenecks underway and practice changes being designed	Analysis completed and practice changes being put in place and evaluated	Bottlenecks rarely occur and are quickly tackled when they do	There are no bottlenecks caused by process or supply failure
There is no ability to increase capacity when admissions increase – tipping point reached quickly	Analysis of admissions variation ongoing with capacity increase plans being developed	Staff understand the need to increase capacity when admissions increase	Capacity is usually automatically increased when admissions increase	Capacity is always automatically increased when admissions increase
Staff do not understand the relationship between poor patient flow and senior clinical decision making and support	Staff training in place to ensure understanding of the need to increase senior clinical capacity	Staff understand the need to increase senior clinical support when necessary	Senior clinical decision making support is usually available and increased when necessary	Senior clinical decision making support available and increased automatically when necessary to carry out assessment and reviews 24/7

There are daily and weekly operational calls with the trust and the local authority to meet demand and mitigate system risk. Patient flow is also being observed and managed at a Community and Primary Care level by the successful adoption and roll-out of EMIS Community. LNWHT have rolled out Red & Green AND safer – Patient Flow Bundle and work is on-going across other sites. LoS rapid improvement programme for acute and community is being implemented in preparation for Winter:ECIP assistance where necessary – see Winter Readiness Self-Assessment document -October 2017 – Easter 2018.

7.6.4. Implement multidisciplinary discharge teams

Not yet established	Plans in place	Established	Mature	Exemplary
Separate discharge planning processes in place	Discussion ongoing to create integrated health and ASC discharge teams	Joint NHS and ASC discharge team in place	Joint teams trust each other's assessments and discharge plans	Integrated teams using single assessment and discharge process
No daily multidisciplinary team meeting in place	Discussion to introduce MDTs on all wards with trust and community health and ASC	Daily MDT attended by ASC, voluntary sector and community health	Integrated teams cover all MDTs including community health provision to pull patients out	Integrated service supports MDTs using joint assessment and discharge processes
Continuing Health Care assessments carried out in hospital and taking "too" long	Discussion between CCG and trust to establish discharge to assess arrangements	Discharge to assess arrangements in place with care sector and community health providers	CHC and complex assessments done outside hospital in people's homes/extra care or reablement beds	Fully integrated discharge to assess arrangements in place for all complex discharges

On-going discussion between LNWHT, the local authority (hospital social work team) and the CCGs to utilise Homefirst/D2A pathway for CHC and complex assessments with the MDT virtual ward model supporting the discharge to assess pathway– Care Navigators are working with enhanced Practice Nurses within virtual ward to support GP Led Anticipatory Care (Care Planning) - This is in place but requires further roll out/refinement.

7.6.5. Implementing Home First Discharge to Assess (DTA)

Not yet established	Plans in place	Established	Mature	Exemplary
People are still assessed for care on an acute hospital ward	Nursing capacity in community being created to do complex assessments in the community	People usually return home with reablement support for assessment	People return home with reablement support from integrated team	All patients return home for assessment and reablement after being declared fit for discharge
People enter residential /nursing care too early in their care career	Systems analysing which people can go home instead of into care – plans for self funder advice	People usually only enter a care/nursing home when their needs cannot be met through care at home	Most people return home for assessment before making a decision about future care	People always return home whenever possible supported by integrated health and social care support
People wait in hospital to be assessed by care home staff	Work being done to identify homes less responsive to assess people quickly	Care homes assess people usually within 48 hours	Care homes usually assess people in hospital within 24 hours	Care homes accept previous residents trusting trust /ASC staff assessment and always carry out new assessments within 24 hours

8 week pilot began on 12/6/17, with local authority support as a key stakeholder. Evaluation is currently in progress and this will inform the next steps. Plan is in development with project group to support the achievement of A&E target which is the delivery of 25 discharges per week on the Home first pathway by end of September.

7.6.6. Seven-day services

Not yet established	Plans in place	Established	Mature	Exemplary
Discharge and social care teams assess and organise care during office hours five days a week	Plan to move to seven day working being drawn up	Health and social care teams working to new seven day working patterns	Health and social care teams providing seven day working	Seamless provision of care regardless of time of day or week
OOHs emergency teams provide non office hours and weekend support	New contracts and rotas for health and social care staff being drawn up and negotiated	New contracts agreed and in place	New staffing rotas and contracts in place across all disciplines	New staffing rotas and contracts in place and working seamlessly
Care services only assess and start new care Monday to Friday	Negotiations with care providers to assess and restart care at weekends	Staff ask and expect care providers to assess at weekends	Most care providers assess and restart care at weekends	All care providers assess and restart care 24/7
Diagnostics, pharmacy and patient transport only available Monday to Friday	Hospital departments have plans in place to open in the evenings and at weekends	Hospital departments open 24/7 whenever possible	Whole system commitment usually enabling care to restart within 24 hours, seven days a week	Whole system commitment enabling care always to restart within 24 hours, seven days a week

Services are available with plans in place to support hospital discharge at the weekend. Patient flow is happening 7 days per week. On-going work alongside partner organisations to mirror 7 days/week patient flow with provision of system-wide services (LAs, CCGs, Acute Trusts, Voluntary sectors).

7.6.7. Trusted Assessors

Not yet established	Plans in place	Established	Mature	Exemplary
Assessments done separately by health and social care	Plan for training of health and social care staff	Assessments done by different organisations accepted and resources committed	Discharge and social care teams assessing on behalf of health and social care	Integrated assessment teams committing joint pooled resources
Multiple assessments requested from different professionals	One assessment form/ system being discussed	One assessment format agreed between organisations /professions	Single assessment in place	Resources from pooled budget accessed by single assessment without separate organisational sign off
Care providers insist on assessing for the service or home	Care providers discussing joint approach of assessing on each other's behalf	Care providers share responsibility of assessment	Some care providers assess on each other's behalf and commit to care provision	Single assessment for care accepted and done by all care providers in system

The partners aim to have trusted integrated assessors who can complete assessments on behalf of the MDT, this will be trialled during the 2017/18 winter period subject to process approval by stakeholders.

7.6.8. Promoting choice and self-care for patients

Not yet established	Plans in place	Established	Mature	Exemplary
No advice or information available at admission	Draft pre-admission leaflet and information being prepared	Admission advice and information leaflets in place and being used	Patients and relatives aware that they need to decide about discharge quickly	Patients and relatives planning for discharge from point of admission
No choice protocol in place	Choice protocol being written or updated to reduce seven days	New choice protocol implemented and understood by staff	Choice protocol used proactively to challenge people	All staff understand choice and can discuss discharge proactively
No voluntary sector provision in place to support self-funders	Health and social care commissioners co-designing contracts with voluntary sectors	Voluntary sector provision in place in the trust proving advice and information	Voluntary sector provision integrated in discharge teams to support people home from hospital	Voluntary sector fully integrated as part of health and social care team both in the trust and the community

Policy was agreed by LNWHT A&E Delivery Board in November 2016 and the embedding of system-wide protocol underpinned by fair and transparent escalation process; informed choice on options available at a set time frame and strengthen “facilitated discharge”.

7.6.9. Enhancing health in care homes

Not yet established	Plans in place	Established	Mature	Exemplary
Care homes unsupported by local community and primary care	CCG and ASC commissioners working with care providers to identify need	Community and primary care support provided to care homes on request	Care homes manage the increased acuity in the care home	Care homes integrated into the whole health and social care community and primary care support
High numbers of referrals to A&E from care homes especially in evenings and at weekends	Specific high referring care homes identified and plans in place to address	Dedicated intensive support to high referring homes in place	No unnecessary admissions from care homes at weekends	No variation in the flow of people from care homes into hospital during the week
Evidence of poor health indicators in Care Quality Commission (CQC) inspections	Analysis of poor care identifies homes where extra support and training needed	Quality and safeguarding plans in place to support care homes	Community health and social care teams working proactively to improve quality in care homes	Care home CQC ratings reflect high quality care

Training sessions with GP practices allied to care homes through the new PACT project to facilitate the care planning process is in progress – bid submitted for new training resources Process Innovation Education – HEE NWLL on October 6th – outcome awaited. Further work is underway to integrate community MDT teams and GP practices with care homes to improve the hospital discharge process, and reduce avoidable unplanned admissions. Alongside this we have an enhanced ‘Falls’ programme focussing on falls prevention in care home.

8. National Metrics

8.1. Non-Elective Admissions

Since 2014/15 Harrow’s rates of non-elective admission have increased relative to comparable local CCGs (Brent; Ealing; Hillingdon; Hounslow).

In 2016/17 Harrow’s NEL annual non-elective admission rate was significantly higher than in Brent, Ealing, Hounslow or Hillingdon. The increase from 15/16 to 16/17 was 13%, lower only than Hounslow (15%) and significantly higher than the average of 5%.

The additional cost to Harrow of this higher rate relative to the other CCGs, ranges between £0.5m - £2m per year.

The 18/19 BCF plan is to limit the increase in NELs to 1.4%.

- Occupied bed days (OBDs) for Harrow’s registered population in 16/17 were 439.4 per 1,000 population; only Hillingdon among the five comparable local CCGs has a higher rate of OBDs than Harrow (447.8).

- Harrow's increase from 15/16 to 16/17 was 9.5%, compared to an average among the five CCGs of 4%, lower only than Hillingdon (12.9%).
- Harrow's OBDs among 0-16 year olds are significantly better, showing an increase of 3.5% from 15/16 to 16/17, the lowest among the group of CCGs, which average 6.2%.

Therefore there is an imperative to respond now to a growing issue to avoid non-elective, elective and accident and emergency admissions.

Harrow is therefore to accelerate deployment of the Integrated Urgent Care Pathway, aligned with the NWL plans and Better Care Fund (BCF) developments, to provide residents with an alternative to A&E. This means further relieving pressure by reducing delayed hospital transfer and offering reablement and rehabilitation following discharge from acute or community hospitals.

8.2. Admissions to Residential and Care Homes

Performance on this measure has been consistent over the past few years and ranked in the middle of London authorities. BCF schemes have not had a significant effect on this indicator. We are planning to maintain the absolute level of admissions for over 65s, which due to an increasing population is a 4% reduction in the indicator over the next two years. Admissions to residential care will continue to be a "last resort" alternative to support in the community, accepting that those with the greatest level of need will be most safely cared for in a registered setting, something which is actively monitored through our Adult Social Care Survey (ASCS) results.

The direction of travel in relation to the admissions to residential care is expected to reduce over the term of the BCF through a number of new initiatives designed to enable residents to remain in their own homes, and promote independence. These initiatives include investment in supported housing options, as well as increased discharges directly to a home setting.

8.3. Delayed Transfer of Care

Please refer to 6.5.1.

8.4. Effectiveness of Re-ablement

BCF schemes have not greatly impacted this indicator in the past, as performance has remained fairly constant, with a high volume of re-ablement provided with a below-average success rate. Data for 2016-17 showed a 24% increase in requests for social care support following hospital discharge, which means an already high volume of cases could not grow further without weakening the effectiveness achieved.

Our strategy over the next two years is likely to more effectively target re-ablement services (for all age groups and referral settings) for those who would be most likely to benefit from the service. Clients with very high levels of need will achieve more effective outcomes through direct referral to long term support teams, while those with much lower levels of need may not benefit sufficiently from the full home support package and require something less intensive. By building on data analysis which has

taken place over the past year, we are now in a position to drive improved performance on this metric through an evidence-based approach that is likely to result in a lower volume of re-ablement services being offered, but with much more effective outcomes. Targets have been set in order to ensure at least average performance in London for the denominator, with the numerator also achieving average level of effectiveness. The reduction in numerator may not be so severe if we can achieve the same level of performance for a greater number of clients.

9. Harrow's Two Year Expenditure Plan, including Disabled Facilities Grant

Please refer to Chapter 6.3 and Planning Template

10. Financial Risk Management and Programme Governance

10.1. Organisational Financial Risk

The national picture for the finances of the public sector continues to remain very challenging. Projections by London councils based on the government spending plans are for additional reductions of over 30% over the next two years.

For London Borough of Harrow financial risks please refer to Chapter 6.5.2.

For Harrow CCG financial risks please refer to the Financial Recovery Plan in the appendices.

10.2. Financial Risk in the 17/19 plan

The financial position of the both the CCG and the LA is challenging and our shared challenge is whether the Council and CCG strategies are able to absorb any further reductions in funding and all other challenges through increasingly efficient ways of working.

Harrow Council is one of the lowest funded councils in London. In 2015/16 Harrow's revenue spending power per head was £159 (or 17.3%) lower than the London average which ranked Harrow 105th out of 150 local authorities. Subsequent difficult financial settlements have not improved the funding position for the Authority. Reserves and contingencies are needed to protect the Council's good financial standing during a continuing period of economic uncertainty. General Fund reserves are around £10m which is only 6% of the Council's controllable budget. This ranks Harrow in the lowest quartile for reserves nationally. In February, Council approved the budget for 2017/18 and noted further savings of £8.043m in 2018/19 and a remaining budget gap of £8.998m for 2019/20. Budget growth of £4.629m for Adult social care (funded by the 3% precept) was agreed for 2017/18 to fund underlying pressures, however the increasing complexity and market capacity are likely to add further pressure during 2017/18 and subsequent years.

Given the financial challenges faced by the Council, the reduction in social care funding is not considered sufficient to enable the national condition to be met. The funding level for the protection of social care for 2018/19 detailed in the financial template does not represent agreed funding but reflects the starting point for the discussions. Negotiations are on – going and will be revisited as part of the planned mid term review.

The committed funds within the BCF are intended to protect, to maintain services and to build on current performance levels through continued joint working between the organisations and their partners. However the partners acknowledge the challenge of this in light of the challenging nature of the health and social care economy. Both organisations have signalled their on-going commitment to further developing their joint and integrated working arrangements including supporting the development of a Harrow Accountable Care Organisation – planned to be operational from April 2018.

This will include a systematic review of the existing out of hospital pathways to identify potential improvements in performance and to release much needed capacity across the whole system to support reinvestment in community services.

- The 2017/19 BCF indicates that it will be challenging to maintain service levels given the reducing financial envelope and increasing volume and complexity of service users presenting with social care needs. Alongside this we intend to proactively monitor a number of areas including: Joint monitoring of planned BCF performance outputs including trends and forecasted pressures.

- Joint monitoring between the local authority and CCG of hospital pathways, processes and systems effectiveness.

- Effective management of social care market suppliers to support capacity and performance e.g. capacity maintenance with providers of reablement.

- Joint monitoring of discharge pathways and alternatives to residential care.

- Joint monitoring of DFG to support levels of independence within people's own homes and supporting discharge from hospital.

- Monitoring of the impact of new initiatives e.g. D2A – Harrow Home First, OPAL's – new frailty model – subject to funding agreement.

There are significant financial challenges for London Borough of Harrow (LBH) in maintaining the level of social care services provided, particularly given the reduction in CCG BCF funding. This includes pressures relating to the demographic picture in Harrow as set out earlier, where the numbers of vulnerable citizens are growing whilst complexity is also increasing. Amidst the challenging financial environment it is essential that social care is protected so as to keep people safe and meet statutory obligations. In protecting social care we are also working innovatively with stakeholders, aiming to maximize the opportunity for co-production and empowering service users in the design of adult social care.

Any risk items for escalation will be taken to the HWBB Joint Executive meeting for local resolution before being taken to the HWBB in the event of no local decision being taken at the initial stage.

Risk sharing agreements and contingency plans for delivery of the Better Care Fund are outlined as follows:

Some key risks identified in the delivery plan are:

There is a risk that:	**Mitigating Actions**
The WSIC / ACS programme is then able to demonstrate that financial investment in integrated community based services can release; more outcomes, efficiencies and resources from acute services than are invested	• Wider basket of outcome measures to be tracked • Minimal direct QIPP savings attributable to WSIC Programme in 2017/18 • Consideration also to be given to tracking non cashable benefits
Partners unable to agree overall scope of Programme	• Programme built around existing projects, organizational priorities and analysis of healthcare priorities in Harrow • Significant national and international evidence to support priorities set within Programme
Delays in mobilizing resources required to deliver Programme result in outcomes not being achieved within timescale set	• All contracts and service agreements to be in place
GP Practices do not effectively engage in Programme	• New, simplified and integrated payment and reward mechanism to be developed • Shared IT system across providers – EMIS Community (live November 2016). • Better joint working with other partners anticipated following roll out of integrated community services model
Shifting of resources may destabilise existing providers, particularly in the acute sector	• The development of plans will include whole system and ACO discussions and further work on co-design of, and transition to future service models
The implementation of the Care Act will result in an increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans	• Ensure the use of the Care Act money is in line with allocation
Social care cannot be maintained within agreed funding levels, resulting in overspends	• iBCF and precept (if raised) will provide additional resources to reduce overspends • Established financial monitoring process in place within the Council

Figure 5 Risks identified in the delivery plan

10.3. Risk Management

Risk management is part of the remit of the Joint Executive HWB Board which reviews significant risks to meeting the BCF plan each month. Any issues will be dealt with at the meeting and where necessary

reported to the full HWB Board. Risk management is supported internally by dedicated risk management teams who also hold the remit for managing patient/social care user risk.

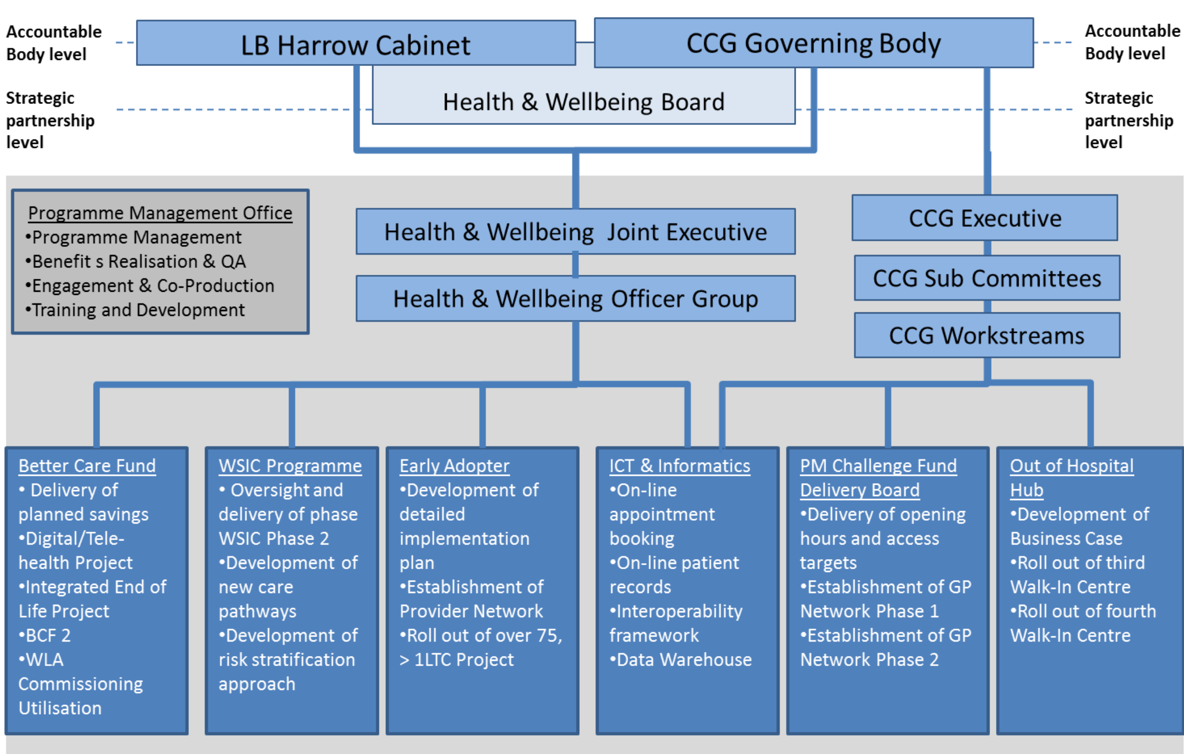
Risks related to the delivery of any aspect of the BCF, for example meeting predicted activity levels, are reviewed at relevant Local Authority, CCG forums, i.e. planned care work stream – CCG or LA Adult social care senior management team.

Financial models to support the development of the local and NWL STP are being jointly developed by CCG CFOs. These plans are expected to assist in contributing to and achieving financial balance for health budgets. These plans will be presented as they are developed for consideration and approval through the relevant governance processes (CCG & LA), to ensure that any proposals can be delivered within the existing MTFS and financial plans.

The CCG has developed a recovery plan that has been submitted to NHSE. For 2017/18 the CCG is planning for £21.2m in year deficit ((6.5)% of recurrent resource limit). To deliver this plan the CCG will need to deliver a £17.5m QIPP (savings) plan.

Any exception levels in activity plus actions for mitigation are escalated to the relevant LA/CCG Board or committee.

Harrow Health and Social Care Transformation Programme - Governance Overview



- The Health and Wellbeing Executive continues to operate as the Programme Board for all health and social care integration projects, including Better Care Fund projects;
- The CCG Executive oversees those projects and initiatives which are exclusively NHS-focused and decisions will be passed to the CCG Governing Body for sign off;
- The Health and Wellbeing Officer Group meets monthly to provide direction and coordination to the programme.

Strong governance arrangements are established to support the delivery of the wider health and social care transformation programme which incorporate at programme board level chief officers from the CCG, the Council and key providers.

There is also a direct reporting line to the Health and Wellbeing Board and on-going scrutiny and engagement.

The existing Section 75 Agreement to support the management and distribution of Better Care Fund resources, associated with the achievement of the non-elected admissions targets will be revised to take account of changes within the revised plan and the CCG investment to the fund.

This will be presented for consideration and agreement to the Harrow Health and Wellbeing Board following completion of the Better Care Fund quality assurance process.

10.4. BCF Risk Log

Harrow CCGs corporate Board Assurance Framework manages and flags risks and issues around share work with the Local Authority.

Please refer to appendices for examples BAF 1a, 1b, and 2.

10.5. Measuring the Impact of the Plan

Quarterly written submission to National partners are done via the BCF nationally provided template.

Monitoring of the plan is bi monthly via the HWBB. The HWBB Joint Executive Board oversees the plan on a monthly, and monitors the operability of the plan. However commissioned services within the plan, are monitored via the respected commissioner e.g the CCG , LA or the Mental Health Trusts routine contract monitoring meetings. The plan will also be subject to a mid-term review at which point the HWBB will consider the impact and benefits of the plan and potential for any further investment in services arising from any efficiencies - this will be reviewed within the context of financial recovery.

10.6. Capturing and Sharing Learning

Harrow actively takes part in local, STP and regional workshops, learning sessions, and networks, as it continuously endeavours to evolve and transform its health and care system in order to best meet its populations changing and very demanding priorities.

- *Commissioning for Outcomes* Workshops – Change Academy
- Health and Care Systems Working Group, London-wide (Monthly)
- Accountable Care Learning Lab (Quarterly)
- North West London Accountable Care – Collaborative development across 8 CCGs
- Networking with local ACS Development
- Kings Fund Learning Development Network

- NHSE Webinars on Accountable Care and *Leading Successful Change*
- CCG PMO

The aim is to continue this, and further involve borough partners and stakeholders to further strengthen the integration agenda.