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

# Harrow ICP

# 2020/21 Better Care Fund Submission

## Harrow Health and Wellbeing Board Paper

# Elements of the Plan

The BCF Plan comprises 3 elements:

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

2) **BCF Outcome Metrics**: Proposed plans for 2021/22 outcome measures that will be submitted for sign-off by NHSE are included in the slides below.

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

# Submission Process

The submission has been endorsed by the Harrow Health and Care Executive.

A draft submission was made on 16/11/21, subject to the approval of the Health and Wellbeing Board.

NHSE will consider the submissions from each HWB area and are expected to provide feedback prior to a final decision on approval, which is expected in January 2022.

# 1. Agreement of the Financial Schedules

| | Total Opening Plan (20/21 Prices) | CCG Contribution to LA | LA Uplift | 21/22 Proposed CCG contribution to LA | NHS Funded | CCG Uplift (Non NHS) | Proposed 21/22 - Total NHS contribution | Proposed Plan 21/22 |
|---|---|---|---|---|---|---|---|---|
| Minimum CCG Contribution to Health | 9,835,183 | - | - | - | 9,835,183 | 521,265 | 10,356,448 | 10,356,448 |
| Minimum CCG Contribution to LA | 6,436,002 | 6,436,002 | 341,089 | 6,777,091 | - | - | - | 6,777,091 |
| **Total** | **16,271,185** | **6,436,002** | **341,089** | **6,777,091** | **9,835,183** | **521,265** | **10,356,448** | **17,133,538** |

- The CCG Contribution to the local authority has been agreed: £6,777,091.
- The Local Authority has confirmed the schedule of allocations for LA commissioned schemes funded through the CCG Contribution.
- The value of the NHS Provided Schemes element has been agreed: £10,356,448.
- The schedule of NHS Provided Schemes has been revised to align with current allocations.

# LA BCF Schemes

| Ref | Description of schemes funded with CCG contribution to LA | 21/22 Value (£) |
|---|---|---|
| Har17 | Quality assurance & safeguarding support to care providers to ensure quality provision to keep people safe within their homes | 947,300 |
| Har18 | Advocacy & DoLs support | 436,300 |
| Har19 | Information, advice and respite services | 1,537,812 |
| Har20 | Range of services to support safe and timely hospital discharge | 1,426,400 |
| Har21 | A range of services to maximise independent living | 1,333,400 |
| Har22 | Co-located LA staff supporting development of integrated services | 430,500 |
| Har23 | CCG Growth 20/21 | 324,290 |
| Har24 | CCG Growth 21/22 | 341,089 |
| | **Total** | **6,777,091** |

# NHS BCF Schemes

| Ref. | Scheme Type | Value (£) | Service |
|---|---|---|---|
| Har01 | High Impact Change Model for Managing Transfer of Care<br>4. Home First/Discharge to Assess - process support/core costs | 1,484,128 | CLCH Short Term Rehabilitation Team |
| Har02 | Integrated Care Planning and Navigation<br>2. Assessment Teams / Joint Assessment | 1,365,448 | CLCH Rapid Response |
| Har03 | Bed based intermediate Care Services / 4. Other | 1,619,364 | Intermediate Care Beds |
| Har04 | Prevention / Early Intervention / 4. Other | 419,364 | Rewind Programme |
| Har05 | Residential Placements / 8. Other | 399,364 | Harrow spot-purchase funding |
| Har06 | Residential Placements / 8. Other | 200,000 | Care Home Support Team |
| Har07 | Reablement in a persons own home / 1. Preventing Hospital Admissions | 224,000 | CLCH Falls Service |
| Har08 | Residential Placements / 7. Discharge from hospital | 1,247,583 | Harrow Complex Care |
| Har09 | Prevention / Early Intervention / 2. Risk Stratification | 2,417,753 | WSIC contract value |
| Har10 | Growth 20/21 | 458,179 | |
| Har11 | Growth 21/22 | 521,265 | |
| | | **10,356,448** | |

# 2. BCF Outcome Metrics

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

These plans, once agreed at the HWB, will be submitted to NHSE for approval.

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

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

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

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

| | | 21-22 Q3 Plan | 21-22 Q4 Plan |
|---|---|---|---|
| Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for:<br>i) 14 days or more<br>ii) 21 days or more<br>As a percentage of all inpatients<br><br>(SUS data - available on the Better Care Exchange) | Proportion of inpatients resident for 14 days or more | 10.3% | 11.1% |
| | Proportion of inpatients resident for 21 days or more | 4.9% | 5.9% |

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



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

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

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

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

# Setting and Delivering Outcome Metrics : Unplanned hospitalisation for ACS conditions

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

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

- This represents a sub-set of the NWL Operating Plan indicator for Non-Elective Admissions (NEL), which requires a return to 19/20 activity levels ie a return to pre-Covid levels without growth.
- The proposed plan is equal to the total number of ACS admissions in 19/20: 2,030.
- Modelling of activity in the year to date (M1-5) indicates that, if activity trends throughout the year mirrored those in 19/20, there would be 1,756 admissions of Harrow patients in 21/22.

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

| | |
|---|---|
| Ambition: | No more than 146 placements made or intended |
| Performance: | August 2021 65 |

Data source: Adult Social Care Outcomes Framework

Comments:

- On track performance would be 61
- Currently slightly outside target
- Harrow's national rank has improved since 2017/18 when 30th to ranked 15th in 2019/20
- Strengths based approach to person centred planning
- Exploring D2A model to increase reablement and maintain independence

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

| | |
|---|---|
| Ambition: | To retain current performance as a minimum |
| Performance: | Provisional 2020/21 96% |

Data source: Adult Social Care Outcomes Framework

Comments

- No target set but would seek to maintain current performance
- National performance ranking improved since 2017/18 130th to 15th in 2019/20
- Develop further the Reablement Offer through ICP – hospital discharge, community and existing citizens
- DFG – housing adaptations

# 3. Supporting Narrative System Working to Develop the BCF Plan

- 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 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 endorsed by the HHaCE on 12th November

# 3. Supporting Narrative System Working to Deliver the BCF

- 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.

# 3. Supporting Narrative System Working to Deliver the BCF

The following local developments will support the Harrow Health and Care System to deliver 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 succeeded 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.

# 3. Supporting Narrative: System Working to Deliver the BCF

**Integrated Working in Harrow**

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

The ICP 100 Day Plan 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.

# 3. Supporting Narrative System Working to Deliver the BCF

**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.

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).

# 3. Supporting Narrative System Working to Deliver the BCF

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.

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.  The hub has delivered:

- 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

# Next Steps

- Submission to NHSE – final assurance expected in January.

- Monthly reporting of performance against BCF Outcome Metrics to HH&CE for assurance of implementation of plans and the alignment of developing system priorities and service development.