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

# Winter Preparedness 2022/23

Harrow Borough-Based Partnership

# Overview and ambition

It is the ambition of the Borough Based Partnership in Harrow that our winter plan is a plan for the Place for Harrow and its citizens and carers. We are seeking to achieve, through a collaborative planning process led by our Health and Care Executive, that we move away from a focus on individual organisational capacity planning towards a Place Plan. This is especially important as we approach the Winter of 22/23 which will be impacted by the Global cost of living crisis and pressures that are being experienced throughout the year in the health and care system.

The Place plan for Harrow will focus on:

- Taking preventative action to mitigate where possible, the impact of illness of individuals, families and the health and care system, through our flu and COVID immunisation delivery, particularly amongst groups experiencing the highest levels of health inequalities;
- Continuing to strengthen our support in primary and community teams to prevent admissions to hospital and ensure a robust discharge pathway out of hospital to maintain effective care for people who need the support of hospital services;
- Harnessing our local assets in Harrow; our building and community spaces to provide a warm and safe places within our communities, where people can come together for company, extending this where possible to a range of community activities to support health and wellbeing of our citizens;
- Engaging communication plans with local citizens to support them to navigate the local health and care offer, so care can be provided in the right place;
- Addressing the wider determinants of health that will impact our local population over the winter, through a robust information, advice and support offer to support income maximisation, support home adaptations to create energy efficiencies and action to reduce the risks of homelessness. We will undertake a targeted engagement programme with our front line teams across social care, children's services, health, housing and the voluntary and community sector to support awareness raising of these services so effective signposting is in place.
- Put in place a range of additional winter schemes from any national funding sources that are made available to support our capacity and response in these areas.

# Supporting information



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# Preventative action: immunisations

**Phase 5 Covid Vaccination – Commenced from 5th September**

- All 5 PCNs and 11 pharmacies have signed-up to deliver phase 5
- JCVI decided that cohorts 1-9 should benefit from the campaign
- PCNs are required to vaccinate their housebound patients in cohorts 1-9

| Cohort | Cohort descption | Eligible Population |
|---|---|---|
| 1 | Care Home Residents & Residential Care Workers | 688 |
| 2 | 80+ & Health and Social Care workers | 25,453 |
| 3 | 75-79 | 7,775 |
| 4 | 70-74 & CEV | 14,306 |
| 5 | 65-69 | 10,584 |
| 6 | At Risk | 37,312 |
| 7 | 60-64 | 6,913 |
| 8 | 55-59 | 8,905 |
| 9 | 50-54 | 10,624 |
| **Total** | | **122,560** |

**Flu Vaccination – Commenced from 5th September**

General practices and school providers must **demonstrate that all** eligible patients are offered a free vaccine.

| Eligible group | Where to have the flu vaccine |
|---|---|
| All children and adults from 6 months of age upwards in a clinical risk group | GP practice (all ages) or participating community pharmacy (age 18 years and above) |
| All children aged 2 or 3 years on 31 August 2022 | GP practice |
| All children from reception age (aged 4 -5) to school year 6 (aged 10-11) - regardless of educational setting | School and/or community clinics delivered by the School-age Immunisation Service. |
| Pregnant women | GP practice, participating community pharmacy, or antenatal appointment |
| Frontline social care workers (that do not have access to employer led occupational health vaccinations) | Workplace, GP practice or participating community pharmacy |
| Those aged 65 years and over | GP practice, participating community pharmacy |
| Those in long-stay residential care homes | Care home |
| Adults aged 50-64 years old not in a clinical risk group and some children of secondary school age not in a clinical risk group, to be introduced later in the season. | GP practice, participating community pharmacy (50-64 years), school or community clinic upon invite from school age immunisation service (secondary school age children) |

# Out of hospital response

The Harrow Partnership has made significant progress towards its goal of developing truly integrated out of hospital teams at a neighbourhood level to improve our citizens' experience of care, reduce unplanned acute care and intensive social care packages and support a robust discharge pathway.

This has included investing in a service, provided by Harrow Together, to support patients discharged from hospital that is now supporting 100 patients every month in their own homes.

Integrated services to provide care and treatment to diabetic patients are currently being implemented and a programme of developing a new frailty pathway is underway.

In addition there are a number of programmes underway at NWL level that will give us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could impact on admissions over the next six months is as follows:

- The development of our virtual wards programme
- Continued roll out of post covid syndrome clinics
- Go live of respiratory hub-lets
- Continued work roll out of virtual monitoring
- 111/999 Push pilots with urgent community response continue

# Communications campaign

The purpose of this year's winter communication campaign is to support local residents with decisions about their health and the services they use, by providing information and redirecting people at the point of need. The plan will build on success of the 2021 campaign and use data from the Whole Systems Integrated Care Dashboard to target and support the right areas and communities. This plan brings together the main objectives for winter from four main work streams - Urgent and emergency care; Vaccination (flu/*Covid booster); Children and young people; Primary care.

The three focusses on the campaign will be:

**1. Vaccinations** (flu and Covid boosters)

**2. Where to go** (GP, 111, Pharmacy, UTC, A&E)

**3. Self-care**
(General winter messages – stay warm, active and connected)

**System issues we will address:**

- Attendance at A&E and UTC – provide relevant information at the point of need to help redirect patients with low acuity and primary care needs
- Increase usage of 111 online
- Provide support information for parents
- Build confidence in GP front of house – publicise patient journey (including phone calls and online consultation ) and support unregistered patients
- Increase uptake of flu vaccination
- Support winter Covid-19 vaccination programme

Whilst there will be a NW London wide campaign, we will work in partnership and resources will be regularly available for boroughs to localise or create their own.  It can look different but we should all be focussing on the same messages at the same time to maximise impact.

# Addressing the wider determinants of health

- Harrow Council, through the **Harrow Homelessness Reduction Board Operational Subgroup**, have collated a signposting resource, bringing together the range of support services available to Harrow citizens in the areas detailed below. This is being developed as a public facing document now, jointly through the NHS and Local Authority.

- Housing advice services
- Information and advice services (regional, local and specialist)
- Financial hardship
- Food help
- Support during pregnancy and for families with children

- Low cost furniture and electricals
- Support with utility bills
- Fuel poverty support
- Mental health support
- Free and discounted local activities

We will actively share this resources amongst front line teams, as well as directly to our communities, so that effective signposting is in place to support our citizens in accessing this range of services.

- Focusing specifically on fuel poverty and income maximisation, we are holding in September a series of workshops with the Seasonal Health Intervention Network (SHINE) which is a fuel poverty referral network and free energy advice service for Harrow residents. SHINE London offers a dedicated helpline and affordable warmth interventions to ensure households get the help they need to reduce utility bills, tackle energy debt, and ultimately stay well and war .
- These workshops will be followed up with a webinar, reaching a wider pool of front-line professionals across health, social care, housing, children's services and our voluntary and community sector partners, along with a Q&A on how front-line teams can best support the Harrow community over the winter.

# Additional winter schemes

There is, as yet, no confirmation of what additional Winter Pressures funding of acute, community based and primary care services will be available in 22/23.

However, a decision on the first tranche of additional funding, which is likely to focus on bed capacity, is expected in September.

The Borough Partnership has generated a long list of potential schemes that were submitted to NWLICB in July (see slide below).

Although there has been no confirmation that there will be further tranches of funding, in previous years additional system funding was made available by NHSE at the beginning of winter, for immediate implementation.

The originators of each of the proposals will complete a questionnaire confirming which of the criteria (see slide below) are met by each scheme and the risks to rapid implementation.

The results will be discussed by the Harrow Health and Care Executive - a prioritised list will be agreed by the Joint Management Board.

# Additional winter schemes : Long List

| Harrow Partnership Winter System Pressure Proposals | | | |
|---|---|---|---|
| **Acute Care** | **Community Care** | **Mental Health Care** | **Primary Care** |
| **Additional Beds**<br>27 Additional beds across Northwick Park and Central Middlesex Hospitals | **Supporting Discharged Patients in the community**<br>Expansion of discharge support to 7 days medically fit but vulnerable discharged patients to prevent deterioration in the community, including home cleaning; support in paying bills<br><br>Increase Social Work capacity in Community Review Process<br><br>Review funding of placements for people discharged from hospital | **Avoid Admissions**<br>Review of homelessness / MH pathway to provide alternative to A&E / hospital admission<br><br>Community Crisis Service / Beds for Adults and Older Adults<br><br>Community crisi beds for people with moderte to severe learning disabilities. | **Increase Access to Primary Care**<br>Increased appointment capacity in general practice, GPs and allied healthcare professionals beyond our plan for the Enhanced Access DES<br>Increase use of online consultations and improve digital literacy amongst patients |
| **Patient Flow**<br>Increase assessment, diagnosis, decision making, care and discharge - improving throughput on acute medicine wards NPH | **Prevention of Illness**<br>Strengthen vaccination resource for housebound people<br>Raise awareness of impact on individuals' health and wellbeing of fuel poverty and support income maximisation and fuel efficiency | **Avoid A&E Attendances**<br>Improve speed of access to drug and alcohol provision for people in crisis. | Additional first contact physiotherapist appointments<br>Data analysis of patients attending UCC/A&E to formulate plan to reduce avoidable UCC?A&E attendances and work with frequent flyers<br>MDT working and proactive case management of patients discharged from hospital |
| **Discharge**<br>**Expansion of STARRS team and consulatants to support discharge from Northwick Park Hospital**<br>A&E and to avoid admissions<br>VSC staff to support carers. | **Support to People on Waiting Lists**<br>**Voluntary Sector to provide support to long waiters for elective and community care.**<br>Additional Social Work resource in AED and community to support prevention of admissions and to facilitate discharge. | | Patient education and empowerment on self-management of minor illness<br><br>Tackling vaccine hesitancy and increasing vaccination uptake, including flu/Covid vaccines/childhood imms. to reduce infection rates and aim to reduce morbidity and GP/UCC/A&E attendance |
| **A&E Support**<br>Strengthen management and decision making to improve use of capacity: additional doctors and nursing staff<br><br>UTC Redirection: Continuation of existing service. | **Homelessness Crisis Support**<br>**Additional community accommodation to prevent homelessness precipitating admission or preventing timely discharge.**<br><br>**SW/ VSC SWISH workers to support people in crisis due to cost of living.**<br><br>**Workforce Bank** | | |