NW London Out of Hospital Recovery Plan: Harrow

5th June 2020
Harrow Health & Care Executive Approved v5.0

Contents

1. Introduction
Harrow Out of Hospital Recovery Plan

For a number of years Harrow has been on a journey towards integrated, person and community-centred care – from the original Whole System Integrated Care (WSIC) model for over 65s; to the decision in 2016 to establish the Integrated Care Alliance / Integrated Care Partnership (ICP); and in 2019 to transition from the development stage of the ICP to delivery at-scale.

All partners have shared how hard this journey has felt, even at the best of times – and in common with systems across England and around the world, never have the challenges for us individually and collectively been greater than in the recent months of the Covid-19 outbreak.

When, after significant discussion and self-reflection, we committed in February 2020 to the next "100-days" of our ICP development – with six shared priority areas of implementing our holistic Frailty Model; aligning our Mental Health Services; adopting a Population Health Management approach to diabetes; mobilising our Community Assets; integrating with our Voluntary and Community Sector partners; and developing our joint Learning Disabilities support – no-one could have foreseen what the next 100 days would fully bring.

However, as we look back on those 100 days since the beginning of March, when the newly formed Harrow Health & Care Executive (HHaCE) became the epicentre of our ICP and of our work with local partners on supporting each other in responding to Covid-19 – bringing together, as it has, on a weekly basis senior representatives of the acute, community, mental health, social services, primary care networks, voluntary and community sector, CCG and broader council services – we see the foundations of a system that we believe will enable us to drive improvements in health and wellbeing, reductions in inequalities, and the sustainable use of collective resources: both to meet current demands across these areas and our future health and wellbeing priorities for Harrow as a whole.

This is not to suggest that the next steps will be easy – in many ways, following on from the unprecedented challenges of re-purposing our health and care systems to meet the challenges of Covid-19, the process of continuing to manage safety and risk; capacity and flow; support for both existing and new long-term conditions and care needs; and of accelerating the journey of integration across the partnership; is an even bigger ask of our workforce, our relationships, and all of those who are involved in delivering care in our communities. Nonetheless, in many areas implementation of this plan is already underway.

As we recognised in February, our five Primary Care Networks will be critical to the success of this, with primary care at the heart of our out-of-hospital recovery plan. But it is only by working together as a single team, in support of all of the people of Harrow, that we will succeed in delivering safe, effective care which harnesses the diverse assets of our organisations and our partnership – enabling all of those we care for to "**Start Well, Live Well, Work Well and Age Well**".

2. How we work
Harrow Integrated Care Partnership

In engagement with partners across Harrow, including our patient and public representatives, they tell us consistently the next stage of our ICP development needs to:

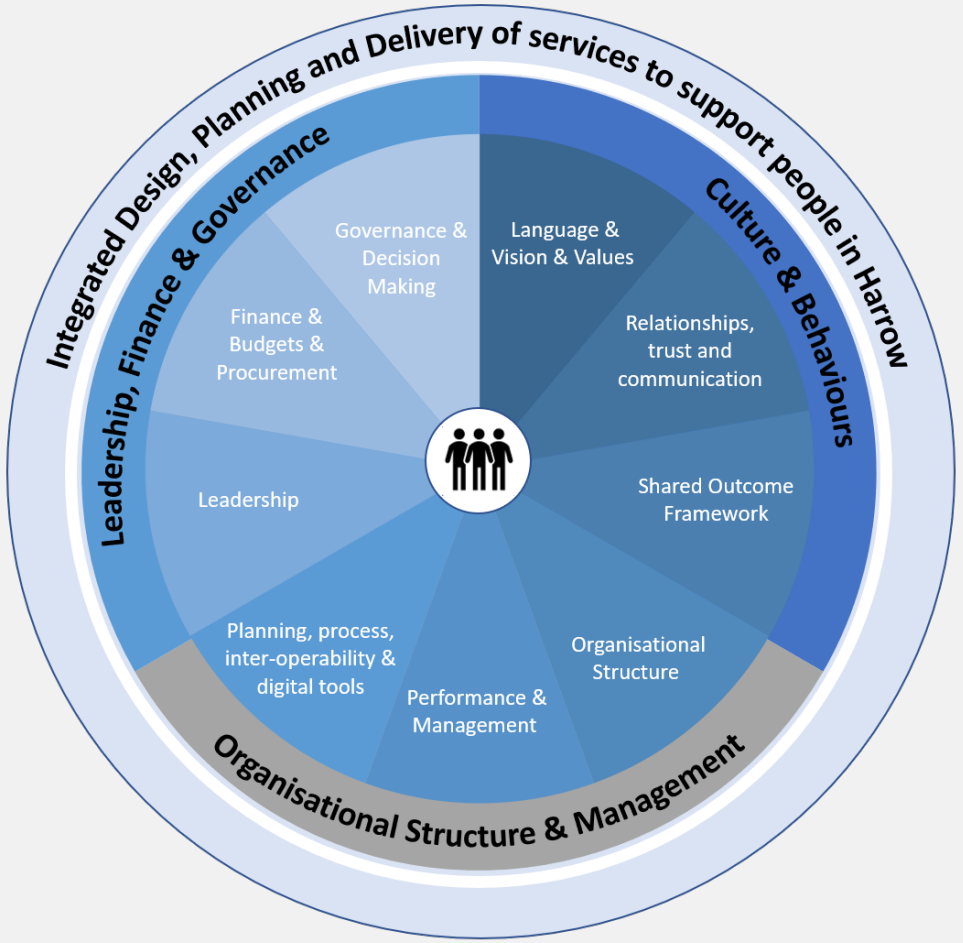
- **show real and tangible improvements** for patients and staff throughout the borough.
- **making integrated working "business as usual"**, building on progress and learning to-date.
- **develop through collaboration with Primary Care Networks** and the communities they support.
- **be underpinned by shared and realistic plans**, **resources and funding**.

We recognise that future changes will need to be phased over time, with individual parts of Harrow having the flexibility to adapt local responses to local community and individual needs.

However, there is also a very real commitment to making the borough-based partnership the way in which Harrow enables and achieves truly integrated care for all of its partners and communities; one which capture the progress which has been made over the last three months in developing our collaborative working and new ways of meeting demand; together with an energy around ensuring that we make the further changes required to safeguard and support our population in the short, medium and longer term.

To achieve this, our Recovery Plan will be underpinned by:

- **effective joint design, planning, and delivery built** on a shared view of local priorities and needs.
- **leadership and governance** that is streamlined and works together and not in conflict or duplication with organisational and NWL system structures.
- **support to each other with pooled resources and finances** where there is agreement to co-develop and transition to new ways of working.
- **investment in shared organisational development** and behaviours which will enable collaborative working and build relationships.



2. How we work
Shared principles (1/2)

For each aspect of our plan, we have ensured our proposals reflect principles developed jointly to guide provision and development of care in our communities across North West London as a whole (recognising the common historic challenges, and the potential to work together to support broader improvements):

Characteristics of the past	Characteristics of the present and the future	What this means for out of hospital care
Inconsistent approach and variable quality and effectiveness	**One system working with consistent safety and effectiveness:** best practice infection control across all services (remote access to services as default, and segregation of physical services), and providing the most effective care-based on evidence (e.g. GIRFT); and adopting action learning model to test our models to consistently improve.	• *Common IPC guidance and service segregation* • *Addressing inequalities* • *Scope children and adults, cradle to grave, physical and mental health* • *Consistent support to shielded patients* • *Consistent support to care homes across NWL* • *Virtual first will be the default with talk before you walk*
'Doing to', creating dependency and passivity	**One system working with our communities:** empowering and activating people to help themselves, supporting communities to help one another; and working with our communities to be clear and transparent about what is happening and why, including what we may need to stop doing.	• *Support expansion personalised care and devolved budgets, co-production* • *Voluntary sector and volunteers as key partners* • *Focus on social isolation and social exclusion* • *Importance of focussing on wider determinants of health to promote health lives rather than treating illness e.g. connection between employment and mental health*
Silos of specialism	**One system working with a team of teams:** enabling our staff to work as teams without walls – more easily integrating across community, primary, secondary, tertiary and mental health care as well as across NHS and social care (e.g. portable arrangements and trusted assessor model).	• *Consistent community services offer building on pre-Covid plans – rapid responses, core planned service* • *Joined up care up around the whole person building block primary integrated provision including social care* • *Continued elimination of DTOCs working with local authorities, future discharge model* • *PCN will be the default unit of provision in primary care* • *Single point of contact for accessing and coordinating services* • *Lead community trust for each borough working in collaboration with other Trusts* • *Lead community trust facing each hospital* • *Utilising our skills and expertise to best effect to deliver care rather than being dictated by employing organisation or funding flows especially across NHS and Local Authority* • *Reduce bureaucracy that stifles progress and innovation but with appropriate governance*

2. How we work
Shared principles (2/2)

Characteristics of the past	Characteristics of the present and the future	What this means for out of hospital care
Information poor and led by events	**One system working with shared clinical & operational intelligence:** using real-time information to proactively identify people with high care needs (e.g. shielded patients); using a single PTL to ensure fair and timely access; combining real time operational data to support mutual aid across sites & service (e.g. manage capacity and demand); and using all of this information to learn fast and improve where necessary.	• *WISC – use of population health management tool, across all organisations* • *Population health management based on good data should drive our approach to our care for residents* • *Common IT platform between primary, community and mental health interoperability* • *Common single care planning tool*
Separate organisations competing	**One system working with collaboration across sites:** using the facilities we have as part of a single network; putting the right services in the right places according to best practice and need to enable safe, effective and equitable care and mutual aid; and ensuring fair and equitable outcomes to everyone in NWL, based on need.	• *Addressing inequalities* • *Sharing existing and back office function at scale including PCN and Trusts* • *Planned community services on the PCN footprint as far as practicable (geographical coherent) recognising service resilience and flexibility* • *Build on multiborough services and shared across NWL….. If already exist share them, e.g. build out* • *Joint approach to services undertaken by both LA and NHS such as CHC*

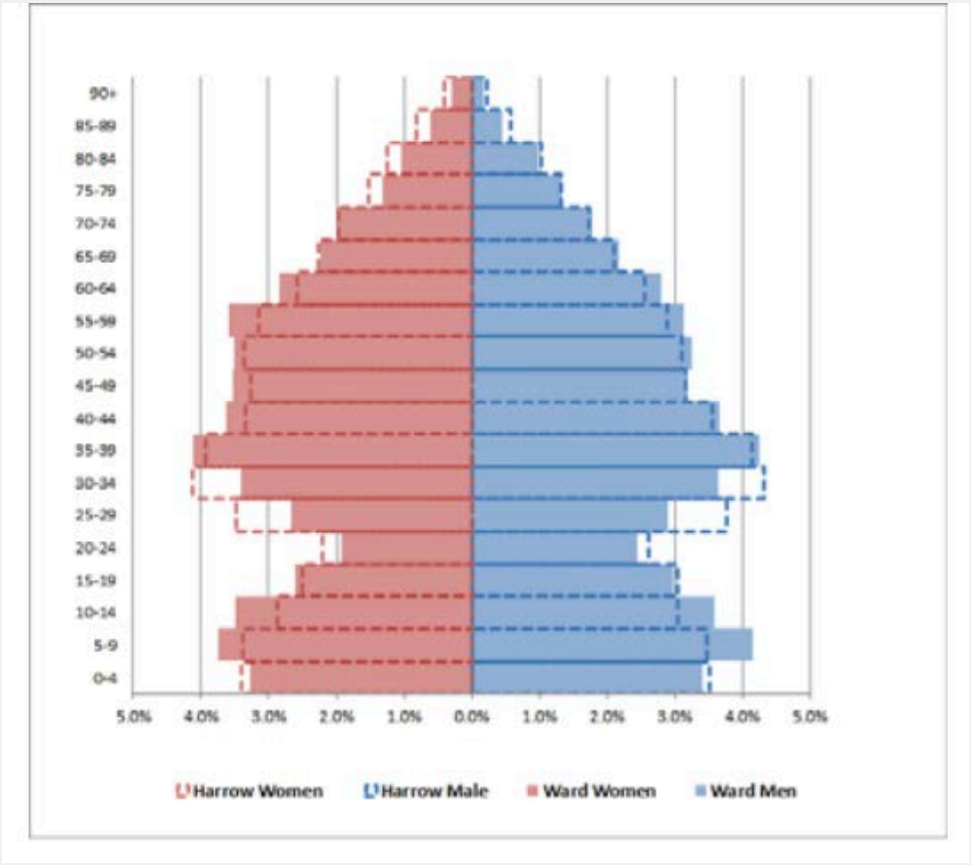
In parallel with collaboration across our community-based services, colleagues working in the acute sector have been a fundamental part of the Harrow Health & Care Executive and our borough-based response. We will continue to engage jointly in the development of the Harrow ICP and in ensuring that our out-of-hospital plans are co-ordinated at a North West London level, including understanding and managing the risks as patient pathways are restarted in the context of "pent-up" demand and continuing restrictions on capacity resulting from the need for Covid-19 related safeguards and controls.

Understanding demand and capacity across NW London will be critical to this process, as will regular engagement and communication with our primary and community services to ensure that there is effective expectation setting and management at a local level, in support of the broader sector recovery plan.

3. Managing Population Health & Tackling Inequalities
The Harrow context

- **Harrow has a population of over 250,000** and is characterised as a "densely-populated" borough with 410 confirmed cases of Covid-19 per 100,000 population as of 26th May 2020.
- **Harrow has an ethnically diverse population**, with White 42%, Asian/Asian British 43% and 8% from a Black/African/Caribbean/Black British ethnic background.
- **There are big variations in life expectancy throughout the borough**: men in west Harrow can expect to live for 5.5 years longer than those in Greenhill, and women in inner south Harrow can expect to live greater than ten years longer than women in Wealdstone.
- **15% Harrow population is over 65 and 4.3% Harrow population over 80.** Recent research by the BMA shows that 50% over 65s already live with a degree of frailty.
- **According to the most recent census data Harrow's population includes 24,620 carers**, the second highest level in London, often looking after older people with Long Term Health conditions who are at higher risk from Covid-19, and needing greater support to recover.
- **The national survey of adult carers in 2016 showed approximately 40% of carers receiving support from Harrow were themselves over 65**, potentially managing one or more long term conditions of their own, and also at enhanced risk from Covid-19.
- **Harrow has 57 Care Homes** in total, including:
  - 12 Nursing homes (627 beds)
  - 34 Learning Disability / Mental Health homes (265 beds)
  - 11 Residential homes (296 beds)

  with at least a further 5 homes in other boroughs supported by Harrow GPs.
- **Harrow currently has over 12,000 shielded people** living in the borough.



Sources: PHE, Harrow JSNA, Harrow Council, ONS, BMA (2018)

The North West London health and care partnership

3. Managing Population Health & Tackling Inequalities
Addressing the impact of Covid-19

As part of our response planning we have considered the recent Public Health England review of disparities in risks and outcomes for Covid-19. The PHE analysis has looked into effects of age, sex, deprivation, region and ethnicity, but it does not take into account the existence of comorbidities, which are strongly associated with the risk of death from Covid-19 and are likely to explain some of the differences. Continuing to improve the holistic management of long-term conditions in Harrow is a key priority for our partnership, as (working with VCSE colleagues) is addressing the broader socio-economic determinants of health and wellbeing, including inequalities exacerbated by the effects of the Covid-19 outbreak. However, as an area with a diverse population and a diverse workforce, we recognise our shared responsibility to address emerging disparities in risks and outcomes specifically in our immediate and future plans:

Risk factor	1. Age and sex *Older people, Male*	2. Geography *Urban areas* 3. Deprivation *Deprived areas*	4. Ethnicity *BAME groups*	5. Occupation *Nursing, Social Care, Other Key Workers*	6. Inclusion health groups *Migrants, those with no fixed abode*	7. Care homes *Living in care homes*	8. Comorbidities *Diabetes & other Long Term Conditions*
Priorities for our Recovery Plan	• **Integrated support** to our shielded population. • **Development of Covid-19 protected and risk-managed pathways** co-ordinated through our five PCNs. • **Targeted investment in prevention** to support population health and wellbeing, including encouraging uptake of Health Checks.	• **Use of population health data** including WSIC and Harrow Public Health to identify and support deprived areas and at risk populations within Harrow. • **Close working with Local Authority and VCSE partners** to target broader determinants of health and wellbeing.	• **A focus on BAME support** co-ordinated across mental and physical health services. • **Effective communication and engagement** across all of our communities living and working in Harrow to ensure that equal access to advice, guidance, services and support. • **Proactive support and co-ordination** through our PCNs including promotion of Health Checks.	• **A rigorous and co-ordinated focus on staff mental and physical heath** and wellbeing across NHS, local authority and VCSE organisations. • **Ensuring ongoing availability of PPE and testing, and effective "zoning"** and management of patients and service users across all care settings, supported by our PCN virtual "homes".	• **Improved community resilience and responsiveness** including co-ordination through the Harrow community hub and partnerships with local VCSE organisations. • **Working with colleagues across NWL** to address ongoing challenges and opportunities including in providing effective support for homeless health.	• **A named clinical lead per home** providing a co-ordinated Single Point of Access**.** • **Weekly reviews and 24x7 support** across all our Care Homes • **Proactive calls on weekends** to high-risk homes across Harrow. • **On-call geriatric consultant** available in support. • **Co-ordinated PPE and testing** for staff and residents.	• **A specific focus in our recovery plans** on standing up services and support for those living with one or more Long Term Conditions, including as one of our top three priorities improving management of diabetes. • **Establishment of the LTC "home"** to support co-ordination through our PCNs of support and services.

3. Managing Population Health & Tackling Inequalities
Our Strategy

Our Joint Health and Wellbeing Strategy 2020-2025 aims to improve the health and wellbeing of the local community and reduce health inequalities across all ages. We believe in the context of Covid-19 recovery, it is more vital than ever that we work together to deliver these commitments.

Our vision for Harrow is that of a healthy, happy borough. All individuals should have equal opportunities to education, health care, healthy living conditions and access to healthy food and physical activity opportunities. These opportunities should be available and appropriate to all, at all stages of life. Maintaining a life course approach to this strategy allows for focus on opportunities and impact on all life stages.

1. **Reducing the gap in life expectancy:** There is currently a difference in life expectancy across the borough of seven years for men and nine years for women. Through the course of the five years of the strategy, and through the actions across the life course, we aim to decrease this gap. Particular actions that will contribute to this outcome are those addressing the economical stability of the borough, looking at school outcomes, and looking at the living environment in the borough. Ensuring a good start in life for all, regardless of ethnicity, socio-economic group, or gender, will play a key part in tackling inequalities.
2. **Focusing on prevention:** Through focusing on prevention we will work to increase rates of physical activity, address access to healthy foods, improve oral health, and ensure services are available to support early intervention and screening (e.g. through the Health Checks programme); stopping smoking; substance use; healthy sexual behaviours; and self care which is facilitated and encouraged. Through a focus on prevention we aim to halt the rise of obesity prevalence in both adults (QOF) and children (NCMP Year 6) by 2025.
3. **Improving emotional wellbeing:** Emotional wellbeing and resilience is vital for a healthy happy population. We will reduce recorded rates of anxiety in the borough (annual population survey) and in schools (developing schools questionnaire). Emotional wellbeing is important through out childhood and adulthood, for resilience and happiness. Actions across the life course in different settings - schools, workplaces, primary and community care - will tackle emotional wellbeing and increase access to mental health services.
4. **Ensuring an integrated approach to care:** Through an integrated approach, care will be delivered in the right place, at the right time. Across the care system, impact will be seen including through a reduction in attendances in A&E in adults. We will ensure care is centred around the patient in the community, through an integrated approach which breaks down organisational barriers. We will work to reduce variation across care provision, keep care local and improve access.

3. Managing Population Health & Tackling Inequalities
ICP Priorities and Success Measures

We will evolve and build upon the ICP's work on population health management, to ensure that for each of the areas identified in this recovery plan we have in place robust measures for managing our progress in the short, medium and longer term. We recognise that Covid-19 has introduced new risks; that we now have individuals presenting with more complex and severe needs; and that those recovering from Covid-19 will need additional support. CLCH is working in collaboration with Sollis and primary care colleagues in Harrow to establish a population health management programme that extracts and monitors multiple health metrics from the WSIC platform in order to provide PCN-level data to help our MDTs to prioritise high risk patients and prevent their deterioration and admission.

Pre-Covid Risk Stratification (WSIC)	Well	Stable	Rising Risk	High Risk	Specialist / End of Life
Definition	**77% of adult population** – patients with no long-term conditions or risks who may be most suited to transactional care e.g. routine appointments.	**19% of adult population** – patients with existing conditions who are not outliers for service use, or control their health. Likely to be suitable for routine Long Term Condition management at practice level.	**0.6% of total adult population** – patients with existing conditions who are also outliers for service use, or control of their health. Likely to be suitable for pro-active care at network or practice level.	**2.9% of the total adult population** – very complex patients with co-morbidities and / or high admission risk who may benefit from case management to co-ordinate their care more effectively.	**0.7% of the total adult population** – patients already receiving End of Life or Specialist Services and therefore probably not appropriate for case management or care planning.
Areas of Focus	**Prevention and strengths-based work**	**Early diagnosis and self-care**	**Primary care management and surveillance**	**Crisis management and unplanned care**	**Last phase of life**
Key Measures	• *Improvement in self-reported Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS)* • *Rates of Immunisation* • *Rates of Health Checks* • *Proportion Harrow residents report adequate access to health food (residents survey)*	• *Proportion of adults physically active (PAMS)* • *Uptake of community offers (Social prescribing evaluation)* • *Self-management of LTC* • *Early identification of dementia* • *Dementia prevalence* • *Access to Advice and Guidance* • *Care for children with ASD*	• *PAMS* • *LTC-related admissions* • *Early identification of LTCs* • *OTC and LCV prescribing* • *IAPT access 90% GP Access Hub Utilisation* • *Patient satisfaction: GP Access* • *Equipment costs* • *Device costs for enteral feeds* • *Phone advice and support* • *Early identification of cancer*	• *PAMS* • *In NEL attendances and admissions* • *LAS call-outs from care homes* • *Delayed Transfers of Care* • *Long length of Stay* • *Excess bed days* • *HCCT referrals (1500pa)* • *Mental Health DTOC* • *C2C* • *O/P follow up*	• *Patients dying in their place of choice*

3. Managing Population Health & Tackling Inequalities
Addressing mental and physical health inequalities

Tackling health inequalities will involve embedding the tools and approaches for effective population health management: The Harrow Public Health team is working with the NWL WSIC team to extract and analyse de-identified data sets for the improvement of Harrow's population health (including Long Term Conditions) and the reduction of unwarranted variation. The data will be used to determine key areas of focus for integrated care, broken down by practice and PCN.

Reversing the inverse care law: eliminating unwarranted variation in resources and outcomes: diabetes, depression and hypertension. We will continue to target hard-to-reach communities through multi-language communication; health and social care staff attending community meetings and hubs to deliver key messaging around health and well-being; linking into communities via patient champions; and proactive promotion of health checks across the population.

Supporting community resilience: working in partnership with Harrow Council and Voluntary & Community Sector to deliver support to Self-care and Long Term Condition management (in priority areas such as Diabetes and Dementia); to tackle health inequalities and stabilise mental wellbeing; and to expand shared education, training, and engagement of other key service areas such as housing.

Support to vulnerable people and families, including mental health and learning disabilities: our approach to identifying and reducing inequalities through support to vulnerable people and families in this period will include:

- **Improved access to Mental Health information, tools & advice** as part of community transformation, with specific work on Complex Emotional Needs (CEN).
- **Investing in long-term psychological support for frontline staff**.
- **A focus on BAME support** including trust-wide approaches being developed within CNWL.
- **Mental Health rehabilitation and step down models** to support people in the community.
- **Increasing access to Talking Therapies (IAPT)** and counselling including online therapies.
- **Increase access to CAMHS**.
- **An integrated crisis offer that enables community based support and patient choice** including Mental Health Emergency Centre at Northwick Park Hospital and new community based VSCE-delivered "crisis-havens".
- **Learning Disabilities recovery planning** managing the anticipated surge in demand for known patients alongside preparing for any backlog in LD Eligibility & Autism Diagnostic assessment; with remote advice & consultation available to non-specialist services.

3. Managing Population Health & Tackling Inequalities
Support to Children & Young People (1/2)

During the Covid-19 outbreak, we have worked hard to maintain our support to Children & Young People across Harrow. As we move into the recovery phase, we will be building on these developments and relationships, working together as the NHS and Harrow Council with key local partners including schools and the voluntary & community sector; expanding our digital offer; and implementing the THRIVE framework.

Harrow 0-19

- **Increased our digital offer** with new birth visits taking place virtually where possible.
- **Maintained essential elements of service** including where there are safeguarding concerns; and in support early of identification, e.g. via face-to-face Health Visiting.
- **Developed proactive linking with schools** to support them in both closing-down and to re-open, including re-establishment of immunisation programmes.
- **Child health and wellbeing duty line:** managing key health development checks and immunisations.
- **Maintained all essential healthy child contacts** as per community guidance and provide support and advice as required.
- **Followed up all new births where jaundice / low birth weight** or other health concerns were flagged.
- **Recovery of childhood immunisations** to pre-COVID levels as a minimum. We will analyse available data to support recovery and develop a robust communication programme emphasising the importance of immunisations and the safety measures we are taking in relation to providing them.

Looked After Children

- **Maintained Initial and review health reviews** virtually.
- **Ensured CYP had access to advice and support** as required.

Expanding the Thrive Framework

Harrow Horizons, our Emotional Wellbeing Service co-produced with children, young people and their families, and commissioned jointly with **the CCG and local authority**, has harnessed digital technologies to meet the challenges of Covid-19. Working with those up to age 18 (or 25 for CYP with special education needs and/or disabilities) it forms a key part of our Thrive Framework and brings together partners from across the system. We are now working with service users and the provider to explore how we can embed innovation and alternative delivery models as part of our commitment to Prevention and Early Intervention, and developing community resilience.

3. Managing Population Health & Tackling Inequalities
Support to Children & Young People (2/2)

Core CAMHS

- **Working with local partners to implement the Thrive model and update transformation plans** including early identification of concerns with children; and upskilling partners including schools, local authority, VCS and parents to ensure children have a comprehensive support network skilled and able to support their individual needs.
- **Working towards achievement of Long Term Plan goals** including recruitment of staff in line with mental health investment standard.
- **How we 'live with Covid' and increase service provision and footfall on-site** whilst managing social distancing and infection control across the CAMHS estate.
- **Bereavement support** under review and development, including earning from Grenfell.

Urgent Care

- **EAS review to scope long term provision**.
- **Surge in A&E presentations anticipated** as lockdown measures lift, with associated staffing plans and support from volunteers as appropriate.

Digital

- **CAMHS website / digital platform offer to be further developed** as part of longer term CAMHS communication & engagement project.
- **Covid-19 digital transformation to be harnessed as part of business-as-usual CAMHS provision** (increase in digital appointments from 15% pre-Covid to 80%).

Communication & Engagement

- **CAMHS-wide communication and engagement project being launched**.
- **Key stakeholders kept up-to-date** on service provision changes in response to evolving advice and guidance.

Collaboration

- **Discussions continue around pan-NWL opportunities and challenges** emerging from Covid-19.
- **Links with schools as lockdown measures are adjusted** to support and manage potential surges in referrals (e.g. social anxiety and school refusal).
- **Increased integration between the 0-19 Nursing Service and Harrow's Children's Centres**.

Community Paediatric Services

- **Recovery of our jointly-commissioned SALT and OT Services** embedding new ways of working across the system including in education and other settings, ensuring that the interfaces with families and schools are in place to undertake statutory assessments for children and young people with an EHCP.

4. Working together
What's worked well and learning from our Covid19 response (1/2)

It is easy to list the many changes that have taken place across Harrow since March 2020, to celebrate the way in which services have responded and transformed to meet the demands upon them, as well as to recognise the lessons-learnt both for future management of Covid-19 and future approaches to our health and wellbeing as a whole.

Whilst the rapid adoption of digital technologies is perhaps one of the most obvious effects of the outbreak, it is also just one example of how we have moved as an ICP from a process of piloting, at limited scale and over many months; to rapid implementation of major changes across the whole of Harrow in a matter of days and weeks.

Underpinning these more profound changes have been the thousands of daily conversations between colleagues across Harrow, supporting each other and those they are caring for, throughout the evolution of the pandemic.

We have seen our Primary Care Networks and practices come together as never before to work together and to ensure the resilience of our primary care system upon which the rest of our joint working relies; mirrored in the collaboration across broader acute, community, mental health, public health, social services and our voluntary and community sector to help safeguard our population and to continue to provide vital services to those in need.

There have been daily COVID Care Home calls between the LA, CCG, local public health, community providers to manage evolving care home outbreaks and to respond as an ICP - born out of a willingness to understand the detail of the problems facing our care homes and to apply strategic solutions which focussed on the operational issues that matter and how we could help each other.

And there have been frequent, often daily primary care leadership meetings between CCG and PCNs, with daily bulletins of key changes in guidance and response restructuring developments and weekly forums with the wider general practice workforce**.** All of this has set the context within which we have jointly developed the proposed recovery plan for Harrow.

However, we recognise that the coming period will bring new, as well as existing, challenges. As we re-open services both inside and out of hospital, the need to protect patients, service users and staff will continue to impact on our capacity to meet demand. Patients are likely to wait longer for referral and treatment, and as a result we need to continue to expand and build upon advice and guidance, self-management and broader community support services. At the other end of the spectrum, many people remain deeply concerned around using our services; from children and parents, to vulnerable older people, we need to reassure them our services are safe.

4. Working together
What's worked well and learning from our Covid19 response (2/2)

Our recovery plan recognises the importance of continuing this work, and particularly, of ensuring that those on the frontline continue to have the autonomy to make the decisions needed in the interest of the individuals and communities of which they are a part. There has been particular learning around how we protect our care homes and successfully shield those at greatest risk from Covid-19 infection, even as we also work on the wider health and wellbeing needs of individuals across Harrow as a whole. It is critical this learning is not lost, as we manage and mitigate the risks of future outbreaks nationwide.

We will ensure that we stand-up preventative services as a priority, including child immunisation and, over coming months, our resources for managing winter pressures; and build on the wider contribution of the voluntary and community sector in Harrow, including in social prescribing, supporting self-management, identifying and aiding victims of abuse, and managing the impact of Covid-19 on the wider socio-economic determinants of health.

We recognise the model for children is particularly complex as risks and profiles frequently evolve, children are dependent on their parents/carers to access services, and much of our school system currently remains closed. We therefore need to re-enable universal face-to-face provision to a greater extent, to pick up issues early, and to maintain a good balance between new ways of working and our safeguarding responsibilities. Whilst we have been able to move some new birth visits virtual, Health Visiting is particularly vital to identifying vulnerable families. We will be looking at how we introduce the Maternal Early Childhood Sustained Home-visiting (MECSH) programme to help strengthen this area, alongside increased used of digital interventions.

Social prescribing is already playing a key role in helping to stabilise long-term conditions and support individuals to live healthy and well, and we will be seeking to expand the current levels of collaboration between the voluntary & community sector and primary care across all areas of our response to immediate and future health needs. In this way we will ensure that primary, voluntary & community, NHS community and social services "wrap around" our patients and service users and provide a genuinely integrated set of services that support the outcomes that matter to them.

In addition, we understand the fundamental role that unpaid carers play within Harrow. In many cases they have been particularly affected by the lockdown and the need to suspend routine services and support, and we need to ensure that their needs are taken into account as we begin the recovery journey, alongside the ongoing health and wellbeing of those they care for.

Last, but by no means least, we recognise that we could not have done any of this without the commitment of our staff, across all health, local authority and voluntary & community services. Their welfare is a core part of our plan for the months and years to come.

4. Working together
Key developments since March 2020

At the start of the Covid-19 outbreak in London, a decision was taken to co-ordinate Harrow's response through the newly-formed Harrow Health & Care Executive, co-chaired by Harrow Council's Corporate Director of People Services and Harrow CCG's Managing Director, with senior representation from all local partners. There has been significant learning, with much more to do, but examples of the achievements across the partnership since the beginning of March 2020 include:

Integrated Care Partnership development

- **Weekly Health & Care Executive meetings**: escalating issues, developing shared plans, and co-ordinating our Covid-19 responses.
- **Relationships & Culture:** strong recognition of individual and team efforts across organisational boundaries, in supporting our communities through Covid-19.

Urgent response services

- **Rapid establishment of COVID 19 Hub:** during initial phases of outbreak.
- **COVID Rapid Response team:** created to support Care Homes and the Frail Elderly.
- **Development of Acute-based, Community-led Discharge Hub:** to ensure safe patient flow from hospital to community / home.
- **Mental Health Emergency Centres (Adults & CAMHS):** based at Northwick Park Hospital.

Primary care resilience

- **SITREP reporting in Primary Care:** overseen by our PCN Clinical Directors.
- **Practice Co-horting Plans:** to ensure sector resilience.
- **Home Visiting Services for Shielded Patients:** including phlebotomy and INR monitoring.
- **Pulse Oximetry Deployment and Monitoring Service:** with VCSE partners.

Support to care homes

- **24/7 Support**: established across Harrow Care Homes.
- **Proactive Calls**: on the weekend to 'high-risk' Homes.
- **On-call Geriatric Consultant**: available to support GPs (Mon – Fri, 8am – 8pm).
- **Urgent Local Testing**: arranged for residents and staff affected by outbreaks.

Robust testing arrangements

- **Expansion of Hub Activities**: to include COVID testing and patient monitoring.
- **Integrated Working**: with health and social care around testing in care facilities.

Rapid deployment of digital solutions

- **Online Consultations**: adopted across primary care.
- **Local Data Sharing**: between health and social care for Shielded Patients to ensure effective deployment of care teams.
- **Distribution of IT Equipment**: to support virtual consulting in General Practice.

Community resilience

- **Volunteering / GoodSAM App**: bereavement and mental health support.
- **Local Authority Community Hub**: co-ordinating food parcels and welfare support.

Mental Health

- **7-day working** for Community Mental Health Teams.
- **Cohorting and swabbing** on wards.

5. Planning for recovery and second wave:
Managing safety, risk, capacity and flow

Our priorities for Harrow build on the progress to-date in responding as a partnership to Covid-19, but recognise the specific challenges ahead, including in restoring access to services and support across our population to both shielded and non-shielded individuals, adults and children, and those requiring mental and physical health and care support.

The Covid-19 outbreak has put further pressures on a system already under financial strain and whilst we have been able to support each other to respond to the requirements of the Covid-19 throughout the last three months, we are already seeing the effects in relation to increased demands across a wide-range of services; and, in a number of cases, increased acuity in those now presenting who require our help and support.. Our key priorities are:

Managing Safety and Risk: across our population as a whole, including ensuring that effective measures are in place to support those living, working and receiving services in Harrow, whichever health or care services they require access to; and those who are in need of additional support, whilst being shielded, self-isolating, and / or recovering from a period of Covid-19 infection.

- **We will achieve this by continuing to develop our borough delivery model for ensuring that care is as safe as possible, with our PCNs working in partnership with Mental Health, Community, Social Care and Voluntary Sector organisations**; including “Virtual First”; robust programmes of staff testing; ensuring ongoing supply of PPE; supporting self-care; and implementing appropriate “zoning” within services – all to provide an environment in Harrow which is both safe, and recognised to be safe, by those who need to access help and those providing it.
- **We know a particular priority in Harrow will be continuing to support our many Care Home residents and shielded individuals**, with specific arrangements in place for them; but we also recognise that only by safeguarding the population as a whole will we be able to progress our recovery journey.

Managing Capacity and Flow: many of our services were already under significant pressure pre-Covid-19, and the restarting of services which were temporarily paused during the Covid-19 outbreak will create new demands.

- **Our Recovery Plan focusses on improving productivity through integrating our work and our teams**, “standing-up” services in a way which develops and transforms them and doesn’t just go back to how we were working before; and reducing emergency needs through proactive intervention in the community co-ordinated at the frontline. Critical to our success will be effectively supporting those with Long Term Conditions and tackling existing and new health inequalities across Harrow.

5. Planning for recovery and second wave:
Managing Safety and Risk (1/3)

Borough delivery model: ensuring that care is as safe as possible

Our PCNs are working with Mental Health, Community, Social Care and Voluntary Sector organisations to support the safe delivery of proactive, patient-focused care, including enhanced prevention and self-care programmes to enable people to live independently and well now and into the longer term. The same model will also support provide reactive care to our population as a whole, including shielded and non-shielded patients, those living in their own homes and those in residential and nursing care, recognising that as we move forward these groups are not fixed and we will need to manage effectively transitions between them. Our approach to managing safety and risk will be supported by a robust process of segregation, testing, information sharing, PPE, communications and training:

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5. Planning for recovery and second wave:
Managing Safety and Risk (2/3)

We will build on our PCN multi disciplinary team (MDT) model to co-ordinate our support to local people across all groups and care settings, including:

Zoning	Testing
COVID protected Ensuring that essential services continue to be delivered in safe settings. Contact will be virtual by default for proactive, routine and urgent care services. PCN level hubs central to the coordination of proactive care for this cohort. Where face-to-face is needed, these will be delivered in COVID protected zones with segregated teams within our out of hospital care settings to ensure robust infection control. Continued work in inpatient mental health settings to sustain and enable cohorting and isolation of C19+ patients who require inpatient mental healthcare.	**Patient Testing/Track and Trace** The COVID Hub team tests residents at local care facilities as well as developing results co-ordination protocols to update to GP records for all tests. This will be co-ordinated with our local track-and-trace programme.
COVID risk-managed Reactive urgent services to be managed within COVID risk-managed zones within General Practice, and across all health and care partners, supported by the escalated care hub (hot hub) with staff trained and confident in the use of PPE for this group.	**Staff Testing** Staff testing services will be established at multiple locations in Harrow, with the COVID hub acting as our primary testing site. Testing, initially for symptomatic key workers, is extended to asymptomatic as well as carer agencies.

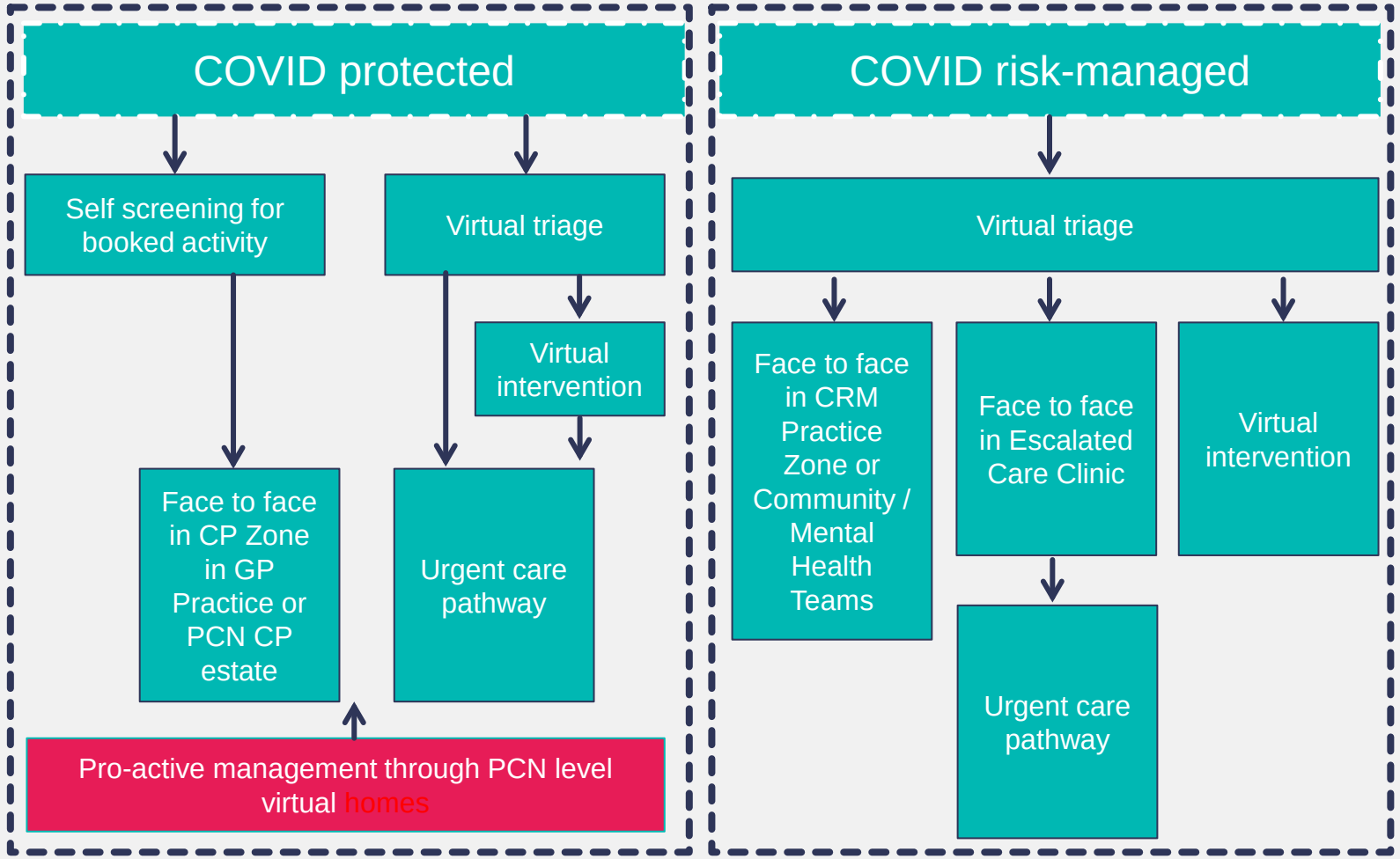
5. Planning for recovery and second wave:
Managing Safety and Risk (3/3)

We recognise that the Covid-19 status of individuals in Harrow requiring health and care support will change over time – including those who are being shielded, those whose infection status is unclear (symptomatic or asymptomatic but identified as having been at risk of being exposed) and those who are in recovery.

Our approach will ensure that our population have access to the services they need through a robust process of self-screening and virtual triage, with appropriate pathways for each individual to safeguard them, our staff, and other patients and service users.

To achieve this we will ensure high standards of infection prevention and control measures across primary care and community settings aligned with the specific pathways for COVID "protected" and COVID "risk-managed" patients: supporting GPs and community services wit digital access, PPE, re-design of estate and teams to meet these requirements and manage associated risks.

We acknowledge that these measures will put additional pressure on our capacity in this period. As such, it is critical that we fully engage patients and communities in managing expectations and demand; and deliver on the supporting transformation and integration aspects of our plan.



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5. Planning for recovery and second wave:
Support to Shielded Patients (1/3)

Our borough model for shielded patients and their carers is one that upholds patient safety and infection control measures at the forefront, promotes proactive management of health and care needs and supports the mental health and wellbeing of our shielding population and their carers.

The core components of the model are:

- **Proactive care planning and management of health needs: Overseen by long-term conditions "homes"** in each of our PCNs, all shielded patients will be assigned a case manager to coordinate their care needs and have a care plan in place for how their needs will be managed. This includes care planning and case management for shielded patients; ensuring appropriate CMCs are completed and care is coordinated. Where face-to-face contact is needed, the case management approach will ensure all needs can be addressed in one appointment.
- **Health and social care needs will be managed virtually by default, with the rapid deployment of new technologies to support remote monitoring** and home visits made for key monitoring and diagnostics such as phlebotomy and INR monitoring.
- **Where all virtual means have been exhausted and face to face contact is required, the case manager will ensure that all health and social care needs can be addressed in a single consultation** by drawing on the full MDT and providing these services in a COVID-protected only site to reduce insorfar as possible future infection risks.
- **An integrated approach with local council and voluntary and community sector partners, with welfare support coordinated with Harrow Council** including social care and a focus on the frail and elderly in particular.
- **Provision of dementia care in care homes and in people's own homes** – including post diagnosis support for patients and carers. A telemonitoring pilot is currently underway with Harrow Council (Mysense and Ethel), with the intention to proceed to full implementation post-completion. Integrated health and care services will also provide support through the virtual ward and the provision of VCSE social prescribers working with our partners in Harrow Community Action.

5. Planning for recovery and second wave:
Support to Shielded Patients (2/3)

We recognise that the most appropriate person to help support and co-ordinated the care of shielded patients will vary from person to person, and in some cases will be the individual themselves. We will focus on supporting GPs to make first contact whenever appropriate and to undertake a full consultation virtually, and to act as an enabler to request other teams attend where follow-up is required.

- **Urgent care primary care & non COVID urgent pathway***:* All urgent primary care needs will be met with a home visit from the registered GP Practice or a home visit from the community rapid response team; equipped with full PPE to maintain infection control. Where a patient needs to attend urgent care services on a face to face basis, their shielded status will be recorded in their care plan, and on entry to the urgent care service, they will be moved to a robust isolation zone from point of entry.
- **Mental health and well being:** The mental health and well being needs of our shielded patients will be overseen by the mental health and wellbeing "home" in each PCN. These hubs will be the central coordinating points for social prescribing link workers and volunteers in each PCN area. There are also three transformed CNWL Primary and Community Mental Health Hubs wrapped around the 5 Harrow PCNs.
- **The Social Prescribing link workers will be the conduit for shielded patients through to Harrow Action and their network for third sector providers**, ensuring that shielded patients are able to seamlessly access the support that they need. The Harrow volunteering service will be coordinated at PCN level, via the GoodSAM App to the following services (1) check in and chat (2) patient transport (3) community response (shopping and medication collection) and (4) NHS transport. They will also be the route through to Help Harrow for food where needed.
- **Proactive support, virtually through our mental health and wellbeing hub, will be central for this group.** The mental health and wellbeing hub will establish an integrated response with CNWL services for additional NHS services, aligned with further support options such as "check in and chat" function launched on 4th May for patients across CNWL who have been advised to shield and other vulnerable patients that are self-isolating.
- **Clinical Directors across WLT and CNWL are working together to align approaches around NWL memory services** which are not be able to operate in the same way as pre-COVID-19 due to the risks inherent in face-to-face appointments with older vulnerable individuals. This includes:
    - **Model staffing numbers** required to open services to all new referrals
    - **Develop a remote working policy** to conduct remote cognitive assessments either by video / teleconsultation; and re-open groups.

We are working together to manage the changes required operationally, so that the services can re-open to routine referrals on 1st July 2020.

5. Planning for recovery and second wave:
Support to Shielded Patients (3/3)

Our Mental Health and Community "Virtual Offer" now includes:

Mental Health

- **All patients under the Community Mental Health Hubs and Older Adult / Memory service who are shielding / isolating due to Covid-19 have been contacted by a member of the team** to provide support and advice.
- **All shielded patients are being offered the opportunity of a face-to-face appointment / consultation via Zoom or telephone consultation should they prefer.** They are supported in their decision.
- **All shielded patients in Adult / Older Adult Mental Health have been provided with a named worker** (care navigator or support worker) who keeps in regular contact and is able to arrange food deliveries and provide self-help materials.
- **Patients are discussed virtually at the daily virtual MDT** if there are any concerns.

Community Services

- **Technology is in place for virtual patient consultations** for example in areas such as diabetes and cardiology.
- **We are now moving to video conferencing for classes** such as Pulmonary Rehabilitation.
- **As required, shielded patients will be seen as a home visit**.
- **Where there is a the need for a patient to attend a clinic** for example to equipment requirements these will be at start of the day to avoid un-necessary contacts.

5. Planning for recovery and second wave:
Support to Care Homes

Supporting our care homes will involve a co-ordinated response linking the work of our PCNs with borough-wide co-ordination and assistance.

PCN MDT

- **A named clinical lead per home** to ensure a co-ordinated Single Point of Access (SPA) for homes.
- **Twice weekly reviews of patients** virtual where possible but face to face where clinically required.
- **Proactive support** including a range of primary and community disciplines for example regular health checks, podiatry, dental, continence advice.
- **Medicines optimisation** and re-use of medication.
- **Out of hours access** to GP support.
- **Advanced care plans** offered to all residents.

Central Co-ordination

- **Support for borough acute discharge.**
- **Central co-ordination of Harrow Care Home testing** and results.
- **Co-ordinated use of ICBs** for residents required to stay in isolation for 14 days following discharge from hospital.
- **Link with the PCN LTC Model** and admissions avoidance.

Borough Response (LA and NHS)

- **An integrated approach between the Local Authority and the CCG** to ensure that care homes have an on-going programme of training and education e.g. PPE, dementia care and challenging behaviour.
- **Accessing national funding to support gaps in infection control** and workforce.
- **Support for capacity planning**, quality and safety concerns, and safeguarding.
- **Linking with neighbouring boroughs** to ensure coverage and medical support for cross-border residents and transition to re-registration.
- **Healthcare training and seminars** at the quarterly Care Home Managers' Forum.
- **The Integrated Care Homes Group** currently meeting week-daily in response to Covid-19 will continue to meet regularly to plan recovery and deliver integrated models of care to care home staff and residents.
- **Support for care homes as independent / private businesses** to form a collaborative network for sharing information and responding collectively to the needs of the care home population and staff around training and development and quality improvement.
- **Daily COVID Care Home calls** between LA, CCG, local public health and community providers to manage evolving care home outbreaks and respond as an ICP.
- **Webinars** for care homes and carers.

6. Proactive Planned Care
Primary Care Networks

For pro-active planned care, our PCNs will continue to work to provide a coordinated and proactive approach to long term condition management. Five long term condition "virtual homes" will be established in Harrow, one for each of our PCNs, coordinating support to people with long term conditions on behalf of their registered GP. The purpose and functions of the long-term condition virtual homes will be:

- **Providing single points of contact and coordination within each PCN** for pro-active long term condition care, particularly Practice QOF requirements.
- **Innovating with, and deploying, available technology** to support remote monitoring and self-management of patients with long term conditions.
- **Use of apps and online services will be provided** for services such as falls prevention that were previously delivered in face to face class settings.
- **Remote classes for falls and rehab services** harnessing online platforms to make help and support accessible as part of community recovery plans.
- **Decision support tools will be made available to patients** to use in their own homes.
- **We will coordinate a borough-wide deployment of telemonitoring devices** to support patients in managing their conditions.
- **Delivering a personalised, case management approach** working in collaboration with system partners, to plan and coordinate care needs, minimising face to face contacts and where contact is needed, that all patient needs can be met in a single consultation.
- **Shared approaches to health checks and immunisation** to support uptake.

- **Using appropriate estate within the PCN to deliver services in COVID protected "cold sites" for:**
  - **Pro-active and preventative services** (such as flu immunisations).
  - **Out of hospital care** (community cardiac clinics, audiology services, physiotherapy etc.).
- **Coordinating key monitoring and diagnostic services for shielded patients** in the PCN area (phlebotomy, INR etc.).
- **Coordinating across the PCN self-management and expert patient programmes.** There will be the inclusion of the Expert Patient as a dedicated team member within each locality model, working along side care co-ordinators.
- **Revised launch date for Harrow transformation community mental health hub**, factoring in learning from Covid-19 response e.g. 7 day working; virtual offer.
- **Psychological support to frontline staff** as part of NWL STP approach.
- **CYPMH working with local partners to implement the Thrive model** with early identification of concerns with children and upskilling partners including schools, local authority, voluntary sector and parents to ensure a comprehensive support network skilled and able to support individual needs.

6. Proactive Planned Care
Proposed Model of Care

The following summarises our proposed model of care for supporting patients to access and professionals to deliver proactive care in a way which is integrated around the needs of individuals and our communities:

Triage-led reactive care

- Triage-led model delivered via digital as far as clinically possible
- Access to same day consultation for all
- Face to face settings determined by blue/amber/green/shielded status to ensure safe care
- Health need resolved within minimum time and with minimum settings
- Rapid access to acute specialist advice to reduce
- 8 – 8, 7 days a week

Team-based proactive care

- Focus on prevention and proactive care
- Timely identification of conditions
- Use of population health data to prioritise care and improve outcomes
- Care plan-led holistic physical and mental health care
- Care delivered on a team basis
- Specialist input and management of disease accessible in the community

Team-based care in the home

- Responsive, co-ordinated delivery of proactive care
- Maximise use of the multi-agency team and care planning to deliver person-centred care
- Care plan at the centre of care delivery
- Minimise individual and episodic contacts with services
- Use of telemonitoring and equipment to support prioritisation of clinical review and decision-making

Shielded care

- Proactive monitoring, holistic physical and mental health care, specialist input and management of disease
- Proactive co-developed care plan in place that supports self-care and wellbeing
- Minimise face to face contact with health and care professionals, working as a team to support the patient
- Identification of shielded group via SCR to maximise safe delivery of urgent/unplanned care

6. Proactive Planned Care
Long-Term-Condition Management

Analysis of Harrow's population health data has highlighted the importance of integrated approaches to tackling diabetes, respiratory conditions and child asthma as part of our recovery plan. However, we also recognise that the Covid-19 outbreak has also created new pressures and demands. As such, we will:

- **Ensure early identification and proactive management of the broader health impacts of Covid-19** for those who are now or will be in the future recovering in the community. Our GPs are creating a new Practice-based risk register for those patients who were hospitalised with Covid-19 infections, particularly those who received Intensive Therapy Support, to allow close monitoring and to identify and manage the full range of post-Covid physical and psychological complications
- **Identifying where resource pressures are likely to occur** including reviewing the capacity of existing respiratory teams and the impact as we re-establish broader community services, such as podiatry, where we are already experiencing a rapid pick-up in demand.
- **How we re-assure individuals in Harrow living with one or more long term conditions around the availability and safety** of the services upon which they rely.

Diabetes

- **Re-establishing the roll out of the REWIND programme**, identifying Diabetes Clinical Champions at a Practice level to work alongside the Specialist Diabetes GP and nursing Community teams.
- **Identifying those patients within diabetes plus at least one other cardiovascular or respiratory condition** and ensure both care planning and case reviews are in place at three-monthly intervals.

Respiratory

- **Each practice to review its respiratory disease registers** to ensure those patients tested positive for COVID 19, and admitted for to hospital as a result, are included.
- **Care Planning and Case Management of patients with COPD, post-COVID airway damage, or chronic respiratory illness** undertaken at three- to six-monthly intervals, depending on the severity of the condition.
- **Patients on home-based oxygen therapy should have their case reviewed** monthly by community respiratory teams.

Child Asthma

- **Practices to ensure their Asthma Registers are updated** following the COVID outbreak.
- **Care plans to be in place for all children diagnosed with asthma**, and who are receiving regular medication.
- **Any child admitted to hospital with asthma or a respiratory condition will be reviewed by their GP within 48 hours of discharge**, with care plans updated accordingly. Post admission reviews to be undertaken regularly by the practice teams.

6. Proactive Planned Care
Advice and guidance, palliative care, integrated discharge

In addition to the development of long term conditions "virtual homes", borough-wide leadership will be provided to develop proactive planned care in the following areas:

Advice and guidance

We will implement a staged roll out of IT-based *Advice and Guidance* system for Primary Care with an initial focus on top 5 specialities; MSK, Gynaecology, Dermatology, Cardiology, Gastroenterology. Further specialities will come on stream as processes are embedded and assured.

Through the wider PCN partnership organisations clinical expertise will be deployed to undertake a thorough re-evaluation of the needs of those patients on outpatient service waiting list for six months or longer. This expertise can also be used as part of a PCN-based Advice & Guidance service as well as localised specialist clinics.

Development of PCN-based outpatient speciality services such as dermatology and cardiology.

Palliative care services

We will take forward the learning from COVID crisis on palliative care services by developing a seamless integrated palliative care model between acute, community and primary care.

We will define and secure the role of hospice services in the Palliative Care system as one which is leading system integration.

Palliative care and End of Life funding streams will be aligned to create single, merged budget across the system. This will be supported by the creation of a Palliative Care Board with PCN representation to determine budget spend and system development.

Integrated discharge

Integrated discharge will be maintained and further developed by the Integrated Discharge Hub at LNWUHT.

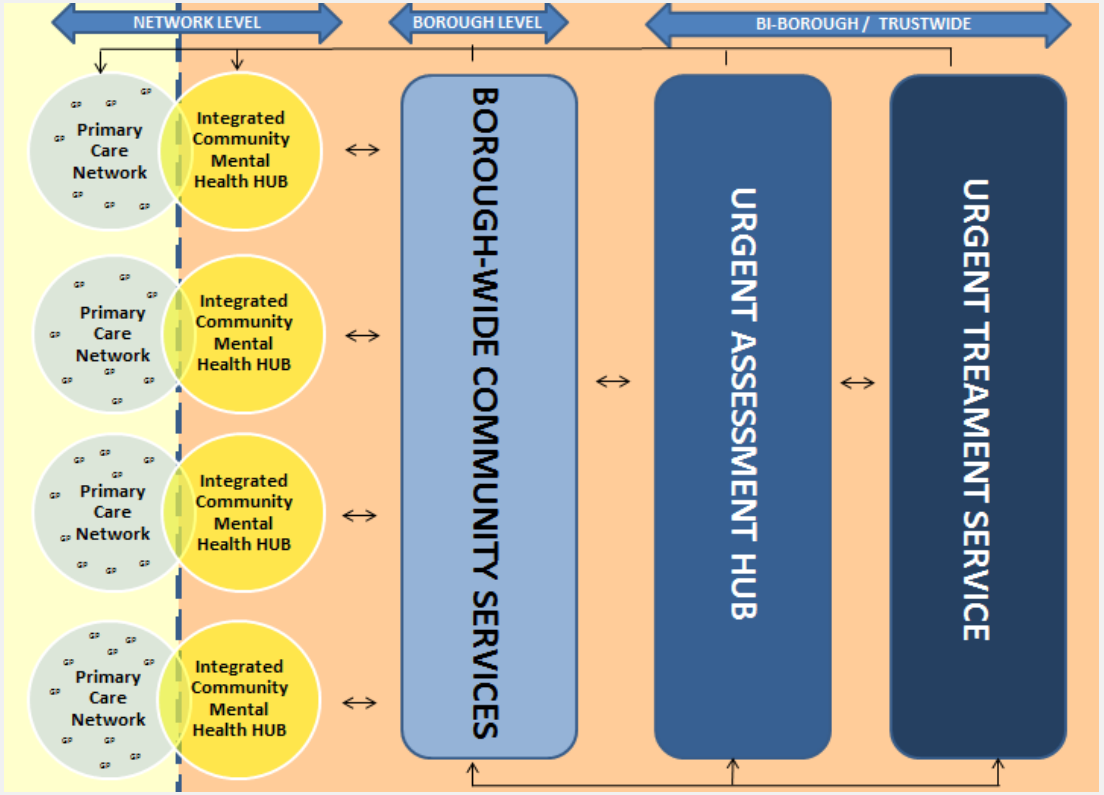
The scope of the hub will be expanded to include elective and non elective patient discharges and non acute-based bedded services will be included in the discharge hub's remit; facilitating discharge of all patients.

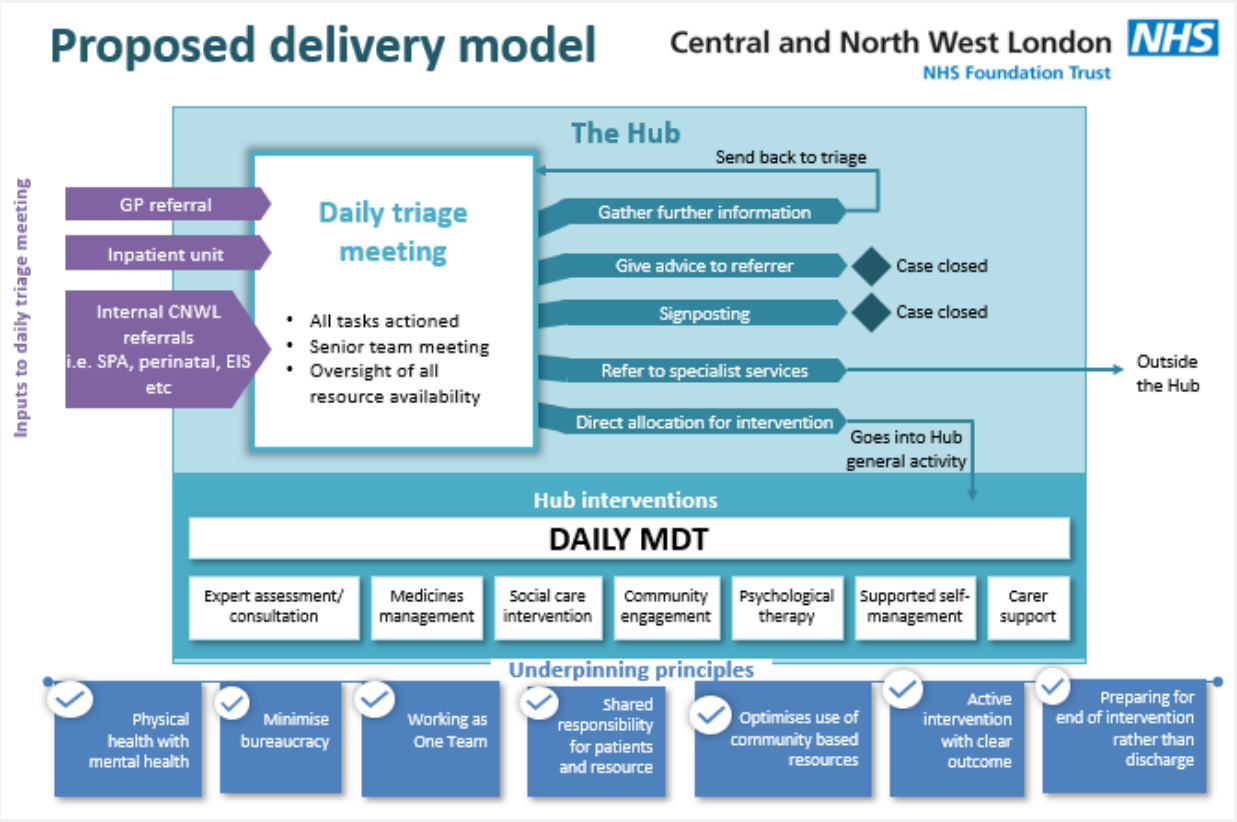
The discharge hub will be aligned with PCN level long term condition "homes", as well as our *Whole Systems Integrated Care* service. This will support the tracking of patients from primary care, through acute services and back to community.

Defined non elective pathways will be in place with anticipated LOS for common conditions.

6. Proactive Planned Care
Integrated Primary and Community Mental Health (1/2)

We will launch our integrated primary and community mental health model aligned to PCNs, incorporating learning from Covid-19 and building on gains made during caseload reviews as part of our emergency response, whilst delivering on the mental health commitments of the Long term Plan. This will incorporate our experiences of 7 day working and development of our "virtual" offer, learning from staff and patient feedback during the Covid-19 crisis, ensuring accessibility to those who are shielding or C19+ in future





6. Proactive Planned Care
Integrated Primary and Community Mental Health (2/2)

Mental Health Support Teams (MHSTs)

Mental Health Support Teams (MHSTs) will provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing.

- Harrow has submitted an expression of interest in implementing mental health support teams in 2020-21 (Wave 3).
- The vision is to deliver innovative support for vulnerable children and young people across Harrow.
- Our focus is on a place-based approach that targets the entire community and aims to address issues that exist at the neighbourhood level.
- The MHSTs build on the strong local collaboration between the Harrow CCG, Harrow Council, Public Health, the Young Harrow Foundation and local charities including Mind in Harrow, Barnardo's and the local CAMHS provider (CNWL).
- Teams will be led by CNWL, who are currently providing child wellbeing practitioners in Harrow Schools.

7. Integrated Community Based Urgent Care
Our approach

Our integrated community-based urgent care model (reactive pathway) will combine our borough and PCN-level response. It will operate on "Talk before you walk" principles, with a virtual first online triage by the registered GP or 111 service with support for self-care provided where this is clinically appropriate; and will involve a fundamental redesign of Urgent Care services in order to meet the system requirements post Covid-19. The core components will be:

- **Enhanced access to Primary Care** to reduce reliance on Urgent Treatment Centre capacity.
- **Embedding the use of Virtual Appointments** wherever appropriate, ensuring equality of access to vulnerable groups such as disabled residents, homeless people.
- **Enhance and promote the effectiveness of NHS 111 services** and align to GP Access; with 50% of GP Access Centre appointments given to NHS 111.
- **Reduce capacity for Walk in and Urgent Treatment Centres** – move to appointment-only functions where possible.
- **Re-examine the Acute Hospital Front Door**, and non ambulance services; including our requirements post-Covid-19.
- **Establish GP triage function for Harrow**, supporting NHS 111 access.
- **Maintain the "Virtual First and Foremost" approach**. Single, virtual triage model based at the GP Access Centres or PCN based.
- **Re-designed Mental Health Urgent Care offer**, meeting Covid-19 recovery principles and local needs as well as delivering against the Long Term Plan objectives around enhancing community-based MH crisis care and alternatives to A&E / admission.

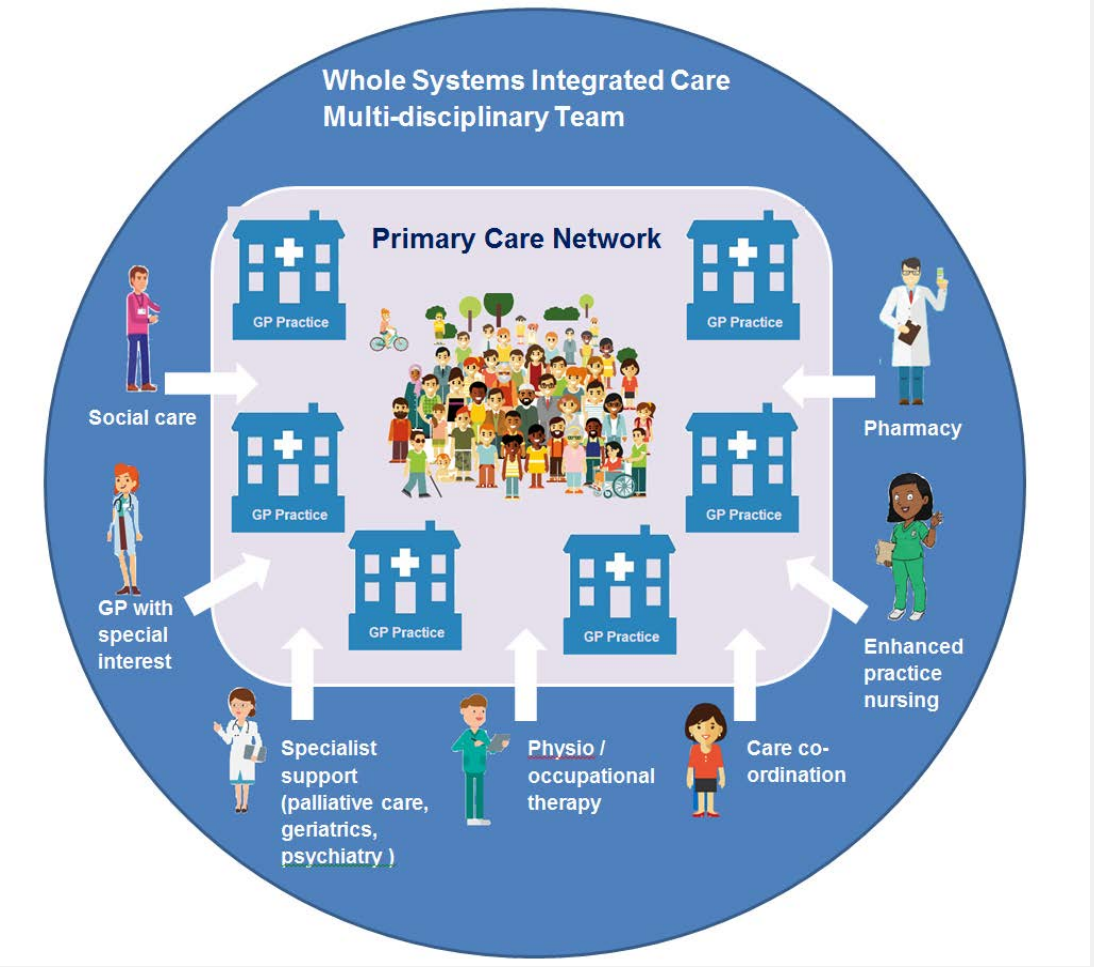
- **Enhancing Same Day Emergency Care (SDEC) pathways** to cover community-based intervention – referral to acute only where complex diagnostics or Consultant examination is needed.
- **Virtual SDEC chair or bed in patients home** or place of residence using telemonitoring and community rapid response service.
- **Discharge Hub able to take ownership of patients in Emergency Department** working on the premise that all patients can be discharged until proven otherwise.
- **Extend the functionality of the Advice and Guidance systems** to include Urgent Care. Make better use of Physician of the Day, Surgeon of the Day, and "Consultant" of the Day model to deploy Advice and Guidance and reduce referrals.
- **Enhanced, integrated pathways for palliative care** building on the experience of Covid-19 to-date, and incorporating feedback from frontline staff, carers and relatives.

7. Integrated Community Based Urgent Care
Multi-disciplinary working

Escalation of LTCs, MDTs, and integrated admission avoidance including social care

In delivering integrated, community-based urgent care, each PCN will be supported by our whole systems integrated care service.

- **At the heart of the service will be an MDT, including community nursing, mental health and social care** building on principles and practice of joint working established both before and during the Covid-19 outbreak.
- **This will provide integrated admissions avoidance** for complex long term conditions and frail patients.
- **The team will bring together the MDT around each Primary Care Network** to support GPs in out-of-hospital care management.
- **The service is consultant-led** as part of a borough-wide service with the MDT aligned to each PCN.
- **Rapid response services will be integrated within the MDT**, supporting urgent care needs and working to support patients staying in their own homes.



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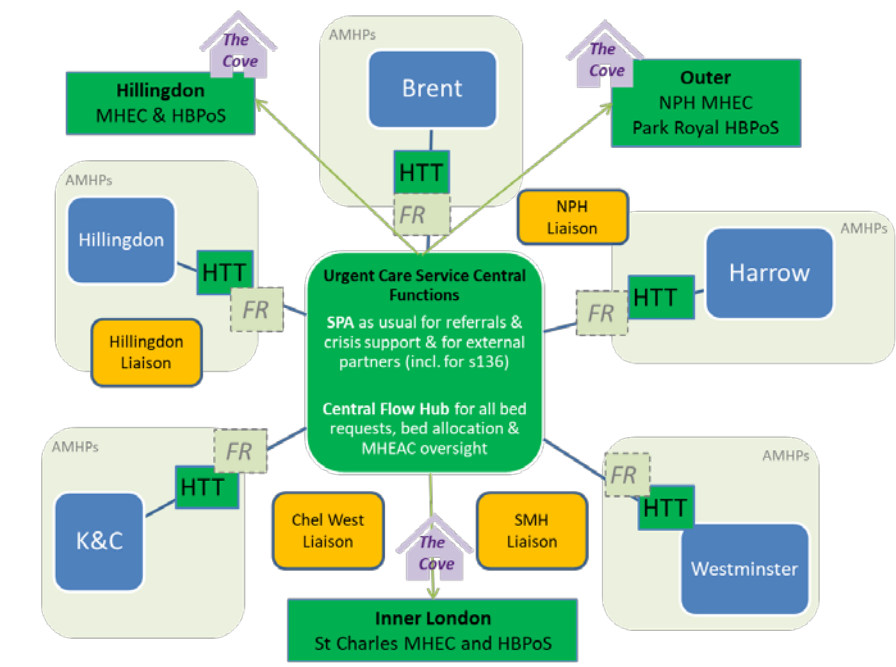
7. Integrated Community Based Urgent Care
Mental Health

We will deliver our Mental Health Urgent Care Service redesign embodying our recovery principles, responding to local complexities and enhancing the community based crisis offer (including alternatives to A&E and admissions). As part of our recovery plan we will develop the NWL model to ensure all required functions are in place and accessible in Harrow, including learning from Covid-19, with the Cove running a virtual offer at present to enable access for those requiring support.



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8. How we will support implementation
Supporting the wellbeing of our staff

During this period there have been increased concerns, uncertainty and sadly deaths amongst our staff members.

We will support staff to manage their wellbeing by helping staff with approaches, changes and understanding of how to manage what is within or beyond our control.

IAPT Service: available to staff in Harrow

- A staff offer, tailored around the COVID situation;
- A trained counselling team, experienced in working in bereavement counselling;
- Support for post traumatic stress disorder (PTSD) for those frontline professionals experiencing trauma daily;
- Support for anxiety and depression, including anxiety caused by loneliness;
- Strategies to deal with isolation and uncertainty, and how to lift the mood.

Self Help

- **Silver Cloud** is an online provider offering guidance or packages that staff can work through in their own way (with a specific Covid-19 support package).
- **NHS Our People** offers support for the health and care workforce including nurses and other frontline staff who need support with their mental health during the Covid-19 pandemic.
- **Good Thinking** offers a Covid-19 specific response to Londoners feeling anxious, stressed or struggling with other mental health concerns in response to the pandemic.
- **Headspace** offers a science-backed app in mindfulness and meditation, providing unique tools and resources to help reduce stress, build resilience, and aid better sleep. The offer is free access to all NHS staff with an NHS email address until 31 December, active now.

Throughout this process we will take every opportunity to address parity of esteem across the care settings, such as the many carers working across the care home and home care sector in Harrow, including co-ordination and engagement through Harrow's Social Care Portal: a dedicated app for the adult social care workforce to support staff through the coronavirus pandemic, it acts as a single one-stop shop providing the latest guidance and advice including learning resources, discounts, and resources to support mental health and wellbeing.

8. How we will support implementation
Developing integrated training and education

There is a commitment across Harrow to building on the joint learning and sharing of know-how which have underpinned our response to Covid-19.

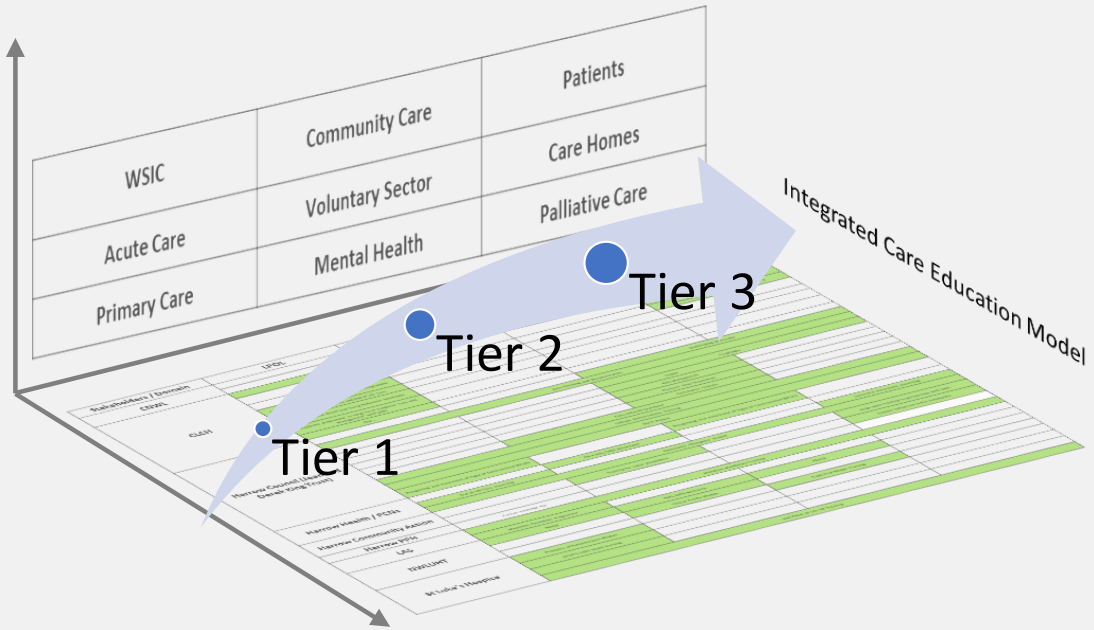
Formal and informal networks have both played a key part in this: including regular joint system meetings, rapid cascading through instant messaging services, shared communications and wide-reaching virtual GP forums. These have been supported through well-attended virtual learning sessions, organised around the need to ensure convenience and accessibility for all relevant staff.

This rapid learning has translated directly into existing and new service delivery and we believe there is a significant opportunity to extend this in the recovery period to promote cross-organisational and multi-professional joint training as part of the "new normal".

The ICE Project set up by the CEPN / Training Hub, resourced by and in partnership with the ICP, has scoped the current training and education landscape in Harrow for frailty, LPOL, dementia and care homes and produced recommendations across three tiers:

- **Tier 1:** *Those that require general awareness.*
- **Tier 2:** *Those who encounter people living with frailty, dementia or approaching end of life through their work but who would seek support from others for complex management or decision-making.*
- **Tier 3:** *Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for care delivery.*

Education and training are key enablers of doing things differently and will be a core part of supporting our shared recovery in Harrow.



The North West London health and care partnership

8. How we will support implementation
Supporting our Primary Care Networks

Our PCNs are central to the delivery of this plan for Harrow. Ensuring that the right capability and capacity is in place is critical, and will focus in the following areas:

- **Use of population health data:** Population health data will be provided on a monthly basis, by Harrow CCG and in collaboration with Harrow Public Health team. This will enable PCNs to direct resources appropriately and take a data driven approach to service transformation.
- **Quality improvement:** Coming from a strong foundation of collaboration for quality improvement, as demonstrated through the successful ERM approach in 2019/20 which saw demonstrable improvement in management of non-elective referrals and A&E attendances, PCNs have been accelerating their collaboration through the Covid-19 period. The establishment of the "home" approach in each PCN, providing leadership and coordination functions for mental health, care homes, long term conditions and child health builds on these strengths, bringing together clinicians to raise quality, share approaches and agree best practice models of care.
- **Clinical leadership across and within the PCNs:** PCN CDs have played the central leadership role within their PCNs in ensuring primary care resilience through the Covid-19 pandemic. They have established cohorting plans for each of these areas, and review daily SITREPs from their Practices. Through the SITREP data they have been pro-actively providing support and guidance in terms of work flow, demand management, clinical support and workforce matters. Twice weekly leadership meetings between the CCG and PCN CDs have enabled this clinical leadership to thrive across PCNs and provide robust information exchange and joint leadership in the development of the new care models. This leadership role will continue to build as PCN clinical directors lead the development of integrated services within their PCNs, with General Practice at the heart and wider MDTs formed in a population health approach.
- **Team development**: Through the transitional period of implementing the out of hospital recovery plan, team development is essential to bring our primary and community care teams on the journey and support the integration of local teams supporting defined populations within PCNs. Our approach to team development will build on an MDT model to develop working relationships that will be central to our overall approach to organisational development in the context of integrated care.
- **Flexible workforce and new roles:** PCNs will increasingly look to the capabilities and capacity of their total workforce, rather than focusing at a practice level. The development of PCN hubs will align skill sets across the PCN.
- **Use of our estates:** Using our estates in different ways to minimise infect risks and create Covid-protected areas for a shielded patients will mean that we align the local workforce to patient need and to where services can be delivered safely in the future.

8. How we will support implementation
Developing Harrow Integrated Care Partnership

We will continue to develop integrated working across Harrow through the Harrow Health & Care Executive and Harrow Joint Management Board.

- **Building effective, fully operationalised ICP will require us progress and activity across a range of areas simultaneously.** This includes reconciling the challenge of managing the current, day-to-day reality with re-imagining that reality, recovering services in ways which support our integration agenda.
- **It also requires a system-wide response: A system is built on the interactions of its parts.** All parts are inter-dependent and the system needs all parts to work well together. As such, it cannot be about one part of the system "taking over" the others. It is about building on our alliance of commissioners, providers, and the communities they serve, starting each and every time with how best to support the long-term health and wellbeing of the people of Harrow.
- **We have developed and agreed a clear framework to understand and progress the next steps we need to take, across all parts of our system, in support of our short, medium and longer term goals:**
  - **Leadership, Finance and Governance:** The ICP represents a significant challenge to traditional organisational and statutory boundaries of responsibility and it requires significant strength and depth of leadership to work together for the benefit of the system. We will continue to develop our joint governance structures and processes on empowering the right people making the right decisions at the right points. The financial pressures within Harrow are particularly severe and growing, and for the ICP to be a success, financial structures and decision-making will need to be similarly aligned to support the objectives of this plan.
  - **Culture and Behaviours:** The development of an ICP cannot be achieved by simply changing system structures and processes, but requires people to continue to come together around a shared vision and shared outcomes. This means building deep levels of trust and understanding, enabling staff and patients to navigate through the complexity of our current systems and come up with new ways of working, as has been reflected in our Covid-19 response.
  - **Organisational Structures and Management**: It is very unlikely that any ICP will take the form of a traditional organisation, and certainly not in the foreseeable future. The ICP will require a pragmatic set of structures and processes to operate effectively, ones which priorities and incentivise collaboration.
  - **Integrated Design, Planning and Delivery**: Sitting across all of these areas, is the need for an integrated capability to co-produce change in the Harrow system, and to see future planning through to the effective delivery of shared, priority outcomes; including management of individual and collective risks on behalf of the partner organisations.

8. How we will support implementation
Our key enablers

Many of the critical enablers of this plan remain the same as in the pre-Covid period. Some, such as our digital capabilities, have been developing at pace. Our experience is that there will be a number of other key steps to enabling further transformation of services, infrastructure and outcomes, at pace, including:

1. **Nominated leads from across the system ensuring we maximise reach and impact:** individual, named SROs for each area of the Harrow plan, drawn from the organisations and individuals that make up the partnership, but each empowered to operate on behalf of the system as a whole.
2. **Agreeing and implementing effective, governance, decision-making and funding agreements:** co-ordination through the Harrow Health & Care Executive supported by and supporting the work of the Harrow Joint Management Board and newly reconstituted Clinical Leadership Board, recognising the key role that clinical leadership has played in Harrow throughout our response to-date; and phased implementation, together with a shared approach to managing required financial resources and any associated service pressures.
3. **Using Population Health Management data to target our effects effectively:** including the current work being led by CLCH with primary care partners to prioritise and co-ordinate support to high-risk grounds.
4. **Developing our shared approach to risk management:** capturing the key risks facing us individually and collectively, in relation to both day-to-day operations and delivery of our updated plans, and managing these jointly – building on the work, support and relationships which have been developed as we have jointly responded to Covid-19.
5. **Co-ordinating support to our communities through our PCNs and VCSE partners:** investment in primary care and multi-disciplinary working to support improved mental and physical health and wellbeing. Working together, our five PCN Clinical Directors will continue to enable innovation across the networks, including realising the vision of virtual “homes” to support key groups within our population.
6. **Working in partnership with our communities:** including proactively securing feedback on recent experiences and our proposed plans, and co-producing future solutions through active engagement of the population of Harrow in understanding and shaping how we will respond to the challenges of the coming months, with our practices playing a core role in engaging individuals and communities alongside established channels including those of Harrow Council.

8. How we will support implementation
Our immediate priorities

- **Confirm and communicate latest borough testing and Track & Trace plans.**
- **Confirm Infection Prevention and Control arrangements** in place across all care settings.
- **Implement Covid-19 Lessons Learnt** in consultation with staff and patients / service users.
- **Identify areas of increased demand** (incl. impact and dependencies) and immediate system-wide measures to manage flow, aligned to NWL sector recovery plans.
- **Develop our shared System Risk Log and resource plans.**
- **Ongoing review of support for Shielded Residents**.
- **Accelerate programmes of support for learning disabilities, prevention, self-care and social prescribing.**
- **Development of MDT care models and virtual "homes" at PCN level** covering:
  - **Long Term Conditions**
  - **Mental Health and Wellbeing**
  - **Children and Young People**
  - **Care Homes**
  - **Frailty**
- **Reconstitute the Harrow Clinical Leadership Board** to reflect our evolving health and care priorities.
- **Refresh Terms of Reference for Harrow JMB and HHaCE** in line with the priorities of our Recovery Plan.
- **Develop our overall communications and engagement plan** working across the partnership to ensure key messages reach those in need.
- **Establish our approach to integrated education and training** building on the ICE work completed in Harrow before the Covid-19 outbreak.

8. How we will support implementation

Developing Harrow Integrated Care Partnership: our next 100 days