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

Harrow Borough Based Partnership

The Borough Based Partnership Plan and 2022/23 delivery priorities

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Building the Borough Based Partnership Plan

What are the needs of the Harrow population, how do we understand them and respond to them?

- JSNA refresh – population health needs
- Analysis of themes from community engagement

What will we be able to achieve as a partnership that we cannot achieve as individual organisations?

- Mapping of partner organisation priorities
- Away day and 1:1 discussions

How are we currently performing as a system in relation to performance, outcomes, quality and finances?

- Analysis of system performance, outcomes and quality completed
- JMB to discuss impact of financial landscape on BBP delivery

What does the future integrated health and care system look like and what will the role of Borough Based Partnerships be within it?

- Live discussions between the ICS and BBPs
- ICS objectives for BBP captured and addressed in the Borough Plan

North West London Integrated Care System

Our mission

Working with children, families and communities in Harrow to support better care and healthier lives

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Delivery framework and partnership priorities

Our mission: Working with children, families, and communities in Harrow to support better care and healthier lives			
Our objectives	1. Reduce health inequalities through embedding a robust population health management approach at a borough and neighbourhood level	2. Developing truly integrated out of hospital teams at a neighbourhood level to improve our citizens experience of care and reduce unplanned acute care and intensive social care packages	3. Deliver transformational change in care pathways to deliver high quality integrated care, improving outcomes and addressing variation
Core work programme	• Set our Harrow Population Health Management methodology and implement at borough and neighbourhood level • Aligning data and intelligence across partnership organisations • Delivery of core 20 plus 5 programme	• Digital integration • Estates development as an enabler for integration • Integrating our training and education offer across the partnership • Strengthening our support to carers • Supporting the development of Harrow's Primary Care Networks	• Frailty through implementation of the integrated frailty model for Harrow • Long term conditions care, with specific focus on diabetes care and hypertension • Mental Health and learning disability services transformation • End of life care: strengthening integration and ensuring a choice of where to die for Harrow citizens
Delivery priorities for 2022/23	• Establish a community capacity building and leadership programme for Harrow to support community groups access to help them address issues which are important to them.	• Workforce development programme: - In the long term by promoting, as a partnership, Harrow as a place to live and work - In the short to medium term, better engagement and problem solving with our front-line teams to support retention and best use of our resources	• Deliver transformational change for our children and young people, through: - A "think family" approach across all workstreams - Strengthening the integration between health, social care and schools - Integrated physical and mental health services, across primary and secondary care, aligned at a neighbourhood level

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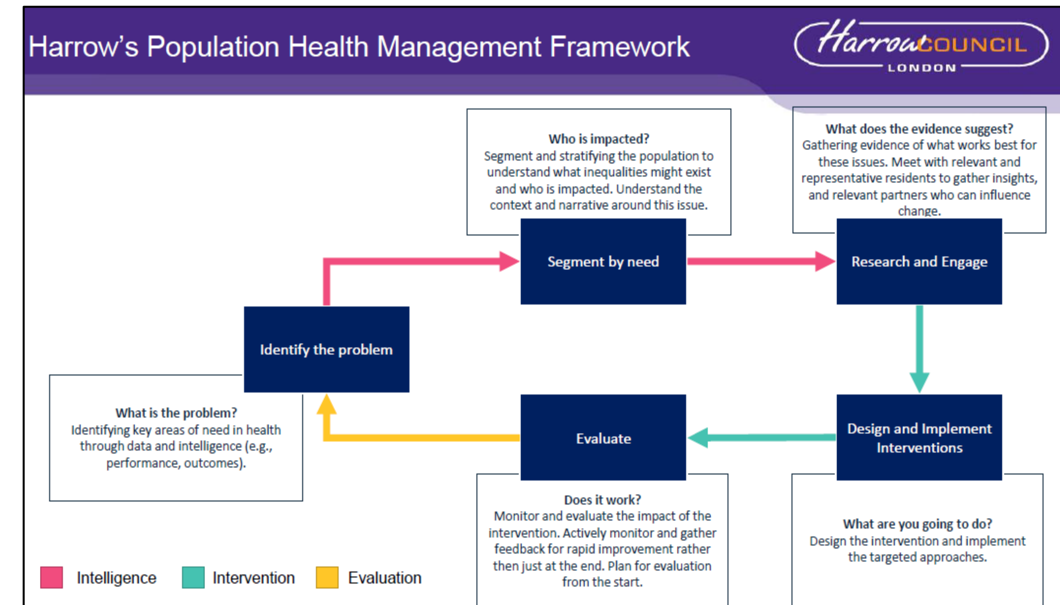
Objective 1: Reducing Health Inequalities

The partnership has agreed three key areas of action, which are detailed in our delivery plan to reduce health inequalities in Harrow:



- To work more closely with communities in Harrow through a community champions programme; training community based leaders in Harrow to lead discussions with Harrow citizens on issues that matter to them, and supporting the delivery of preventative initiatives that support people to stay healthy and well.
- To work across the partnership to better connect data and analytical capabilities that will allow us to link and combine data to support an effective population health management approach.
- Delivery of the *Core 20 plus 5* programme. *Core 20 plus 5* programme is a national NHS England programme of work, designed to support Integrated Care Systems to address health inequalities. Much of the delivery of this programme of work will be through the Borough Based Partnerships in North West London. The programme focuses on 5 key areas for addressing health inequalities:

Core 20 Plus 5 focus areas:

- **Maternity**
- **Severe mental illness (SMI)**
- **Chronic respiratory disease**
- **Early cancer diagnosis**
- **Hypertension case-finding**:

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Objective 1: Reducing Health Inequalities

Over the coming year we will:

- Set up community conversations on a regular basis in all NW London boroughs
- Develop a targeted, data-driven and comprehensive outreach programme in each borough, working across the NHS and local councils and in partnership with the voluntary sector and Healthwatch
- Work with primary care networks to improve their approach to public and community involvement (with NHSE funding)
- Work with community groups and those with reach into local communities to broaden our understanding of our population
- Produce monthly insight reports highlighting feedback from community conversations

Objective 2: Developing truly integrated out of hospital teams

Through engaging with our front-line teams and citizens using our services, we have set out how we would like our services described in the future, for every person accessing our services.

To achieve this, we have set out action in five areas for the partnership:

- Digital integration
- Estates development
- Training and education
- Strengthening our support to carers
- Supporting the development of Harrow's Primary Care Networks

These areas will be delivered alongside a central delivery priority of the partnership in 2022/23 to take action in the short, medium and long term to support the retention of our existing workforce through improving their satisfaction with their roles, and to forge partnerships with higher education institutions and employment assistance bodies in promoting careers in health and care within Harrow and championing it as a borough that is a great place to live and to work.

The professionals with me talked to each other. I could see that they worked as a team.

I always knew who was the main person in charge of my care.

When I used a new service, my care plan was known in advance and respected.

The person in charge of my care helped me to get other services and help, to pull everything together.

I was involved in discussions and decisions about my care and treatment as I wanted to be.

My healthcare team understood, valued and responded to my culture, values and beliefs.

It feels like my GP Practice is connected with the local community

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Objective 3: Transformation change in care pathways

Specific priorities for our transformation work will relate to children and young people:

- Focusing the efforts of partner organisations in the first 1,000 days of a child's life, from conception to age 2.
- As a partnership, will need to address challenges that families in Harrow are experiencing through closer working with families in Harrow, connections with voluntary and community sector groups supporting those families, alongside high-quality maternity, health visiting services and social care services.
- Strengthening our support for children with Special Educational Needs, complex learning and physical disabilities. In Harrow, the number of children with special needs is increasing, driven by better diagnosis, parental engagement and awareness. Even non-complex cases can have a significant impact on the wellbeing of individuals and families and is therefore a central priority for our partnership. Work will focus on early support and more effective transitions, building on the Harrow Risk Register.
- Continuing to improve our work as a partnership to safeguard our children and young people.
- Exploring how the children's social care services eg MASH, Edge of Care and other services eg Mental Health School Teams could develop a multi disciplinary approach to supporting children and young people locally and with schools , Children's Health Hubs, Community Services through the creation of family hubs.
- Building on the strong relationships with the Young Harrow Foundation to extend and sustain programmes supporting vulnerable children and young people through the HAF Programme, and other initiatives for example support during A&E and discharge.

Objective 3: Transformation change in care pathways

Alongside this central priority focus on children, young people and communities, we will deliver transformation across our other key pathways in the following areas:

Frailty
Implementing a new integrated frailty model providing enhanced proactive and reactive care

Long term conditions care, with specific focus on diabetes care and hypertension
Improving management of these conditions in a community setting and an increased focus on prevention

Mental Health and learning disability services transformation
Focusing on prevention, living with mental illness and crisis management.

End of life care
Strengthening integration and ensuring a choice of where to die for Harrow citizens

Outcomes measures for the partnership

The outcomes delivered through this plan, are considered within the context of the Health and Wellbeing Strategy and the longer-term outcomes that it will deliver.

To support this contextual understanding, we are in the process of developed a logic model detailing the broad outcome and delivery framework for the Borough Based Partnership. Of the outcomes identified, we have identified those that are most impactful for the priorities of the partnership, and those which the partnership can monitor their progress towards on at least an annual basis.

Partnership indicators (pending endorsement)

Objective	Partnership measures	Detail
Reduce health inequalities through embedding a robust population health management approach at a borough and neighbourhood level	1. Reduction in number of children 5 and under with tooth decay.	National measure • The incidence of dental decay among under fives in Harrow (42.4%) is the worst in London (Average 27%) and 57% higher than the national average (23.4%). • Target: To improve the Harrow position by 5%.
	2. Improvements in patient reported access to General Practice Services	National patient survey (national data) • The percentage of survey respondents that rate their experience of access to primary care as ‘good’/‘poor’ are currently 68%/14%; NWL is 71%/12% and London 76%/7%. • • Target: To improve ‘good’ and ‘poor’ ratings to the NWL average across age, ethnic and socio-economic groups.
Developing truly integrated out of hospital teams at a neighbourhood level to improve our citizens experience of care and reduce unplanned acute care and intensive social care packages	3. Increase in number of citizens reporting positive experience of care.	Annual survey initiated by the BBP. • Target: Establish baseline in 22/23.
	4. Increase in number of staff reporting satisfaction in their work	• Vacancy rates across clinical and professional roles in partner organisations. Targets TBC. • Annual survey initiated by the BBP. • Target: Establish baseline in 22/23.
Deliver transformational change in care pathways to deliver high quality integrated care, improving outcomes and addressing variation	5. Reduction in Non-Elective Admissions for Ambulatory Care Sensitive Conditions (people with long term conditions)	Definition: Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission. Even if the ACSC episode itself is managed well, an emergency admission for an ACSC is often a sign of the poor overall quality of primary and community care. Long term conditions: Asthma, Diabetes, Epilepsy, Hypertensive Disease, Dementia & Heart Failure Reporting Measures: Rate of emergency admissions for ACSCs • Harrow has a rate of admission by weighted population of 11.47 against a NWL average of 9.89. • PCNs range between 10.3 and 12.81. • Target: To reduce ACSC admissions in all PCNs to the NWL average while reducing variation between ethnic groups.