# Harrow Borough Partnership Winter Plan

Winter 2023/24

Draft 3 - FINAL

Harrow Borough Based Partnership

Supporting better care and healthier lives

# The Harrow Borough Based Partnership

**Harrow Borough Based Partnership brings together our NHS organisations, Harrow Council, our GPs, and local Voluntary & Community Sector.**

**We strive to support each other and our communities as equal partners focussing on better health and wellbeing for all.**

| | | |
|---|---|---|
| NHS North West London Integrated Care System | Harrow Council | Harrow's Primary Care Networks |
| NHS Central London Community Healthcare NHS Trust | NHS Central and North West London NHS Foundation Trust | NHS London North West University Healthcare |
| Harrow Together | Harrow Health Community Interest Company | St Luke's Hospice |

Harrow Borough Based Partnership
Supporting better care and healthier lives

# Introduction

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 winter plan for 23/24 will build on our system learning and evaluation of the Partnership's winter response in 22/23.

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;
- 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;
- Communication with local citizens to support them to navigate the local health and care offer, so care can be provided by the right service and/or individual 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.
- Continuing to strengthen our support and capacity 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;
- Deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place for in and out of hospital care;
- Securing a strong discharge pathway to reduce the length of time our citizens spend in hospital once medically fit to leave, delivering the best outcomes for our citizens and the wider functioning of our urgent and emergency care services.

# Overview of the Harrow Winter Plan

## Prevention and community winter wellness

- Health and wellbeing support through the Warm Hub programme
- Robust flu and COVID vaccination programme across all cohorts
- Addressing the wider determinants of health and admission risks
- Communication and engagement campaign with local communities, to include information about Talking Therapies and mental health perinatal services

## Community based admission avoidance

- Securing primary care access and capacity
- Enhanced Frailty Service
- Rapid response and care home support
- Mental health – crisis alternative- Coves, stepdown beds, Home Treatment Team

## In hospital care

- Discharge Hub and Discharge Support Service
- SDEC
- Acute Hospital Flow and increased bed capacity
- Community rehab bedded care flow
- Mental Health- in-reach to medical wards for people with alcohol problems from Substance Misuse provider

## Discharge pathways

- Enhanced on-site social care
- Increased provision of step down beds
- Integrated intermediate care service, including reablement
- Increased provision for same day equipment
- Increased home care provision, including weekends
- Mental Health- need access to hospital discharge team, to improve flow

# Winter demand and capacity modelling (1/3)

To will be reviewed fortnightly by the Harrow Health and Care Executive.

| Line No | System Indicators | Status | Source | Cohort | Frequency | Current Week | Previous Week | Current Trend | Previous Trend |
|---|---|---|---|---|---|---|---|---|---|
| **Success of Prevention Measures** | | | | | | | | | |
| 1 | Autumn Campaign - Covid vaccination uptake by cohort | | Foundry | Harrow | Weekly | 0.05% | 0.05% | | |
| 2 | Autumn Campaign - Flu vaccination uptake by cohort (including years 7 and 11) | | WSIC/Immform | Harrow | Weekly | 5.90% | | | |
| 3 | Paediatric Asthma Reviews within 48 hrs of AED attendance | | Public Health | Harrow | Monthly | | | | |
| 4 | Paediatric Asthma Reviews within 48 hrs of ED Admissions | | Public Health | Harrow | Monthly | | | | |
| 5 | Winter Wellness MECC sessions uptake | | VAH? | Harrow | Monthly | | | | |
| **Demand pressure** | | | | | | | | | |
| 6 | AED Attends | | NWL BI | NPH | Weekly | 2,062 | 1,776 | | |
| 7 | AED Attends Paeds - Harrow | | NWL BI | NPH | Weekly | 160 | 160 | | |
| 8 | UTC Attends | | NWL BI | NPH | Weekly | 1,359 | 1,359 | | |
| 9 | UTC Attends Paeds - Harrow | | NWL BI | NPH | Weekly | 161 | 161 | | |
| 10 | Community/District Nursing - Number of visits completed (in hours) | | CLCH | Harrow | Weekly | 1,616 | 1,577 | | |
| 11 | Community/District Nursing - Number of rostered staff (in hours) | | CLCH | Harrow | Weekly | 1,455 | 1,471 | | |
| 12 | LA Demand Pressure | | LA | Harrow | Weekly | | | | |
| 13 | MH Liaison AED Referrals | | CNWL | Harrow | Weekly | 57 | 30 | | |
| 14 | MH Liaison AED Referrals - 1 hour response | | CNWL | Harrow | Weekly | 66.7% | 72.7% | | |
| 15 | MH Liaison Ward referrals | | CNWL | Harrow | Weekly | 20 | 73 | | |
| 16 | MH Liaison Ward referrals - 24 hour response | | CNWL | Harrow | Weekly | 83.3% | 94.1% | | |
| 17 | Rapid Response - Number of visits completed (in hours) | | CLCH | Harrow | Weekly | 272 | 332 | | |
| 18 | Rapid Response - Number of rostered staff (in hours) | | CLCH | Harrow | Weekly | 345 | 368 | | |
| 19 | Number of referrals to drug and alcohol service | | CNWL | Harrow | Monthly | | | | |
| 20 | Number of urgent referrals to drug and alcohol service | | CNWL | Harrow | Monthly | | | | |
| 21 | Number of referrals to Harrow Housing pathway for homeless patients with mental health issues | | LA Housing | Harrow | Monthly | | | | |
| 22 | Number of urgent referrals to Harrow Housing pathway for homeless patients with mental health issues | | LA Housing | Harrow | Monthly | | | | |
| 23 | People contacting LA about Damp / Mould | | LA Housing | Harrow | Monthly | | | | |
| 24 | Primary Care Patches Use / Availability | | Primary Care | Harrow | Weekly | | | | |

**Need confirmation that data is collected and reported.**

**Data is reported. Process not yet in place for regular submission to PMO.**

**Data received regularly by PMO**

Harrow Borough Based Partnership

Supporting better care and healthier lives

# Winter demand and capacity modelling (2/3)

To will be reviewed fortnightly by the Harrow Health and Care Executive.

| Line No | System Indicators | Status | Source | Cohort | Frequency | Current Week | Previous Week | Current Trend | Previous Trend |
|---|---|---|---|---|---|---|---|---|---|
| **Pathway Efficiency** | | | | | | | | | |
| 25 | Community Bed DTOCs | | Local Care | Harrow | Weekly | | | | |
| 26 | DTOCs by pathway @ NPH as % discharges vs NWL Boroughs | | Optica / NWL BI | Harrow | Weekly | | | | |
| 27 | NPH DTOCs: Awaiting equipment | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 28 | NPH DTOCs: Awaiting long term placement | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 29 | NPH DTOCs: Awaiting rehab bed | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 30 | NPH DTOCs: Homeless | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 31 | NPH DTOCs: Patient / family choice delays. | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 32 | NPH DTOCs: POC start / restart | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 33 | Number of pts waiting more than 48 hours on a P1 pathway escalated | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 34 | Number of pts waiting more than 5 days on a P1 pathways escalated | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 35 | Number of pts waiting more than 5 days on a P3 pathway escalated | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 36 | Number of pts waiting more than 7 days on a P3 pathway escalated | | LNWUHT / Optica | NPH/Harrow | Weekly | | | | |
| 37 | Bridging Service Indicators | | LA | NPH/Harrow | Fortnightly | | | | |
| 38 | Community Equipment Delays | | Borough Team | NPH/Harrow | Monthly | | | | |
| 39 | Enhanced Frailty service - Current Caseload - Aug & July | | Borough Team | NPH/Harrow | Monthly | 191 | 207 | | |
| 40 | Enhanced Frailty service - Step ups - Aug & July | | Borough Team | NPH/Harrow | Monthly | 69 | 82 | | |
| 41 | Enhanced Frailty service - Step down - Aug & July | | Borough Team | NPH/Harrow | Monthly | 47 | 76 | | |
| **Pathway Improvement** | | | | | | | | | |
| 42 | Complete FIT notes in secondary care | | LNWUHT | NPH/Harrow | Weekly | | | | |
| 43 | Discharges to Care Homes at Weekends | | LNWUHT | NPH/Harrow | Weekly | | | | |
| 44 | Onward referrals (C2C referrals) | | LNWUHT | NPH/Harrow | Weekly | | | | |
| 45 | Discharge Letters sent to GP Practices | | LNWUHT | NPH/Harrow | Weekly | | | | |

**Need confirmation that data is collected and reported.**

**Data is reported. Process not yet in place for regular submission to PMO.**

**Data received regularly by PMO**

Harrow Borough Based Partnership

Supporting better care and healthier lives

# Winter demand and capacity modelling (3/3)

To will be reviewed fortnightly by the Harrow Health and Care Executive.

| Line No | System Indicators | Status | Source | Cohort | Frequency | Current Week | Previous Week | Current Trend | Previous Trend |
|---|---|---|---|---|---|---|---|---|---|
| **Utilisation of community resources** | | | | | | | | | |
| 46 | Capacity Access Improvement Plans - Additional capacity per site and number of redirections from UTC and 111 | | Borough Team | Harrow | Monthly | | | | |
| 47 | Community Rehab bedded care flow / Intermediate Care Beds - Utilisation and LOS | | Local Care | Harrow | Monthly | | | | |
| 48 | Number of contacts at Community Pharmacy Consultation Service not requiring redirection | | Borough Team | Harrow | Monthly | | | | |
| 49 | Uptake / Utilisation of: Enhanced Access Services | | Borough Team | Harrow | Monthly | | | | |
| 50 | Virtual Ward contacts for Cardiology (Heart Failure and AF), Respiratory and Diabetes | | Local Care | Harrow | Monthly | | | | |
| 51 | Uptake / Utilisation of: Care Home Support Service | | Borough Team | Harrow | Quarterly | | | | |
| 52 | Uptake / Utilisation of: Childhood Asthma Clinics | | Borough Team | Harrow | Quarterly | | | | |
| 53 | Uptake / Utilisation of: CYP Health Inequalities Clinics | | Borough Team | Harrow | Quarterly | | | | |
| 54 | Uptake / Utilisation of: Additional Care for Complex Patients | | Borough Team | Harrow | Quarterly | | | | |
| **System Stress** | | | | | | | | | |
| 55 | Hospital Capacity Status | | NPH | NPH | Tuesday | FCP | Black | | |
| 56 | 12 Hour AED Waits | | NWL BI | NPH | Weekly | 340 | 356 | | |
| 57 | LAS Handovers - Average number of 60 min Breaches per day | | NWL BI | NPH | Weekly | 0 | 2 | | |
| 58 | Community/District Nursing - Total number of visits deferred once | | CLCH | Harrow | Weekly | 0 | 1 | | |
| 59 | Community/District Nursing - Total number of visits deferred more than once | | CLCH | Harrow | Weekly | 0 | 0 | | |
| 60 | Rapid Response - Number of referrals with a 2 hour response time | | CLCH | CLCH | Weekly | 56 | 59 | | |
| 61 | Rapid Response - Total number of initial visits triaged for a 2 hour response that were not completed within 2 hours of acceptance into service | | CLCH | CLCH | Weekly | 4 | 14 | | |
| 62 | Rapid Response - Total number of referrals rejected due to capacity | | CLCH | CLCH | Weekly | 0 | 0 | | |

**Need confirmation that data is collected and reported.**

**Data is reported. Process not yet in place for regular submission to PMO.**

**Data received regularly by PMO**

Harrow Borough Based Partnership

Supporting better care and healthier lives

# Management of interface for system efficiency

There is work being done at both local and NWL level to manage system efficiency. Following the 'Delivery plan for improving access to primary care' being published, there are three priorities that will be reviewed:

1. Onward referrals (C2C referrals),
2. Complete FIT notes in secondary care. Call and recall of patients to be done by trusts ,
3. GPs should have access to single email / primary care liaison officers in each trust. Clear points of contact at point of referral for GPs and patients to access secondary care and working GP bypass numbers for the trust to hold in their systems.

The above work is being picked up through 3 working groups which will be reporting to NWL System interface group. Data sharing between primary care and LNWHT; this will be through CIE and LCR. With the trust now switched to Cerner, this should become more seamless.

Over the coming period work will be done to ensure there is an updated contact list that includes bypass numbers for Harrow practices, community services and hospital services. This list will then be made available to health and care services within Harrow. LNWHT will be looking at amending templates for outpatient letters so that service contact details are available for patients and GPs. We are picking this up at Local interface group.

Work will be done with primary care colleagues to ensure referrals are sent through on the correct forms especially when referring to SDEC. Work is taking place within NWL to improve quality of discharge summaries with the possibility of an inclusion of a contact number for the pharmacy team that practices, and community pharmacies can use to discuss medication queries.

A letter will be drafted to be sent to clinical teams in LNWHT and GPs across Brent, Harrow and Ealing. The letter will be like that sent last year but with a refreshed set of priority areas for focus for primary care and LNWHT.

# Sharing of performance data and agreed escalation processes

The Northwick Park discharge hub coordinates the patient level daily calls for system coordination of individual issues and barriers to discharge.

As part of our plan for winter, it is proposed that a more robust system of escalation is introduced to provide senior input for challenges to discharge.

Daily prioritisation of discharges is taking place involving the discharge hub and social care services. The nationally commissioned Optica system is being implemented in NWL ICB and will provide a common source of analysis on the discharge pathway.

Briefings will be circulated to the DASS and Managing Director Harrow BBP three times each week on patients that are delayed, using the following criteria:

- Patients waiting more than 48 hours on a P1 pathway
- Patients waiting more than 5 days on a P1 pathway
- Patients waiting more than 48 hours on a P2 pathway
- Patients waiting more than 5 days on a P3 pathway
- Patients waiting more than 7 days on a P3 pathway

To ensure parity briefing will also be established once a week for Mental Health and Learning Disability patients at NPH Mental Health Unit or on medical wards clinically ready for discharge but delayed in line as follows:

- Patients waiting more than 72 hours on any pathways

The system flow and winter planning workstream will take strategic oversight of delays in the system, beyond individual patient delays to focus on themes and system issues that are factors in delay, for a collective partnership response to support in addressing them.

# Prevention and community winter wellness

**Health and wellbeing support to warm hubs**

Following the successful delivery and evaluation of the Harrow Winter Wellness programme in 22/23, the London Borough of Harrow will be supporting the scheme for the 23/24 winter, running from November 2023 until March 2024. This will be funded from the Public Health grant and BBP inequalities funds. Warm hubs will deliver the following interventions as part of the winter wellness scheme:

- Support the delivery of a number of activities aligned with specific priorities e.g. Making Everyone Contact Count, physical activity, healthy cooking and eating, reducing falls risk, smoking cessation.
- Targeted clinical outreach for specific priority areas through health checks for residents attending warm hubs.
- Distribute warm packs provided by public health.
- Support the community-based Conversation Café model delivery.
- Support the provision of information and advice services delivering from warm hubs.

We have built on last years evaluation through: focusing on expanding the proactive health checks in warm hubs; encouraging collaborative & innovative approaches to engaging with communities; developing an enhanced evaluation offer that will strengthen  the evaluation of the programme this year.

**Addressing the wider determinant of ill health and admission risk**

*MECC:*

Voluntary Action Harrow have been commissioned to deliver the Winter Wellness MECC sessions this winter. The session will focus on how to eat better, stay warm and find the best health help. The session will be open to all colleagues including frontline staff.

*Cost of Living Support and Housing:*

Local Authority have set up a support page for residents to seek support with the cost of living crisis (Help with the cost of living – London Borough of Harrow). A working group has been set up to oversee this.

Housing-related support services including; EACH Counselling & Support, Age UK Hillingdon, Harrow & Brent. Fuel Poverty and Energy Advice; Seasonal Health Intervention Network (SHINE) run by Islington Council for Londoners and Green Doctor (Groundwork)

Damp and Mould work- working group, set up to work together on responding to the regulator/government on damp and mould, developing a comms plan, monitoring trends in the number of cases, developing a strategy.

# Prevention and community winter wellness

**Flu and COVID vaccination**

- The Autumn campaign will commence on around early to mid October.  The cohorts will be the same as Autumn 2022.  All Harrow PCNs will be participating.
- Autumn flu plans to be jointly developed with COVID to reflect the need for co-administration wherever possible.
- Pathway for Newly severely immunosuppressed patients now available.
- The National Flu immunisation programme 2023/2024 has been published. It sets out which groups are eligible for flu vaccinations this coming flu season. 50-64 year olds are not part of the eligible groups.
- Secondary school children in years 7 and 11 are entitled to free flu jab but all school-based delivery will have a hard stop of 15th December to align with the Christmas break.
- Frontline H&SCWs are included in this year's flu programme and vaccinations should be delivered through occupational health schemes.
- Targets for flu will be 100% offer to all eligible and ambition to meet or exceed last year's position.
- All plans must have a strong emphasis on tackling inequalities and focus on groups not coming forward.
- The Immunisation and Flu Task & Finish Group will continue to meet on a monthly basis, moving to 2weekly as we near September (flu season) - Representation of the group is from Borough Team, Public Health, Local authority PCN management leads, Immunisation champions and community pharmacy representation.

# Prevention and community winter wellness

**Communication and engagement with local communities**

NW London-wide communications and engagement winter plan I in place 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 use data from previous winter campaigns and the Whole Systems Integrated Care Dashboard to target and support the right areas and communities.  A local working group has been established across the NWL communication leads and Local Authority communication and BBP team to ensure coordination of efforts and a dynamic response based on vaccination uptake data and urgent care activity.

Specific areas of focus include:

- Full winter messaging flyers launching in October, with Flu campaign, Children and young people campaign and Self-care campaign launching and continuing throughout winter period, with focus on Urgent and emergency care - Vaccination (flu/*Covid booster) - Children and young people - Primary care.
- Harrow Health Citizen Forum [online] in September, December, March with focus on Winter Wellness messaging.
- ‘Town hall’ style in person forum at prominent locations such as St. Peter’s Church with a focus on winter messaging.
- Regular ‘drop-in’ sessions with specific local communities, engagement and information, including co-ordination with local communities on immunisations i.e., Romanian - RCCT, Somalian - HASVO, Gujarati - SKLPC, as well as rhyme time library sessions targeting under 5s and young mothers.
- Local schools link-in to target under 18s and parent/guardians
- EOI process for commissioning local VCS groups to engage resident networks on winter wellness campaigns. This will be live until September, with community grants to be issued for roll-out September/October

# Community based admission avoidance

**Securing Primary Care Access and Capacity**

- Care Home Support as a key focus for preventing winter admissions: a review will commence 02/10/23 of the support provided to care homes to minimise the avoidable use of the UEC system and ensure safe, timely discharges from hospital to care homes
- An action plan for improving reviews and follow up of Children with asthma is in development, which will include increasing training to expand capacity for asthma reviews across the Primary Care workforce, a focused mapping of the discharge and notification pathway for children attending or being admitted to A&E following asthma attack and regular data reporting and review at PCN level
- Two Initial Accommodation Centres established for asylum seekers providing health screening and GP registration
- Enhanced Access now fully embedded (commenced October 2022): additional GP appointments from 6.30pm to 8pm weekdays and 9am to 5pm on Saturday
- Capacity Access Improvement Plans being implemented through practice action plans to create more capacity and increase access, and GP Access Centre operating at the Pinn Medical Centre, targeting 90% utilisation, 7 days a week and bank holidays
- CYP Health Inequalities Clinics and Additional Care for Complex Patients (extended appointments) were implemented in June
- Additional services commissioned through NWL Standard offer implemented from June includes: spirometry; wound care; ABPM; ECG; ring pessaries.
- ehubs implementation improving across Harrow utilising ARRs clinicians.  We are seeing high levels of e-consultation in Harrow.
- Community Pharmacy Minor Ailment Service to be rolled out Q3/Q4 once NHSE have resolved prescribing and liability issues
- Community Pharmacy Consultation Scheme: uptake to be improved through software to facilitate referral that will be purchased and implemented across NWL

# Community based admission avoidance

**Harrow Rapid Response**

- The Harrow  Rapid Response Team will maintain business as usual levels of activity for winter 2023/24 of 1000 patient contacts per month (inc Follow up visits).
- The service averaged 288 referrals per month for winter 2022/23.
- Current service performance is 97.6% against its KPI of a 2-hour response time for all referrals and it is anticipated that this will be maintained in line with performance over winter 2022/23

| | Nov-22 | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|---|
| **Referrals** | 214 | 342 | 325 | 273 |

**Care Home Support Team:**

- The Harrow Care Home Support Team will be supported by Harrow Rapid Response if they see and increase referrals and if they meet Rapid Response criteria.
- Weekends and OOH will be covered by Harrow Rapid Response.
- Activity data for the Care Home support Team is not currently reported, however this will be established for winter 23/24.

**Proactive frailty management**

The Enhanced Frailty service operates all throughout the year and will be carrying on business as usual:

- Systematic proactive identification of frail patients and with escalating risks
- Timely triage
- Step-up to the service and provide appropriate interventions including integrated multi-agency teams bringing skills and capacity together based on the need of the individual
- Step-down and maintenance as appropriate.
- Work with wider system partners i.e. acute, social care etc. for seamless integrated service i.e. work towards a resilient system especially during winter.

Overall ensuring patient benefit from specific interventions and have better care and experience and avoiding non-elective admissions.

**Additional Social Care**

Increased social work capacity to be put in place to work with primary care to support people in the home to avoid hospital admission.

**High Impact Area 2: Frailty** - reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
**High Impact Area 8: Urgent Community Response -** increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission

# In-hospital care

## Say Day Emergency Care (SDEC)

- SDEC
  - 7 day service that runs for 12 hours of the day.
  - The capacity is to see 75 appointments per day, this includes new and follow up appointments.

- Frailty service
  - Service that runs 5 days a week, from 9am-5pm.
  - The capacity of this service is to see 8 patients a day.
  - Inclusion criteria:
    - CFS ≥ 6
    - ≥ 65 years
    - NEWS ≤ 3

## Acute Hospital Flow and increased bed capacity

- Modular unit comprising 32 additional beds for opening late Feb 24
- Recruitment commenced to build staffing capacity ahead of this
- 4 additional elderly care and 2 stroke beds opened winter 22/23 remain open
- TBC scoping of SAU capacity to convert 4-8 trolley spaces to overnight beds
- Virtual ward programs for
  - Cardiology - heart failure and atrial fibrillation (45 pts in each)
  - Respiratory (30 pts)
  - Diabetes (20 pts)
- Move of 10 gastroenterology beds in spring 23 to Central Middlesex Hospital (CMH) to facilitate increased GIM beds at Northwick Park Hospital (NPH).

**High impact area 1: Same Day Emergency Care -** reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
**High Impact area 2: Frailty** - reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
**High impact area 3: Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.

# In-hospital care

**Community Rehab bedded care flow / Intermediate Care Beds**

CNWL has open and locked adult rehab beds across the system which Harrow patients can access if required. Current access to open is immediate, locked rehab can take some time, in which case private providers are sourced to avoid delays.

CNWL has 7 stepdown houses with 40 beds, which Harrow patients can access for up to 2 weeks to support bed flow.

Starting in August 2023, there will be an increased focus on discharge from community rehab beds to ensure robust productivity and flow. This process is commencing with fortnightly meetings with the community rehab providers, social care, discharge hub and Borough Partnership team.

**Mental Health**

The core components of the approach for winter for mental health services are:

- Addressing the growth in delays for patients clinically ready for discharge but waiting for social care support. Exploring the potential for the hospital discharge team to oversee the discharge of patients from MH beds on the NPH site when the team is at full capacity
- Improve flow through housing pathway for patients with mental health issues. Seeking to broker a fast track pathway with housing services.
- CNWL referrals from mental health and learning disability inpatients to ASC with escalation of delays beyond 72hrs
- Improved access to drug and alcohol service through in-reach to medical wards and ED is now well established and effective. The next step is to support access to clinical records across CNWL and Drug and Alcohol service provider.
- Active promotion across the public and health and care professionals of crisis alternative services with capacity: Maternity and mental health perinatal services, IAPT and Coves

**High impact area 4: Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes

# In-hospital care / Discharge Pathway

## Discharge Hub

- The overall aim is to relieve acute pressures by identifying patients to be managed with community support, instead of requiring an acute bed. This is achieved by clinical assessments undertaken by clinical screeners to share community knowledge of services and avoid any delay to discharge.
- NPH discharge hub, remains understaffed and has been supported and managed by LNW to continue to sustain flow.
- The hub is responsible for confirming discharge plans for patients across pathways 1-3 who have new or additional care needs on discharge.
- The NPH discharge team confirms the most daily discharges across the sector and receives on average 40 referrals daily to screening and processing for discharge.
- In advance of the winter, the focus will be on recruiting to the full team establishment, particularly the screeners to identify patients for the community.

## Discharge Support Service

The discharge support service is an essential component of the discharge pathway in Harrow, focusing on both timely discharge for patients on the P0 and P1 pathways as well as focusing on avoiding readmissions through securing community based support for people at the point of discharge.

Over a 6 month winter period, the service will have the capacity to support 500 patients at discharge and 300 post discharge support.

The discharge element will include provision of accompanied taxi service or accompanying patient in Hospital transport if appropriate. There is a standard cohort of 4 staff with coordinator on site Monday to Friday who liaise with the Discharge team to receive referrals but also take direct referrals from other routes if these can be accommodated.

Post Discharge intervention can include telephone calls, referring and signposting onwards to suitable services, home visits and practical support that helps a discharge be successful, thus reducing the risk of readmissions.

**High impact area 5:** Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed

# Discharge pathways

**Enhanced on-site social care**

Seven-day hospital SW cover funded for the winter period.

Increased social work and OT staff to support hospital discharge process.

**Provision of step-down care**

Step down beds have to be purchased on a block rather than spot basis.

Current plans to mitigate additional pressure:

- 5 step down beds currently purchased, which will be increased to 8 from October.
- Funds available for 6 additional residential care beds (currently 558 LD / other)

Additional more complex step down beds (EMI) might be available in the market if additional funding were available.

**Same day community equipment**

Same day equipment delivery service (MRS) has been made available, at greater cost to reduce the longer lead times.

To be used as required to achieve planned discharge date.

Prescribers instructed in use of same day delivery.

Further work to review prescribing process to maximise efficiency of resource use while achieving fastest delivery of equipment.

Data will be made available on use of same day delivery services.

**Home care provision, including weekends**

Development of local bridging services, through the Autumn in advance of the critical winter period, tailored to relieve pressure in the local discharge pathway, to allow eligible P1 patients to be supported with packages of care following relevant assessments for onward support where necessary.

Increased provision of 72 hour domiciliary care or reablement as needed but a follow up or further assessment is needed to support patient recovery at home

**High impact area 6: Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.

# Discharge pathways

**Integrated Intermediate Care service, and reablement provision**

The delivery of the Integrated Intermediate Care Service discharge pathway for facilitation of discharge and prevention of admission for the Winter of 23/24 will be supported through the following developments:

- **Discharge to Assess (D2A) and Short-term Rehabilitation:** CLCH will maintain Discharge to Assess (D2A) and short-term Rehabilitation Pathways in support of discharge delivering 1100 contacts per month over the winter of 23/24.
- **Northwick Park Discharge Hub:** The discharge hub lead post has been recruited to and the post holder starts in September 2023. Discharge hub Clinical screener post recruitment is ongoing with a view to these being fully recruited to by October 2023.
- **Carers Lead role:** Has been recruited to and will support service users and carer needs under the integrated pathway.
- **Training:** Has been implemented in support of the for the delivery of the integrated pathway for the winter of 23/24. Follow up training is planned for September or October 2023.
- **Single Referral Form:** Discharge 2 Assess (D2A) referral form used across NWL and will remain in use, however, CLCH has requested changes to make this form consistent with the single merged referral form for ICCS.
- **ICCS End-to-end patient pathway:** Pathway is complete following face to face sessions with leads.
- **SOP:** A draft SOP has been developed and is being reviewed by stakeholders for implementation for winter of 23/24.
- **Information sharing:** An interim solution to data sharing has been agreed with ICCS partners. Information sharing between Acute, Community and Primary Care Health Services will be facilitated with the go live of the Cerner Patient Administration and Records System in August 2023 at LNWHT using the London Care Record. A virtual desktop solution is proposed for access of across health and social care systems.

# Additional winter schemes

We are currently working on the basis that all additional winter funding coming into the system is known and we will not be expecting additional funding allocations.

However, if this position changes, acknowledging that funding is likely to be focused on specific pressure areas, priorities for investment for Harrow, based on our evaluation of Winter 22/23, would be:

- Additional reablement schemes;
- Expanding the Discharge Support Service, including the addition of handyman services;
- Home First and Trusted Assessors to support patient flow.

# Harrow system risks to the delivery of the winter plan 23/24

| Risk | Risk Owner | Mitigations | Date for review |
|---|---|---|---|
| If CLCH are not commissioned to provide discharge to assess community rehabilitation provision, there is a risk to system flow through increased bed days for medically fit patients. | Jane Wheeler and Jackie Allain | Exploring how this service can be funded non-recurrently this year. Meeting with CLCH/Jane Wheeler soon to work out the details. | September 2023 |
| If we do not address under-utilisation and delayed discharges of Harrow patients within the rehab beds, particularly at Woodlands Hall, there are financial risks to the system, and potential loss of Harrow provision | Melissa Mellett, Lisa Henschen, Shaun Riley<br>Jackie Allain | Bi-weekly discharge group being established.<br><br>Potential to increase scope of discharge hub to cover P2 beds (through integrated intermediate care team) but discharge hub needs full staffing to achieve.<br><br>Stakeholder briefing to be held with NWL ICB | September 2023 |
| If agreements for managing cross NWL and NCL arrangements for discharge support cannot be made in advance of winter pressures (for Harrow residents registered with Barnet GPs) we risk unnecessary delays at Northwick Park | Ian Robinson?<br>Senel Arkut | TBC | TBC |
| If we are unable to secure a stoma care pathway for Harrow residents, we risk hospital delays | ICB (TBD)<br>Senel Arkut | Explore with other London Boroughs how they are working with care providers to deliver stoma care | October 2023 |

# Action Plan

| Action | Lead | Delivery date |
|---|---|---|
| **Domain: interface** | | |
| Update contact list and by-pass numbers for Harrow GPs. Share widely across acute and community providers | Rahul Bhagvat | 9/10/2023 |
| Update outpatient letter details to include names and telephone numbers of clinical teams | TBC | TBC |
| Ensuring Primary Care are using correct SDEC referral forms | Rahul Bhagvat | 9/10/2023 |
| System letter to support efficient ways of working to support winter pressures | Radhika Balu and Jon Baker | October 2023 |
| **Domain: data and escalation** | | |
| Implement local escalation processes for discharge delays as described in the winter plan | Natasha Harmsworth-Blythe, Shaun Riley, Santokh Dalal, Senel Arkut, Lisa Henschen | 9/10/2023 |
| Address any outstanding issues with local data collection for winter performance monitoring | Bharat Gami | 9/10/2023 |

# Action Plan

| Action | Lead | Delivery date |
|---|---|---|
| **Domain: prevention** | | |
| Implement 2023/24 winter wellness scheme for Harrow | Seb Baugh | November 2023 |
| Deliver MECC winter programme | Laurence Gibson | November 2023 |
| **Domain: community based admission avoidance** | | |
| Secure our pathways of support to care homes for admission avoidance and timely discussion – including Care Home Support Team and Primary Care Enhanced Service. Action plan to be developed. | Sandra Arinze<br>Jenny Gorasia<br>Patrick Laffey | 20/10/2023 |
| **Domain: in-hospital care** | | |
| Secure robust discharge flow for patients in rehabilitation units | Lisa Henschen, Bharat Gami, Natasha Harmsworth-Blythe | 09/10/2023 |

# Action Plan

| Action | Lead | Delivery date |
|---|---|---|
| **Domain: discharge pathway** | | |
| Establish bridging service for Harrow | Senel Arkut, Johanna Morgan, Shaun Riley | October 2023 |
| Explore closer alignment between PATCH (children's virtual ward service) and children's community health teams | Philomena Bouzemada and Claire Eves | October 2023 |
| Implementation of the integrated intermediate care service | Jackie Allain and Shaun Riley | November 2023 |
| Agree pathways for Harrow residents registered with Barnet GP (joint meeting between Harrow, Brent and Barnet) | Shaun Riley, Lisa Henschen | November 2023 |
| Explore options for stoma patients through homecare providers | TBC | October 2023 |
| Active promotion of mental health crisis alternatives to front line staff and the public | James Connell, supported by Mental Health workstream | October 2023 |
| Explore potential for discharge hub supporting mental health discharges across health and social care – dependent on hub staffing | Gail Burrell, Natasha Harmsworth-Blythe, Lisa Henschen | December 2023 |
| Implement regular briefings and escalation across discharge pathways for physical and mental health | Shaun Riley, Santokh Dalal, Lisa Henschen | September 2023 |
| Seek to establish data sharing of clinical records across CNWL and Drug and Alcohol service provider | Seb Baugh, Gail Burrell, Deepti Shah-Armon | December 2023 |