# Harrow Borough Partnership Winter Plan

Winter 2024/25

Draft v1

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
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# 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 24/25 will build on our system learning and evaluation of the Partnership's winter response in 23/24.

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, further extending a service offer to our housebound cohort;
- 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;
- Respecting, supporting and harnessing the essential role our unpaid carers provide, by including them in conversations for discharge planning to allow for the correct care support to be available for our residents to reduce any social readmissions;
- 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 – with support to housebound
- 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

- 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

**Transfer of Care Hub and Discharge Support Service**

- Enhanced on-site social care
- Integrated intermediate care service, including reablement
- Enhanced discharge support for patients with dementia and delirium, through interim step-down beds and 24-hour home care provision
- Discharge support to families and carers
- Increased provision for same day equipment
- Increased home care provision, including weekends
- Mental Health will have access to P3 step-down beds

# Winter demand and capacity modelling

This will be reviewed fortnightly by the Harrow Health and Care Executive for oversight and risk management.

| System Indicators | Status | Cohort | Frequency | Current Week | Previous Week | Current Trend | Context |
|---|---|---|---|---|---|---|---|
| Hospital Capacity Status | | NPH | Weekly on Tuesday | | | | |
| AED Attends | | NPH | Weekly | | | | |
| UTC Attends | | NPH | Weekly | | | | |
| MH Liaison AED Referrals | | Harrow | Weekly | | | | |
| MH Liaison AED Referrals - 1 hour response | | Harrow | Weekly | | | | |
| MH Liaison Ward referrals | | Harrow | Weekly | | | | |
| MH Liaison Ward referrals - 24 hour response | | Harrow | Weekly | | | | |
| Delayed Transfer of Care Total | | Harrow | Weekly | | | | |
| Rapid Response – Initial visits not completed within 2 hours | | Harrow | Weekly | | | | |
| No hospital discharges in month that required social care input | | Harrow | Monthly | | | | |
| No of patients being worked with by social care | | Harrow | Monthly | | | | |
| ERM Advanced Care Plans Completed | | Harrow | Quarterly | | | | |

**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**

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# Cross system working

**Escalation processes**

As part of our plan for winter, it is proposed that we continue the escalation pathway that was introduced over winter in 23/24, acknowledging that local arrangements may be stood down in the event on NWL processes introduced to manage high levels of system wide pressures.

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

Locally, a discharge escalation call has been set up that occurs every Tuesday afternoon, there is representation there from the ICB, LNWHT, CLCH, Social Care and Rehabilitation Unit provider leads. On a monthly basis, this call will look at reasons for delayed discharges and will look to address the barriers to timely discharges across all pathways.

For Mental Health and Learning Disability patients at NPH Mental Health Units that are clinically ready for discharge, in hours they will be escalated to the borough director, where this cannot be resolved they will be further escalated to the COO. For patients out of hours, they will be escalated through the on-call system where a senior nurse, senior manager and director will receive escalation.  A medically fit for discharge call is also held with all partners every Monday. Patients who need further escalation will be discussed with Natasha Ramchurn. For assurance of flow a list of patients with update will be sent to the Tuesday afternoon call. Work will commence to secure housing representation at the Monday discharge call.

The complex and urgent care workstream will take strategic oversight of delays in the system to focus on these and system issues that are factors in delay, for a collective partnership response to support in addressing them.

**Driving efficiencies at the system interface**

This work will be led at a North West London level with a focus particularly on the primary and acute interface, directing the system to work in the most productive way possible.  In addition, as we drive through whole population integration across our services though our neighbourhood models, we will work to realise the benefits of this over the winter of 2024/25.  We are targeting fewer hand-offs of care, conversations instead of referral rejections and to put in place provider to provider referral arrangements where possible.

# 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 23/24, the London Borough of Harrow will be supporting the scheme for the 24/25 winter, running from November 2023 until March 2024. This will be funded from the Public Health grant. 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, TBC e.g Social Isolation, befriending services for housebound
- 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 year's 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.

Following successful delivery of warm hubs, the Voluntary Sector has secured additional grants from Cadent to deliver Center for Warmths, these will commence in November and run for 19 months, these centers will provide information and advice, along with free carbon monoxide monitors.

Warm pack distributors will extend beyond warm hubs and conversations will be progressed with our community teams and primary care settings to allow housebound residents to benefit from warm packs when being visited in the community.

**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. Eligible cohorts will be confirmed in due course, following the Government's consideration of JCVI advice. 3 Harrow PCNs will be participating Healthsense, Harrow Collaborative and Health Alliance. 24 Harrow Community Pharmacies will be participating in the campaign.
- 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 2024/2025 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.
- Vaccination UK are the new CYPCIS Service commencing 1st September 2024
- From the 1st September 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 clinical and non-clinical 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 2 weekly in 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 are 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. The winter programme links up and works across NW London communication leads and local authority communication and BBP team to ensure coordination of messaging and a dynamic response based on local issues and feedback

Specific areas of focus include:

- Full winter messaging information on/for: Covid-19 and flu vaccinations, children and young people, self-care, urgent and emergency care and primary care.
- Harrow Citizens' Health  Forum in winter will have focus on Winter Wellness messaging and engagement.
- 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, Conversation Café in St. Peter's Church.
- 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: PCNs will be jointly developing (and delivering) a training and education programme for their respective Care Homes, which will focus on admission avoidance and prevention.
- Taking forward 48-hour reviews in primary care for children having being admitted or attending A&E with exacerbation of asthma and PCNs having protected weekly slots for LNWHT to book into.
- One Initial Accommodation Centres situated in Harrow for asylum seekers. 2 PCN's are providing health screening and GP registration to these patients.
- Enhanced Access now fully embedded - additional GP appointments from 6.30pm to 8pm weekdays and 9am to 5pm on Saturday. Harrow seeing high levels of utilisation; 85% on average.
- 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) continuing into 2024/25.
- Additional services commissioned through NWL Standard offer implemented for 2024/25 includes: Respiratory, Hypertension, CKD, Coil fitting for non-contraception and safeguarding.
- Practices are able to accommodate increased levels of e-Consult enquiries through centralised use of ARRS roles and pooling of resources (Pharmacists, Paramedics, First contact Physiotherapists).
- Enhanced development of eHub services based on PCN/Borough local data, clinical conditions, support for long-term conditions through structured data collection.
- Through the ERM scheme, patients with multiple co-morbidities, will have advanced care plans drawn up to avoid admission into hospital where clinically safe to do so. These care plans will be available on the UCP with a 25% increase from baseline.

# Community based admission avoidance

**Pharmacy First**

- Pharmacy First Service (PFS) which was launched in January 2024 is an advanced service offered by community pharmacy. PFS enables community pharmacists to directly supply prescription-only medicines **(standard prescription charges apply)** for seven common conditions:
  - Sinusitis (12 years and over)
  - Impetigo (1 year and over)
  - Infected insect bite (1 year and over)
  - Shingles (18 years and over)
  - Acute otitis media (1-17 years)
  - Sore throats (5 years and over)
  - Uncomplicated Urinary Tract Infections (women 16-64 years)
- This initiative not only expedites care for minor ailments but also aims to free up appointment allowing GPs to focus on more complex cases. PFS can play a pivotal role to alleviate pressure on general practitioners (GPs) and enhance patient access to health. Most patients can reach a pharmacy within a 20-minute walk and the service provides an alternative pathway for quick and convenient healthcare during the demanding winter months.
- Patients can either self-refer to this scheme or be referred by their GP surgery (via NHSmail or Pharmaoutcome) for the seven common conditions. For minor ailments, a GP referral would be needed.
- There is 97% sign up from Harrow community pharmacies, with 56 out of the 58 pharmacies signed up to deliver the scheme.
- There will be ongoing PCN wide engagement with the LPC and community pharmacies to embed the service within PCNs and the lead of the scheme will be collaborating with local pharmacies to tackle specific practice issues which arise.

# Community based admission avoidance

**Harrow Rapid Response**

- The Harrow  Rapid Response Team will maintain business as usual levels of activity for winter 2024/24 of 1000 patient, 5 contacts per month (inc. Follow up visits).
- The service is piloting proof of concept for emergency department doctors to discharge patients into the community overnight, with the service visiting the patients the following day. This will be from 8:30PM-08:00AM.

**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.
- LNWH and CLCH are exploring a clinical pathway to address the increase in hospital admission for care home patients whose needs could be addressed by existing community service provision. The pathway will aim to prevent avoidable hospital admissions by supporting nursing home patients who would otherwise be in the hospital to receive acute care through the virtual ward by monitoring and providing treatment remotely.

**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 focus to working collaboratively with families to prepare for discharge and manage post-discharge support and expectations of families and carers.

**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

**Acute Hospital Flow and increased bed capacity**

- Northwick Park Hospital - core bedded capacity;
  - 12 winter bed currently remain open across Q1&2, which are planned to continue into Q3&4.
  - There is a plan to open 11 additional beds from October.
- Continuation of the Trust additional staffing for the Northwick Park Hospital and Ealing Hospital ambulance cohort which has been in place non recurrently since the advent of the June 2023 to support the 45-minute ambulance handover Standard Operating Procedure.
- Additional Multi Disciplinary Team staffing to support flow and Length of Stay phasing in from October.

**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 6 stepdown houses with 35 beds, which Harrow patients can access for up to 2 weeks to support bed flow.

CNWL Mental Health Emergency Centre (MHEC) and Mental Health Crisis Assessment Service (MHCAS) offer a calm and therapeutic mental health setting to treat the majority of emergency mental health presentations. MHCAS can also accommodate up to 3 sectioned patients. The service offers full emergency mental health assessments and onward care planning in the department.

To continue to focus on discharge from community rehab beds to ensure productivity and flow, the weekly discharge escalation calls has increased its membership to include community rehab providers.

## 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 CNWL to join the LNWHT CRFD weekly meeting with social care to address social care barriers and improve flow
- Improve flow through housing pathway for patients with mental health issues. Seeking to broker a fast-track pathway with housing services. NWL ICB recognise this to be NWL wide and are looking at how this can be improved.
- CNWL referrals from mental health and learning disability inpatients to ASC with escalation of delays beyond 72hrs, would happen through social care CRFD meetings.
- 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
- Access to P3 discharge funding stepdown beds for older adults who are CRFD.

# In-hospital care

**Northwick Park Hospital Transfer of Care Hub (NWPH ToCH):**

- 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.
- The NWPH ToCH, has recruited substantially and now are fully staffed with clinical screeners and case managers in the Harrow community.
- The ToCH is responsible for confirming discharge plans for patients across pathways 1-3 who have new or additional care needs on discharge.
- The ToCH also links into the Harrow IICCS with P1/P2 IPR Harrow residents being handover to the ToCH case managers in the community
- The NPH integrated discharge team confirms the most daily discharges across the NWL sector and the ToCH receives on average 30 referrals daily to screening and processing for discharge but can receive up to 45 referrals per day.

**Focus for embedding ahead of winter**

- Integration with community teams including rapids and our step-up provisions to Furness within ED,
- Maintaining oversight and ensuring timely move on for those on P2 pathway (across IPR and interim placement) via this service
- Improving the quality of referrals and screening process with clinical input and teaching to the wards.
- Operational 7days a week with a fully staffed structure.

# Discharge pathways

## 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.

## Integrated Intermediate Care Coordination Service (IICCS)

The integrated intermediate care services (discharge support, therapy and reablement operates as a single integrated team in the community for patients who are discharged from hospital or following a period of ill-health in the community.

The vision is to develop a person-centric, flexible approach that helps people retain their ability and independence, achieve health and wellbeing goals that matter to them, reduce readmissions, and prevent, reduce or delay the need for long-term care through case management.

Our case managers support our P1/P2 IPR Harrow residents who reside in Harrow and Brent as well as Brent residents who are receiving care in a Harrow rehab bedded unit. Once medically fit for discharge from NPH, the case manager will serve as a single point of contact between the patient and the other services that make up the IICCS.

The case managers main aim is to reduce hospital readmissions and failed discharges by supporting the patient to ensure their rehab goals are being met, all outstanding care and equipment are delivered as planned and that the patient's identified discharge destination remains a safe and appropriate choice post discharge.

It is estimated that the IICCS will support approximate 10,000 Harrow residents annually (based on the current number of discharge hub - Harrow, community therapy and community reablement referrals), excluding community nursing and specialist services referrals into the community SPA.

# Discharge pathways

**Enhanced on-site social care**

Seven-day hospital SW cover funded.

3 additional assessment staff to support hospital discharge process.

**Home care provision, including weekends**

The bridging service. that was first commissioned with discharge funding in 23/24, will continue to support P1 patients with 5/7 day packages of post-discharge care.

Support at home for patients discharged on a P3 pathway with delirium or dementia.

**Provision of step-down care**

8 additional block step down beds.

10 additional beds for 6 week post-discharge step down of P3 patients from NPH acute and mental health beds with a particular focus on delirium and dementia.

Additional SW / brokerage staff to support flow.

**Same day community equipment**

Since taking over the contract for community equipment in 20+ London boroughs NRS has experienced significant problems in meeting the required standards for the delivery of equipment. These issues have been exacerbated by a recent cyber attack that has severely affected their data systems.

NRS has committed to supporting discharges through closed engagement with Discharge Hub staff to resolve issues.

Data on same day equipment delivery, which has not been available since the cyber attack is agreed to be a priority in restoring the system.

**Strengthening discharge arrangements for patients who have had a stroke in Harrow**

Harrow will be mobilising Early Supported Discharge and Community Rehabilitation over the summer period. The service is expected to start in September and reach full capacity by the end of the year. This is intended to improve outcomes for patients and carers and support the discharge flow.

**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.

# 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 23/24, would be:

- Additional reablement schemes, particularly to support MH discharges;
- Expanding the Discharge Support Service, including the addition of handyman services;
- Falls preventions services

# Harrow system risks to the delivery of the winter plan 24/25

| Risk | Risk Owner | Mitigations | Date for review |
|---|---|---|---|
| GP strike and contract negotiations will mean that no enhanced services will be delivered. Therefore, care planning through ERM will not happen should this happen. | Dr Radhika Balu | To try and put plans in place in advance of the strike | August 2024 |
| Discharge to Assess Funding for Harrow has ceased and the community provider will stand down this service from the 1st September | Patrick Laffey | • Demobilisation will take place over August 2024 to ensure all patients on the case load are safely transferred to community rehabilitation service.<br>• Patients previously utilising this pathway may be able to access ESD service. Patients not suitable for this service will be referred to the community rehab service as per prior to the introduction of the discharge to assess. | 01/09/2024 |
| Capacity in Mental Health social work team to support discharge | Natasha Ramchurn | • Define best pathways and target timescales<br>• Scope the resource and/ or team flow changes needed to deliver this. | September 2024 |
| If we see the rise in admissions as we saw in 2023/24 winter (and based on activity seen in 2024 to date), are current plans are not fully addressing how we meet this level of demand without significant strain being placed on staff and impacting experience of our patients. | Simon Crawford<br>Lisa Henschen | Delivery of admission avoidance programmes. Continue to raise profile of Harrow funding gap to seek system solution. | September 2024 |

# 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 | 9/10/2024 |
| Working through a digital solution to enable LNWHT to book into PCN held back Asthma review slots for CYP | Radhika Balu and Jonathan Lewin | October 2024 |
| | | |
| **Domain: data and escalation** | | |
| Understand better the accuracy of Optica data and if Local Authority can now view this | Hugh Caslake | September 2024 |
| | | |

# Action Plan

| Action | Lead | Delivery date |
|---|---|---|
| **Domain: prevention** | | |
| Promotion of MECC through the INTs | Laurence Gibbson | September 2024 |
| Warm Hubs: begin the process and have hubs ready for delivery from November 2024 | Seb Baugh and Rachel Wright | Now till October 2024 |
| **Domain: community-based admission avoidance** | | |
| Through the ERM scheme, begin care planning for patients with multiple co-morbidities that are at a high risk of admission, based on data for last winter | PCN CDs and respective practices | Now till October 2024 |
| Collaborative pathway from community rapid response team to frailty SDEC being developed, to reduce dependency on ED. | Dr Sabiha Ali and Dr Laura Balica | October 2024 |
| Rapid Response Team: following test for proof of concept of ED clinicians discharging into community overnight, if positive results look at how this can be embedded for winter. | Dev Robert and Bindya Thanki | September 2024 |
| Care Homes: training for clinical staff on IV administration to support nursing home patients in the community needing IV | Shrawan Sharma and Bindya Thanki | September 2024 |

# Action Plan

| Action | Lead | Delivery date |
|---|---|---|
| **Domain: in-hospital care** | | |
| 11 additional acute medical unit beds to open to support winter pressure management | Jason Antrobus | October 2024 |
| Wider winter MDT staffing for flow trust wide to be undertaken | Jason Antrobus | August 2024 |
| | | |
| **Domain: discharge pathway** | | |
| Strengthen collaborative review of patients with no criteria to remain on MH wards | Natasha Ramchurn and Gail Burrell | October 2024 |
| Mobilise stroke ESD and community rehab | Jamie Zanardo and Patrick Laffey | September 2024 |
| Define best pathway and timescale for Mental Health discharges | Natasha Ramchurn and Gail Burrell | September 2024 |
| Scope housing representation for Mental Health discharge calls and establish a Mental Health discharges and housing pathway | Natasha Ramchurn and Gail Burrell | September 2024 |