**Harrow BCF narrative plan template**

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

***How have you gone about involving these stakeholders?***

The details of the 2021/22 BCF submission has been shared with and endorsed by the Harrow Health and Care Executive (HHaCE), the membership of which includes all local providers, the CCG and Local Authority, including the DPH, the voluntary sector and representatives of patients’ groups.

The details of the submission have been shared with the Chair of the HWB and agreed by the Chief Executive and Managing Director of the Harrow Integrated Care Partnership in advance of the presentation of the report to the Harrow Health and Wellbeing Board for approval on 23rd November

The metrics were presented to the Health and Care Executive HHaCE, the Harrow Integrated Partnership Board and the local authority on 25th October.

The comments and discussions were incorporated into the draft submission which was presented to the HHaCE on 12th November

***Executive Summary***

***Priorities for 2021-22***

The objectives of the Harrow Health and Care System (ICP) in 2021/22 are:

* Establish integrated, out of hospital teams at a neighbourhood level
* Take action to address health inequalities in Harrow
* Improve outcomes for the Harrow population and reduce variation

The following schemes, which are being implemented during 2021/22, directly support performance against the BCF Outcome Metrics.

**The Development of Harrow’s Integrated Care Programme (ICP)**

Harrow’s ICP has developed rapidly during 2021/22, accelerated by the need to respond to the challenge presented by the pandemic to the local health and care system.

The 100 Day Plan for the development of Harrow’s ICP is attached as Appendix A.

**Improving the Efficiency and Stability of Discharges from Acute Care**

The main focus, during 20/21, of service development to improve the discharge process has been the implementation, led by the acute trust (LNWUHT), the community provider (CLCH) and the local authority, of an Integrated Discharge Hub (IDH) at Northwick Park Hospital.

This, with the restructuring of ASC teams, has succeded in reducing lengths of stay (LoS) and improving the stable discharge of patients from Northwick Park Hospital (LNWUHT).

**Strengthening the Management of Long Term Conditions**

The Frailty Pathway is the first priority for delivery of the ICP’s objective of establishing integrated, out of hospital teams at a neighbourhood level.

The focus on frailty services will continue throughout 21/22, with further development of the MDT approach to care planning 15% complex / frail patients and the model for integrated falls pathway the key deliverables.

***Key changes since previous BCF plan***

**Service Development**

* The ASC SW teams were restructured to increase capacity to deliver reablement to support quicker hospital discharge and reviews with appropriate support in the community.
* ASC adopted a strengths based model embedded through a phased approach, initially with the early intervention and support team, followed by the Locality teams and is now being delivered by the Hospital SW Team and Promoting Independence Team (PIT). The Teams have undertaken 3 Conversations training to support successful transitions and improve the patient’s journey from the acute setting into the community through the delivery of intensive support with a focus on outcomes, and support plans that are person centred and co-designed with the patient and carer.
* The development and embedding of Integrated Discharge Hubs enabled seamless working – demonstrated by metrics. The focus to be on the patient experience and other elements within the system e.g. paperwork and GP calls

A key service development during 20/21 has been the implementation, led by the acute trust (LNWUHT), the community provider (CLCH) and the local authority, of an Integrated Discharge Hub (IDH) at Northwick Park Hospital.

The aim of the IDH is to reduce lengths of stay (LoS) and ensure the safe discharge of patients from Northwick Park Hospital (LNWUHT).

The hub ensures:

• 7 day service with daily huddles and discharge hub accountability has resulted in a higher number of complex/specialist patient discharges

• Close working with wards has improved patient flow / reduced pressure on hospitals

• Reduced number of Delayed Transfer of Care (DTOC)

• Daily huddles ensure earlier identification of risk – thus near miss rather than harm to patients

• Whole systems working approach – with accountabilities and responsibilities

• Collaborative working has resulted in “working in the best interests of patients” and

improved relationships

• Defined escalation processes e.g. Intermediate Care Escalation (ICE) to support discharge teams find a rehabilitation inc. neuro bed.

• More efficient out of borough placements/discharges, minimising bed blocking.

• Single site NWL brokerage via hub reducing delays and process hand overs

• Introduction of the Intermediate Care Escalation Hub (ICE) for support with complex discharges and access to all commissioned community beds across NWL

***Governance***

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

* The BCF Plan was agreed by HHaCE and recommended to the Health and Wellbeing Board for agreement.
* The BCF has been incorporated into the ICP plan.
* The progress of implementation will be managed by the ICP’s Frailty Workstream.
* Issues with delivery will be reported to the HH&CE for discussion and the agreement of remedial actions.
* The BCF Outcome Metrics will be included in quarterly reports to the HHaCE on the Harrow system’s performance against demand, capacity and outcomes metrics.
* Quarterly reports on the implementation of the Frailty Workstream’s action plan, including the BCF, will be presented to the HHaCE.
* Performance against BCF outcomes and the HHaCE’s discussions of implementation plans will be included in its reporting to the ICS through NWL’s assurance process.

***Overall approach to integration***

***Brief outline of approach to embedding integrated, person centred health, social care and housing services including***

* ***Joint priorities for 2021-22***
* ***Approaches to joint/collaborative commissioning***
* ***Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.***
* ***How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.***

There is an overarching Section 75 Agreement between the NHS and Council which allows collaborative commissioning arrangements.

The ICP 100 Day Plan (see Appendix A) was presented and agreed by the HWBB. ICP priorities and governance arrangements are in place to deliver outcomes for Children and Young People Health, Older Adults and Care Homes, Learning Disabilities, Mental Health, Population Health and Inequalities to support locality based service delivery.

The ICP has undertaken an extensive public engagement, ‘The Harrow Conversation’ which will contribute to informing tackling inequalities.

The participants in Harrow’s health and care system are co-producing a new model of reablement which will be jointly commissioned.

The Discharge to Assess brokerage process is led by the LA who purchase placement on behalf of the CCG.

The Frailty Pathway is the first priority for delivery of the ICP’s objective of establishing integrated, out of hospital teams at a neighbourhood level.

There are a range of ASC and health services to support safe and timely hospital discharge, which have been reviewed and remodelled to ensure that they contribute to an efficient discharge process. For example:

* The ASC SW teams were restructured to increase capacity to deliver reablement to support quicker hospital discharge and reviews with appropriate support in the community.
* ASC adopted a strengths based model embedded through a phased approach, initially with the early intervention and support team, followed by the Locality teams and is now being delivered by the Hospital SW Team and Promoting Independence Team (PIT). The Teams have undertaken 3 Conversations training to support successful transitions and improve the patient’s journey from the acute setting into the community through the delivery of intensive support with a focus on outcomes, and support plans that are person centred and co-designed with the patient and carer.
* The development and embedding of Integrated Discharge Hubs enabled seamless working – demonstrated by metrics. The focus to be on the patient experience and other elements within the system e.g. paperwork and GP calls (see Executive Summary above)
* An approach to joint funding the D2A to ensure a better experience for citizens and efficient administration is being developed.
* Step down beds in intermediate care have been commissioned. Reablement to commence where appropriate to support the step down and back into the citizen’s own home.
* ASC have worked with the main carer service provider, Harrow Carers, to develop their approach to support carers through the development of strengths-based approach to assessing carers.
* ASC have employed a dedicated Carers Lead to raise the profile of carers and challenge conventional practice including during the assessment process.
* An all age Carers Strategy and Needs Assessment are being developed. The development of which will be supported through Carers by Experience, including young carers. The Carers by Experience will be supported through the process by Harrow Carers and YHF.
* ASC have employed an Admiral Nurse who provides support to Carers of citizens with dementia and who will input into the Carers Strategy and Needs Assessment.
* PIT has seen an increase in the referrals and uptake of the service with performance success in admission avoidance.
* Harrow ICP is in the process of exploring the development of an integrated falls pathway with the community services provider CLCH, ASC and CCG.
* Integration Operational Leads’ Group meet monthly to identify areas for integration and, using quality improvement change cycles, improve services by integrating fragmented pathways.
* MDTs at PCN-level for our most frail population
* A new frailty model for Harrow is being developed for implementation in Q4
* Improvement of the diabetes pathway with targeted interventions using a population health approach, with support from Optum (end Q4)
* An integrated training and education model for the health and care workforce to enable integrated support of residents and patients in the community (end Q4)
* A Care Providers’ Support Group meets weekly to help resolve issues raised by care providers (care homes, dom care, day care) and to ensure robust partnership support and response to the needs of the providers and their residents/users.
* We are supporting practices and care homes to complete CMC records to ensure patients are supported to remain in their places of residence if they do not wish to go into hospital (end Q3)
* The Care Homes Response Team (CHRT) is offering training to care home staff in falls prevention, hydration and nutrition and other preventative measures to build resilience to crises and enable early detection of frailty. They also offer clinical support during crises.
* There are plans to align the reablement offers across the local system to ensure patients are better supported to access services and manage their rehabilitation in the community (Nov 22).

***Supporting Discharge (national condition four)***

***What is the approach in your area to improving outcomes for people being discharged from hospital?***

***How is BCF funded activity supporting safe, timely and effective discharge?***

The councils has pooled all placement/care related budgets into the BCF pool, including those used to fund support for the social work teams within hospital settings.

Commissioning arrangements were jointly agreed with the NHS for each of the pathways and are kept under review via the NW Discharge Group and locally between the borough and LA teams.

Separate D2A/COVID Section 75 agreements are in place for the COVID discharge funding, extended from 2020/21 to the current financial year.

A key focus of service development during 20/21 has been the implementation, led by the acute trust (LNWUHT), the community provider (CLCH) and the local authority, of an Integrated Discharge Hub (IDH) at Northwick Park Hospital.

The hub ensures:

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**Supported Discharge**

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

The Integrated Discharge Hub works with all partner organisation to place the patient in the best place aiming for home as the first option.

To embed this, the Partners have improved pathways and introduced new functions, including:

• Improved access to Care at Home

* Working closely with voluntary organisations to support discharge home
* Harrow LA make now place patients on Pathway 3 rather than CHC to ensure longterm care is the most appropriate and always aiming for home
* More access to clinicians to order equipment including single approvals for equipment under £150 to avoid delays

***Disabled Facilities Grant (DFG) and wider services***

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

ASC Officers have close working relationships with Housing colleagues and work together on a range of housing matters including, discharge from hospital, adaptations to support independence at home, development of new schemes, planning move-on from supported living for people recovering from Mental Health.

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

DFG adaptations are used to help to meet the changing needs of older people.

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

**Aids & Adaptations**

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

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

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

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

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

**Social Housing- Transfer applications**

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

**Move on from Supported Housing**

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

**New Supply of Affordable Housing**

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

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

**Housing for Older People**

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

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

Specialist housing for older people, other than residential and nursing care homes, enables an older person to live independently in their own living space with varying levels of support. In Harrow older people can access sheltered housing for older and extra care housing, provided either by the Council and by registered providers (housing associations).

***Equality and health inequalities.***

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

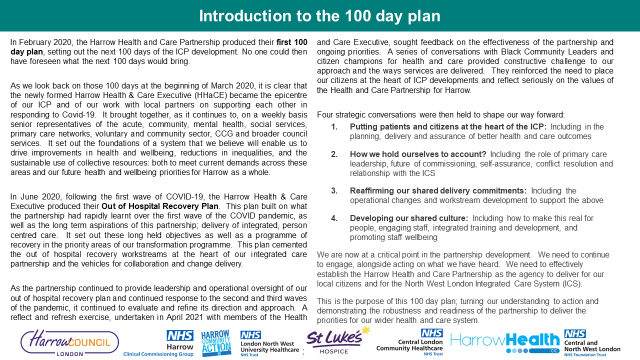
* ***Changes from previous BCF plan.***
* ***How these inequalities are being addressed through the BCF plan and services funded through this.***
* ***Inequality of outcomes related to the BCF national metrics.***

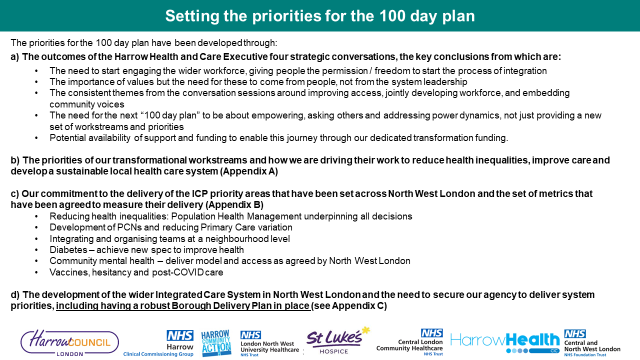
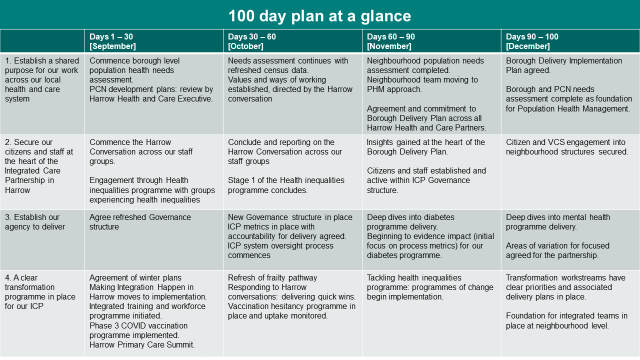
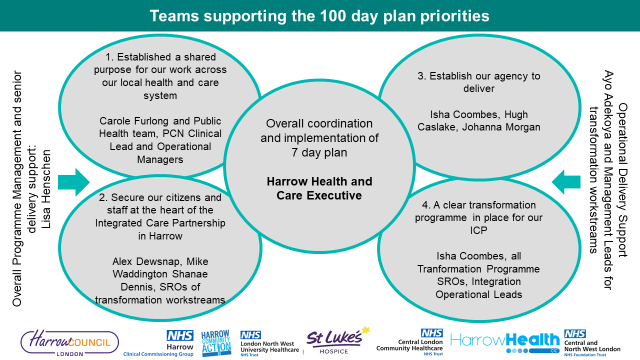
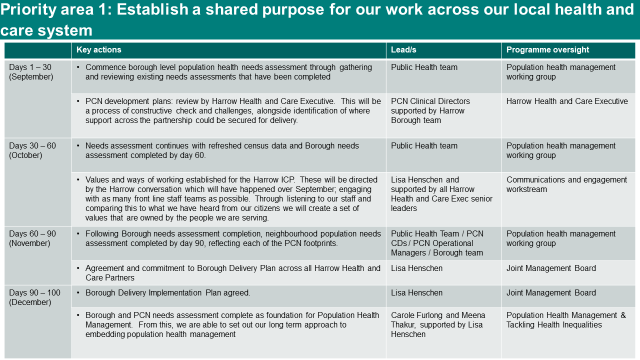
The core purpose of the Harrow ICP is: *tackling health inequalities and improved outcomes and experience through truly integrated care*

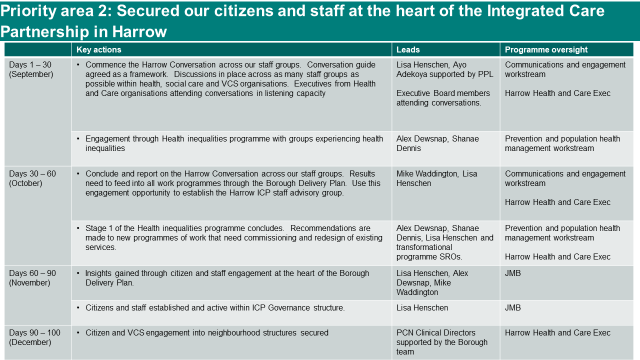
The ICP uses a Population Health Management approach to underpin decision making at all levels (practice, PCN, ICP) to reduce inequalities of access and health outcomes.

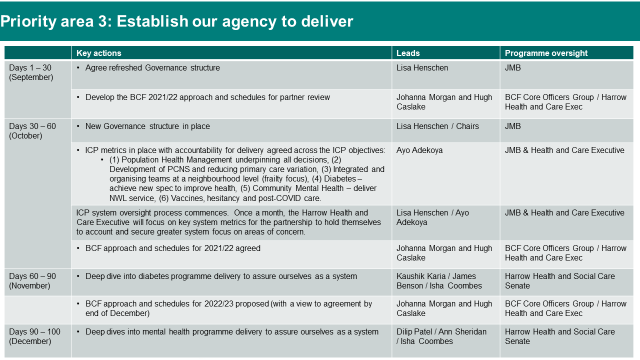
Embedding data analysis at all levels of decision making will provide demonstrable targeting of greatest need in all commissioning and operational decisions.

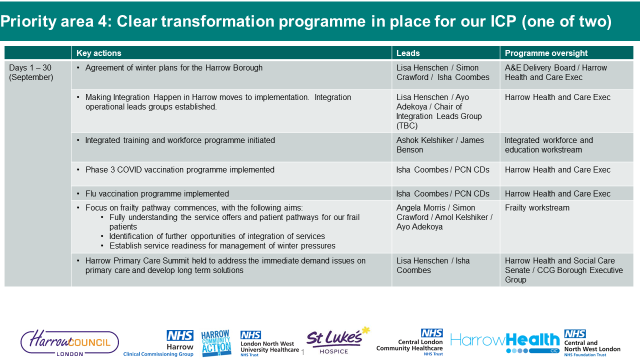
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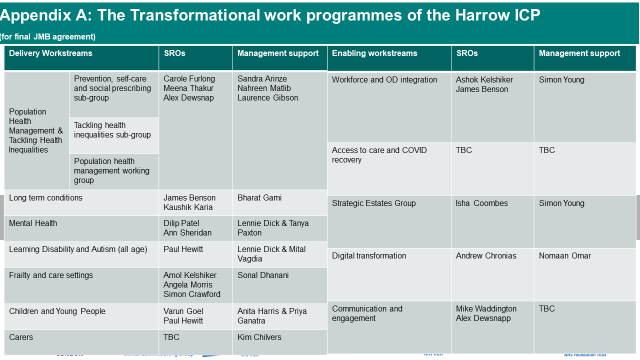
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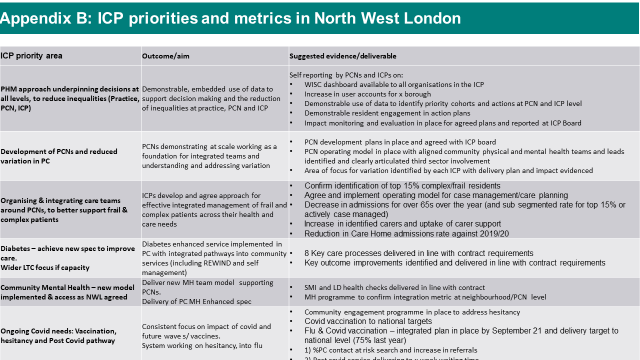
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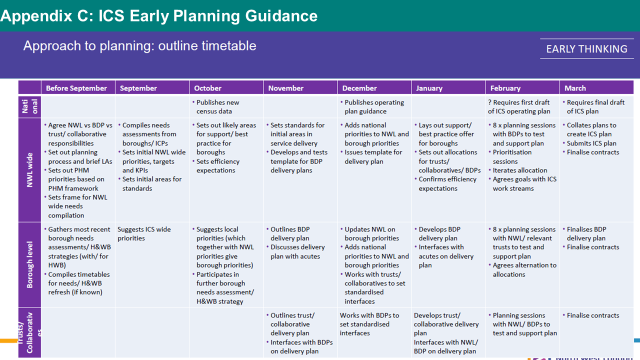
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