Harrow BCF narrative plan template

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The details of the 2021/22 BCF submission has been shared with and endorsed by the Harrow Health and Care Executive (HHaCE), the membership of which includes all local providers, the CCG and Local Authority, including the DPH, the voluntary sector and representatives of patients' groups.

The details of the submission have been shared with the Chair of the HWB and agreed by the Chief Executive and Managing Director of the Harrow Integrated Care Partnership in advance of the presentation of the report to the Harrow Health and Wellbeing Board for approval on 23rd November

The metrics were presented to the Health and Care Executive HHaCE, the Harrow Integrated Partnership Board and the local authority on 25th October.

The comments and discussions were incorporated into the draft submission which was presented to the HHaCE on 12th November

Executive Summary

Priorities for 2021-22

The objectives of the Harrow Health and Care System (ICP) in 2021/22 are:

- Establish integrated, out of hospital teams at a neighbourhood level
- Take action to address health inequalities in Harrow
- Improve outcomes for the Harrow population and reduce variation

The following schemes, which are being implemented during 2021/22, directly support performance against the BCF Outcome Metrics.

The Development of Harrow's Integrated Care Programme (ICP)
Harrow's ICP has developed rapidly during 2021/22, accelerated by the need to respond to the challenge presented by the pandemic to the local health and care system.

The 100 Day Plan for the development of Harrow's ICP is attached as Appendix A.

Improving the Efficiency and Stability of Discharges from Acute Care
The main focus, during 20/21, of service development to improve the discharge process has been the implementation, led by the acute trust (LNWUHT), the community provider (CLCH) and the local authority, of an Integrated Discharge Hub (IDH) at Northwick Park Hospital.

This, with the restructuring of ASC teams, has succeded in reducing lengths of stay (LoS) and improving the stable discharge of patients from Northwick Park Hospital (LNWUHT).

Strengthening the Management of Long Term Conditions
The Frailty Pathway is the first priority for delivery of the ICP's objective of establishing integrated, out of hospital teams at a neighbourhood level.

The focus on frailty services will continue throughout 21/22, with further development of the MDT approach to care planning 15% complex / frail patients and the model for integrated falls pathway the key deliverables.

Key changes since previous BCF plan

Service Development

- The ASC SW teams were restructured to increase capacity to deliver reablement to support quicker hospital discharge and reviews with appropriate support in the community.

- ASC adopted a strengths based model embedded through a phased approach, initially with the early intervention and support team, followed by the Locality teams and is now being delivered by the Hospital SW Team and Promoting Independence Team (PIT). The Teams have undertaken 3 Conversations training to support successful transitions and improve the patient's journey from the acute setting into the community through the delivery of intensive support with a focus on outcomes, and support plans that are person centred and co-designed with the patient and carer.

- The development and embedding of Integrated Discharge Hubs enabled seamless working – demonstrated by metrics. The focus to be on the patient experience and other elements within the system e.g. paperwork and GP calls

A key service development during 20/21 has been the implementation, led by the acute trust (LNWUHT), the community provider (CLCH) and the local authority, of an Integrated Discharge Hub (IDH) at Northwick Park Hospital.

The aim of the IDH is to reduce lengths of stay (LoS) and ensure the safe discharge of patients from Northwick Park Hospital (LNWUHT).

The hub ensures:

- 7 day service with daily huddles and discharge hub accountability has resulted in a higher number of complex/specialist patient discharges

- Close working with wards has improved patient flow / reduced pressure on hospitals

- Reduced number of Delayed Transfer of Care (DTOC)

- Daily huddles ensure earlier identification of risk – thus near miss rather than harm to patients

- Whole systems working approach – with accountabilities and responsibilities

- Collaborative working has resulted in "working in the best interests of patients" and improved relationships

- Defined escalation processes e.g. Intermediate Care Escalation (ICE) to support discharge teams find a rehabilitation inc. neuro bed.

- More efficient out of borough placements/discharges, minimising bed blocking.

- Single site NWL brokerage via hub reducing delays and process hand overs

- Introduction of the Intermediate Care Escalation Hub (ICE) for support with complex discharges and access to all commissioned community beds across NWL

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area

- The BCF Plan was agreed by HHaCE and recommended to the Health and Wellbeing Board for agreement.

- The BCF has been incorporated into the ICP plan.

- The progress of implementation will be managed by the ICP's Frailty Workstream.

- Issues with delivery will be reported to the HH&CE for discussion and the agreement of remedial actions.

- The BCF Outcome Metrics will be included in quarterly reports to the HHaCE on the Harrow system's performance against demand, capacity and outcomes metrics.

- Quarterly reports on the implementation of the Frailty Workstream's action plan, including the BCF, will be presented to the HHaCE.

- Performance against BCF outcomes and the HHaCE's discussions of implementation plans will be included in its reporting to the ICS through NWL's assurance process.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- ***Joint priorities for 2021-22***
- ***Approaches to joint/collaborative commissioning***
- ***Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.***
- ***How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.***

There is an overarching Section 75 Agreement between the NHS and Council which allows collaborative commissioning arrangements.

The ICP 100 Day Plan (see Appendix A) was presented and agreed by the HWBB. ICP priorities and governance arrangements are in place to deliver outcomes for Children and Young People Health, Older Adults and Care Homes, Learning Disabilities, Mental Health, Population Health and Inequalities to support locality based service delivery.

The ICP has undertaken an extensive public engagement, 'The Harrow Conversation' which will contribute to informing tackling inequalities.

The participants in Harrow's health and care system are co-producing a new model of reablement which will be jointly commissioned.

The Discharge to Assess brokerage process is led by the LA who purchase placement on behalf of the CCG.

The Frailty Pathway is the first priority for delivery of the ICP's objective of establishing integrated, out of hospital teams at a neighbourhood level.

There are a range of ASC and health services to support safe and timely hospital discharge, which have been reviewed and remodelled to ensure that they contribute to an efficient discharge process. For example:

- The ASC SW teams were restructured to increase capacity to deliver reablement to support quicker hospital discharge and reviews with appropriate support in the community.

- ASC adopted a strengths based model embedded through a phased approach, initially with the early intervention and support team, followed by the Locality teams and is now being delivered by the Hospital SW Team and Promoting Independence Team (PIT). The Teams have undertaken 3 Conversations training to support successful transitions and improve the patient's journey from the acute setting into the community through the delivery of intensive support with a focus on outcomes, and support plans that are person centred and co-designed with the patient and carer.

- The development and embedding of Integrated Discharge Hubs enabled seamless working – demonstrated by metrics. The focus to be on the patient experience and other elements within the system e.g. paperwork and GP calls (see Executive Summary above)

- An approach to joint funding the D2A to ensure a better experience for citizens and efficient administration is being developed.

- Step down beds in intermediate care have been commissioned. Reablement to commence where appropriate to support the step down and back into the citizen's own home.

- ASC have worked with the main carer service provider, Harrow Carers, to develop their approach to support carers through the development of strengths-based approach to assessing carers.

- ASC have employed a dedicated Carers Lead to raise the profile of carers and challenge conventional practice including during the assessment process.

- An all age Carers Strategy and Needs Assessment are being developed. The development of which will be supported through Carers by Experience, including young carers. The Carers by Experience will be supported through the process by Harrow Carers and YHF.

- ASC have employed an Admiral Nurse who provides support to Carers of citizens with dementia and who will input into the Carers Strategy and Needs Assessment.

- PIT has seen an increase in the referrals and uptake of the service with performance success in admission avoidance.

- Harrow ICP is in the process of exploring the development of an integrated falls pathway with the community services provider CLCH, ASC and CCG.

- Integration Operational Leads' Group meet monthly to identify areas for integration and, using quality improvement change cycles, improve services by integrating fragmented pathways.

- MDTs at PCN-level for our most frail population

- A new frailty model for Harrow is being developed for implementation in Q4

- Improvement of the diabetes pathway with targeted interventions using a population health approach, with support from Optum (end Q4)

- An integrated training and education model for the health and care workforce to enable integrated support of residents and patients in the community (end Q4)

- A Care Providers' Support Group meets weekly to help resolve issues raised by care providers (care homes, dom care, day care) and to ensure robust partnership support and response to the needs of the providers and their residents/users.

- We are supporting practices and care homes to complete CMC records to ensure patients are supported to remain in their places of residence if they do not wish to go into hospital (end Q3)

- The Care Homes Response Team (CHRT) is offering training to care home staff in falls prevention, hydration and nutrition and other preventative measures to build resilience to crises and enable early detection of frailty. They also offer clinical support during crises.

- There are plans to align the reablement offers across the local system to ensure patients are better supported to access services and manage their rehabilitation in the community (Nov 22).

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

The councils has pooled all placement/care related budgets into the BCF pool, including those used to fund support for the social work teams within hospital settings.

Commissioning arrangements were jointly agreed with the NHS for each of the pathways and are kept under review via the NW Discharge Group and locally between the borough and LA teams.

Separate D2A/COVID Section 75 agreements are in place for the COVID discharge funding, extended from 2020/21 to the current financial year.

A key focus of service development during 20/21 has been the implementation, led by the acute trust (LNWUHT), the community provider (CLCH) and the local authority, of an Integrated Discharge Hub (IDH) at Northwick Park Hospital.

The hub ensures:

- 7 day service with daily huddles and discharge hub accountability has resulted in a higher number of complex/specialist patient discharges
- Close working with wards has improved patient flow / reduced pressure on hospitals
- Reduced number of Delayed Transfer of Care (DTOC)
- Daily huddles ensure earlier identification of risk – thus near miss rather than harm to patients
- Whole systems working approach – with accountabilities and responsibilities
- Collaborative working has resulted in “working in the best interests of patients” and improved relationships
- Defined escalation processes e.g. Intermediate Care Escalation (ICE) to support discharge teams find a rehabilitation inc. neuro bed.
- More efficient out of borough placements/discharges, minimising bed blocking.
- Single site NWL brokerage via hub reducing delays and process hand overs
- Introduction of the Intermediate Care Escalation Hub (ICE) for support with complex discharges and access to all commissioned community beds across NWL

Supported Discharge
Supported Discharge Services including Home First continue to support discharge from hospital, with the priority being to support patients to live at their home.

The Integrated Discharge Hub works with all partner organisation to place the patient in the best place aiming for home as the first option.

To embed this, the Partners have improved pathways and introduced new functions, including:

- Improved access to Care at Home
- Working closely with voluntary organisations to support discharge home
- Harrow LA make now place patients on Pathway 3 rather than CHC to ensure longterm care is the most appropriate and always aiming for home
- More access to clinicians to order equipment including single approvals for equipment under £150 to avoid delays

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

ASC Officers have close working relationships with Housing colleagues and work together on a range of housing matters including, discharge from hospital, adaptations to support independence at home, development of new schemes, planning move-on from supported living for people recovering from Mental Health.

Health trusts and the CCG are also involved in some strategic local authority projects, for example, reducing homelessness.

DFG adaptations are used to help to meet the changing needs of older people.

In Harrow older people can also access sheltered housing for older and extra care housing (with on-site care services), provided either by the Council and by registered providers (housing associations) as their needs become more complex, as well as residential and nursing placements.

Aids & Adaptations
Different schemes are available to help people in all housing tenures who require aids, adaptations and home improvements to stay in their own home and continue to live independently.

Harrow Council supports eligible residents through promoting and delivering major adaptations (funded through the Housing Revenue Account for council tenants and Disabled Facilities Grants in other tenures), the handyperson scheme and the 'Staying Put' scheme.

The Disabled Facilities Grant (DFG) programme provides funding for properties to be adapted to meet the needs of disabled people (non-council tenants) to live independently in their own homes.

Adults applying for the grants are means tested to assess whether they are able to contribute to the cost of works, however children do not have to undergo the means test.

Examples include level access showers, through-floor lifts or the construction of extensions to provide additional bedrooms allows households to continue living independently in their own homes and reduces the need for costly residential care.

Social Housing- Transfer applications
Social housing tenants whose current home is no longer suitable for their needs due to health, disability or mobility are given priority to move and can bid for alternative general needs social housing or sheltered housing for older people.

Move on from Supported Housing
Access to social housing continues to be facilitated for some vulnerable groups through move on quotas to support moving from care or supported housing to independent housing.

New Supply of Affordable Housing
The Council is building new homes for the first time in decades and is making use of other opportunities to increase the supply of affordable housing in the borough, such as through the Council's regeneration programme.

The Council works with registered providers (housing associations) to develop new general needs and supported housing and to explore options for existing housing where the accommodation falls below current standards or is not being used to its optimum benefit.

Housing for Older People

Older people are a diverse group of people with a range of different housing needs and preferences, and may choose to live in mainstream housing or in specialist housing.

Mainstream housing is usually general needs housing in the social or private sectors, either rented or purchased. Aids and adaptations can help to meet the changing needs of older people in this type of housing.

Specialist housing for older people, other than residential and nursing care homes, enables an older person to live independently in their own living space with varying levels of support. In Harrow older people can access sheltered housing for older and extra care housing, provided either by the Council and by registered providers (housing associations).

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- ***Changes from previous BCF plan.***
- ***How these inequalities are being addressed through the BCF plan and services funded through this.***
- ***Inequality of outcomes related to the BCF national metrics.***

The core purpose of the Harrow ICP is: *tackling health inequalities and improved outcomes and experience through truly integrated care*

The ICP uses a Population Health Management approach to underpin decision making at all levels (practice, PCN, ICP) to reduce inequalities of access and health outcomes.

Embedding data analysis at all levels of decision making will provide demonstrable targeting of greatest need in all commissioning and operational decisions.

Harrow Integrated Care Partnership

100 day plan: developing our understanding and delivering action

Lisa Henschen, Managing Director, Harrow Integrated Care Partnership

Version 2: 18th August 2021

Introduction to the 100 day plan

In February 2020, the Harrow Health and Care Partnership produced their **first 100 day plan**, setting out the next 100 days of the ICP development. No one could then have foreseen what the next 100 days would bring.

As we look back on those 100 days at the beginning of March 2020, it is clear that 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. It brought together, as it continues to, 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. It set out 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.

In June 2020, following the first wave of COVID-19, the Harrow Health & Care Executive produced their **Out of Hospital Recovery Plan**. This plan built on what the partnership had rapidly learnt over the first wave of the COVID pandemic, as well as the long term aspirations of this partnership; delivery of integrated, person centred care. It set out these long held objectives as well as a programme of recovery in the priority areas of our transformation programme. This plan cemented the out of hospital recovery workstreams at the heart of our integrated care partnership and the vehicles for collaboration and change delivery.

As the partnership continued to provide leadership and operational oversight of our out of hospital recovery plan and continued response to the second and third waves of the pandemic, it continued to evaluate and refine its direction and approach. A reflect and refresh exercise, undertaken in April 2021 with members of the Health and Care Executive, sought feedback on the effectiveness of the partnership and ongoing priorities. A series of conversations with Black Community Leaders and citizen champions for health and care provided constructive challenge to our approach and the ways services are delivered. They reinforced the need to place our citizens at the heart of ICP developments and reflect seriously on the values of the Health and Care Partnership for Harrow.

Four strategic conversations were then held to shape our way forward:

1. **Putting patients and citizens at the heart of the ICP:** Including in the planning, delivery and assurance of better health and care outcomes
2. **How we hold ourselves to account?** Including the role of primary care leadership, future of commissioning, self-assurance, conflict resolution and relationship with the ICS
3. **Reaffirming our shared delivery commitments:** Including the operational changes and workstream development to support the above
4. **Developing our shared culture:** Including how to make this real for people, engaging staff, integrated training and development, and promoting staff wellbeing

We are now at a critical point in the partnership development. We need to continue to engage, alongside acting on what we have heard. We need to effectively establish the Harrow Health and Care Partnership as the agency to deliver for our local citizens and for the North West London Integrated Care System (ICS).

This is the purpose of this 100 day plan; turning our understanding to action and demonstrating the robustness and readiness of the partnership to deliver the priorities for our wider health and care system.

Setting the priorities for the 100 day plan

The priorities for the 100 day plan have been developed through:

a) The outcomes of the Harrow Health and Care Executive four strategic conversations, the key conclusions from which are:

- The need to start engaging the wider workforce, giving people the permission / freedom to start the process of integration
- The importance of values but the need for these to come from people, not from the system leadership
- The consistent themes from the conversation sessions around improving access, jointly developing workforce, and embedding community voices
- The need for the next "100 day plan" to be about empowering, asking others and addressing power dynamics, not just providing a new set of workstreams and priorities
- Potential availability of support and funding to enable this journey through our dedicated transformation funding.

b) The priorities of our transformational workstreams and how we are driving their work to reduce health inequalities, improve care and develop a sustainable local health care system (Appendix A)

c) Our commitment to the delivery of the ICP priority areas that have been set across North West London and the set of metrics that have been agreed to measure their delivery (Appendix B)

- Reducing health inequalities: Population Health Management underpinning all decisions
- Development of PCNs and reducing Primary Care variation
- Integrating and organising teams at a neighbourhood level
- Diabetes – achieve new spec to improve health
- Community mental health – deliver model and access as agreed by North West London
- Vaccines, hesitancy and post-COVID care

d) The development of the wider Integrated Care System in North West London and the need to secure our agency to deliver system priorities, <u>including having a robust Borough Delivery Plan in place</u> (see Appendix C)

The 100 day plan: what we are seeking to achieve

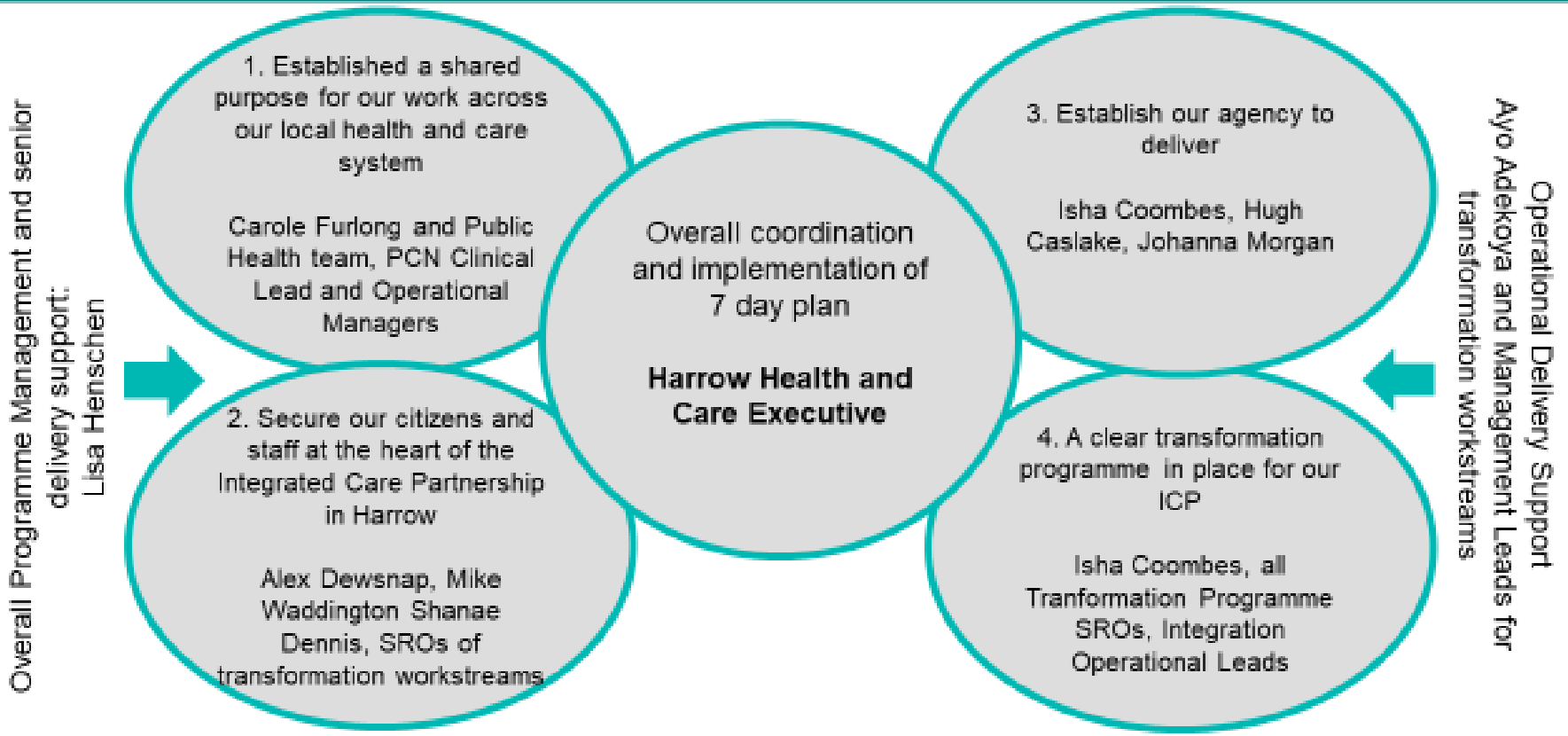
The 100 plan is about laying the foundations for a strong ICP, building the momentum for change as well as delivering change for our citizens. We expect opportunities for positive change to emerge through this process and team will be supported to enact and learn through delivery of these over the 100 day period..

By the end of the 100 days we will have …	Delivered through …	Demonstrated by ..
1. Established a shared purpose for our work across our local health and care system	Clear and agreed priorities and delivery programme	The Harrow Borough Delivery Plan
2. Secured our citizens and staff at the heart of the Integrated Care Partnership in Harrow	The Harrow Conversation	Voice of citizens and staff at the heart of our Borough Delivery Plan. Changes made to digital models in response to citizen voice.
3. Established our agency to deliver	Clear governance, decision making and accountability in place	Agreed Governance structure
4. Be clear on the transformation programme for our ICP	Implementation of transformation programmes	Key indicators in the Harrow Health and Care dashboard

100 day plan at a glance

	Days 1 – 30 [September]	Days 30 – 60 [October]	Days 60 – 90 [November]	Days 90 – 100 [December]
1. Establish a shared purpose for our work across our local health and care system	Commence borough level population health needs assessment. PCN development plans: review by Harrow Health and Care Executive.	Needs assessment continues with refreshed census data. Values and ways of working established, directed by the Harrow conversation	Neighbourhood population needs assessment completed. Neighbourhood team moving to PHM approach. Agreement and commitment to Borough Delivery Plan across all Harrow Health and Care Partners.	Borough Delivery Implementation Plan agreed. Borough and PCN needs assessment complete as foundation for Population Health Management.
2. Secure our citizens and staff at the heart of the Integrated Care Partnership in Harrow	Commence the Harrow Conversation across our staff groups. Engagement through Health inequalities programme with groups experiencing health inequalities	Conclude and reporting on the Harrow Conversation across our staff groups Stage 1 of the Health inequalities programme concludes.	Insights gained at the heart of the Borough Delivery Plan. Citizens and staff established and active within ICP Governance structure.	Citizen and VCS engagement into neighbourhood structures secured.
3. Establish our agency to deliver	Agree refreshed Governance structure	New Governance structure in place ICP metrics in place with accountability for delivery agreed. ICP system oversight process commences	Deep dives into diabetes programme delivery. Beginning to evidence impact (initial focus on process metrics) for our diabetes programme.	Deep dives into mental health programme delivery. Areas of variation for focused agreed for the partnership.
4. A clear transformation programme in place for our ICP	Agreement of winter plans Making Integration Happen in Harrow moves to implementation. Integrated training and workforce programme initiated. Phase 3 COVID vaccination programme implemented. Harrow Primary Care Summit.	Refresh of frailty pathway Responding to Harrow conversations: delivering quick wins. Vaccination hesitancy programme in place and uptake monitored.	Tackling health inequalities programme: programmes of change begin implementation.	Transformation workstreams have clear priorities and associated delivery plans in place. Foundation for integrated teams in place at neighbourhood level.

Teams supporting the 100 day plan priorities



Priority area 1: Establish a shared purpose for our work across our local health and care system

	Key actions	Lead/s	Programme oversight
Days 1 – 30 (September)	• Commence borough level population health needs assessment through gathering and reviewing existing needs assessments that have been completed	Public Health team	Population health management working group
	• PCN development plans: review by Harrow Health and Care Executive. This will be a process of constructive check and challenges, alongside identification of where support across the partnership could be secured for delivery.	PCN Clinical Directors supported by Harrow Borough team	Harrow Health and Care Executive
Days 30 – 60 (October)	• Needs assessment continues with refreshed census data and Borough needs assessment completed by day 60.	Public Health team	Population health management working group
	• Values and ways of working established for the Harrow ICP. These will be directed by the Harrow conversation which will have happened over September, engaging with as many front line staff teams as possible. Through listening to our staff and comparing this to what we have heard from our citizens we will create a set of values that are owned by the people we are serving.	Lisa Henschen and supported by all Harrow Health and Care Exec senior leaders	Communications and engagement workstream
Days 60 – 90 (November)	• Following Borough needs assessment completion, neighbourhood population needs assessment completed by day 90, reflecting each of the PCN footprints.	Public Health Team / PCN CDs / PCN Operational Managers / Borough team	Population health management working group
	• Agreement and commitment to Borough Delivery Plan across all Harrow Health and Care Partners	Lisa Henschen	Joint Management Board
Days 90 – 100 (December)	• Borough Delivery Implementation Plan agreed.	Lisa Henschen	Joint Management Board
	• Borough and PCN needs assessment complete as foundation for Population Health Management. From this, we are able to set out our long term approach to embedding population health management	Carole Furlong and Meena Thakur, supported by Lisa Henschen	Population Health Management & Tackling Health Inequalities

Priority area 2: Secured our citizens and staff at the heart of the Integrated Care Partnership in Harrow

	Key actions	Leads	Programme oversight
Days 1 – 30 (September)	• Commence the Harrow Conversation across our staff groups. Conversation guide agreed as a framework. Discussions in place across as many staff groups as possible within health, social care and VCS organisations. Executives from Health and Care organisations attending conversations in listening capacity	Lisa Henschen, Ayo Adekoya supported by PPL Executive Board members attending conversations.	Communications and engagement workstream Harrow Health and Care Exec
	• Engagement through Health inequalities programme with groups experiencing health inequalities	Alex Dewsnap, Shanae Dennis	Prevention and population health management workstream
Days 30 – 60 (October)	• Conclude and report on the Harrow Conversation across our staff groups. Results need to feed into all work programmes through the Borough Delivery Plan. Use this engagement opportunity to establish the Harrow ICP staff advisory group.	Mike Waddington, Lisa Henschen	Communications and engagement workstream Harrow Health and Care Exec
	• Stage 1 of the Health inequalities programme concludes. Recommendations are made to new programmes of work that need commissioning and redesign of existing services.	Alex Dewsnap, Shanae Dennis, Lisa Henschen and transformational programme SROs.	Prevention and population health management workstream Harrow Health and Care Exec
Days 60 – 90 (November)	• Insights gained through citizen and staff engagement at the heart of the Borough Delivery Plan.	Lisa Henschen, Alex Dewsnap, Mike Waddington	JMB
	• Citizens and staff established and active within ICP Governance structure.	Lisa Henschen	JMB
Days 90 – 100 (December)	• Citizen and VCS engagement into neighbourhood structures secured	PCN Clinical Directors supported by the Borough team	Harrow Health and Care Exec

Priority area 3: Establish our agency to deliver

	Key actions	Leads	Programme oversight
Days 1 – 30 (September)	• Agree refreshed Governance structure	Lisa Henschen	JMB
	• Develop the BCF 2021/22 approach and schedules for partner review	Johanna Morgan and Hugh Caslake	BCF Core Officers Group / Harrow Health and Care Exec
Days 30 – 60 (October)	• New Governance structure in place	Lisa Henschen / Chairs	JMB
	• ICP metrics in place with accountability for delivery agreed across the ICP objectives: • (1) Population Health Management underpinning all decisions, (2) Development of PCNS and reducing primary care variation, (3) Integrated and organising teams at a neighbourhood level (frailty focus), (4) Diabetes – achieve new spec to improve health, (5) Community Mental Health – deliver NWL service, (6) Vaccines, hesitancy and post-COVID care.	Ayo Adekoya	JMB & Health and Care Executive
	ICP system oversight process commences. Once a month, the Harrow Health and Care Executive will focus on key system metrics for the partnership to hold themselves to account and secure greater system focus on areas of concern.	Lisa Henschen / Ayo Adekoya	JMB & Health and Care Executive
	• BCF approach and schedules for 2021/22 agreed	Johanna Morgan and Hugh Caslake	BCF Core Officers Group / Harrow Health and Care Exec
Days 60 – 90 (November)	• Deep dive into diabetes programme delivery to assure ourselves as a system	Kaushik Karia / James Benson / Isha Coombes	Harrow Health and Social Care Senate
	• BCF approach and schedules for 2022/23 proposed (with a view to agreement by end of December)	Johanna Morgan and Hugh Caslake	BCF Core Officers Group / Harrow Health and Care Exec
Days 90 – 100 (December)	• Deep dives into mental health programme delivery to assure ourselves as a system	Dilip Patel / Ann Sheridan / Isha Coombes	Harrow Health and Social Care Senate

Priority area 4: Clear transformation programme in place for our ICP (one of two)

	Key actions	Leads	Programme oversight
Days 1 – 30 (September)	• Agreement of winter plans for the Harrow Borough	Lisa Henschen / Simon Crawford / Isha Coombes	A&E Delivery Board / Harrow Health and Care Exec
	• Making Integration Happen in Harrow moves to implementation. Integration operational leads groups established.	Lisa Henschen / Ayo Adekoya / Chair of Integration Leads Group (TBC)	Harrow Health and Care Exec
	• Integrated training and workforce programme initiated	Ashok Kelshiker / James Benson	Integrated workforce and education workstream
	• Phase 3 COVID vaccination programme implemented	Isha Coombes / PCN CDs	Harrow Health and Care Exec
	• Flu vaccination programme implemented	Isha Coombes / PCN CDs	Harrow Health and Care Exec

	• Focus on frailty pathway commences, with the following aims:
	  • Fully understanding the service offers and patient pathways for our frail patients
	  • Identification of further opportunities of integration of services
	  • Establish service readiness for management of winter pressures
		Angela Morris / Simon Crawford / Amol Kelshiker / Ayo Adekoya	Frailty workstream

	• Harrow Primary Care Summit held to address the immediate demand issues on primary care and develop long term solutions	Lisa Henschen / Isha Coombes	Harrow Health and Social Care Senate / CCG Borough Executive Group

Priority area 4: Clear transformation programme in place for our ICP (two of two)

	Key actions	Leads	Programme oversight
Days 30 – 60 (October)	• Insights gained from the Harrow staff conversations further develops the Making Integration in Harrow programme	Lisa Henschen	Harrow Health and Care Exec
	• Focus on frailty services continue, with MDT approach to care planning 15% complex / frail patients confirmed	Angela Morris / Simon Crawford / Amol Kelshiker / Ayo Adekoya	Frailty workstream
	• Implementation of winter plans	Lisa Henschen / Simon Crawford / Isha Coombes	A&E Delivery Board / Harrow Health and Care Exec
	• Responding to Harrow conversations: delivering quick wins	Lisa Henschen / Jackie Allain / Tanya Paxton	Harrow Health and Care Exec
	• Vaccination hesitancy programme in place and uptake monitored. Ongoing support to Phase 3.	Isha Coombes	Harrow Health and Care Exec
Days 60 – 90 (November)	• Tackling health inequalities programme: programmes of change begin implementation.	Alex Dewsnap, Shanae Dennis	Prevention and population health management workstream
Days 90 – 100 (December)	• Transformation workstreams have clear priorities and associated delivery plans in place.	SROs of all transformational workstreams	Harrow Health and Social Care Senate and Harrow
	• Foundation for integrated teams in place at neighbourhood level.	Lisa Henschen / Ayo Adekoya / Chair of Integration Leads Group (TBC)	Harrow Health and Care Exec

Appendix A: The Transformational work programmes of the Harrow ICP

(for final JMB agreement)

Delivery Workstreams		SROs	Management support
Population Health Management & Tackling Health Inequalities	Prevention, self-care and social prescribing sub-group	Carole Furlong Meena Thakur Alex Dewsnap	Sandra Arinze Nahreen Matlib Laurence Gibson
	Tackling health inequalities sub-group		
	Population health management working group		
Long term conditions		James Benson Kaushik Karia	Bharat Gami
Mental Health		Dilip Patel Ann Sheridan	Lennie Dick & Tanya Paxton
Learning Disability and Autism (all age)		Paul Hewitt	Lennie Dick & Mital Vagdia
Frailty and care settings		Amol Kelshiker Angela Morris Simon Crawford	Sonal Dhanani
Children and Young People		Varun Goel Paul Hewitt	Anita Harris & Priya Ganatra
Carers		TBC	Kim Chilvers

Enabling workstreams	SROs	Management support
Workforce and OD integration	Ashok Kelshiker James Benson	Simon Young
Access to care and COVID recovery	TBC	TBC
Strategic Estates Group	Isha Coombes	Simon Young
Digital transformation	Andrew Chronias	Nomaan Omar
Communication and engagement	Mike Waddington Alex Dewsnapp	TBC

Appendix B: ICP priorities and metrics in North West London

ICP priority area	Outcome/aim	Suggested evidence/deliverable
PHM approach underpinning decisions at all levels, to reduce inequalities (Practice, PCN, ICP)	Demonstrable, embedded use of data to support decision making and the reduction of inequalities at practice, PCN and ICP	Self reporting by PCNs and ICPs on: • WISC dashboard available to all organisations in the ICP • Increase in user accounts for x borough • Demonstrable use of data to identify priority cohorts and actions at PCN and ICP level • Demonstrable resident engagement in action plans • Impact monitoring and evaluation in place for agreed plans and reported at ICP Board
Development of PCNs and reduced variation in PC	PCNs demonstrating at scale working as a foundation for integrated teams and understanding and addressing variation	• PCN development plans in place and agreed with ICP board • PCN operating model in place with aligned community physical and mental health teams and leads identified and clearly articulated third sector involvement • Area of focus for variation identified by each ICP with delivery plan and impact evidenced
Organising & integrating care teams around PCNs, to better support frail & complex patients	ICPs develop and agree approach for effective integrated management of frail and complex patients across their health and care needs	• Confirm identification of top 15% complex/frail residents • Agree and implement operating model for case management/care planning • Decrease in admissions for over 65s over the year (and sub segmented rate for top 15% or actively case managed) • Increase in identified carers and uptake of carer support • Reduction in Care Home admissions rate against 2019/20
Diabetes – achieve new spec to improve care. **Wider LTC focus if capacity**	Diabetes enhanced service implemented in PC with integrated pathways into community services (including REWIND and self management)	• 8 Key care processes delivered in line with contract requirements • Key outcome improvements identified and delivered in line with contract requirements
Community Mental Health – new model implemented & access as NWL agreed	Deliver new MH team model supporting PCNs. Delivery of PC MH Enhanced spec	• SMI and LD health checks delivered in line with contract • MH programme to confirm integration metric at neighbourhood/PCN level
Ongoing Covid needs: Vaccination, hesitancy and Post Covid pathway	Consistent focus on impact of covid and future wave s/ vaccines. System working on hesitancy, into flu	• Community engagement programme in place to address hesitancy • Covid vaccination to national targets • Flu & Covid vaccination – integrated plan in place by September 21 and delivery target to national level (75% last year) • 1) %PC contact at risk search and increase in referrals • 2) Post covid service delivering to x week waiting time

Appendix C: ICS Early Planning Guidance

Approach to planning: outline timetable

EARLY THINKING

	Before September	September	October	November	December	January	February	March
National			• Publishes new census data		• Publishes operating plan guidance		? Requires first draft of ICS operating plan	• Requires final draft of ICS plan
NWL wide	• Agree NWL vs BDP vs trust/ collaborative responsibilities • Set out planning process and brief LAs • Sets out PHM priorities based on PHM framework • Sets frame for NWL wide needs compilation	• Compiles needs assessments from boroughs/ ICPs • Sets initial NWL wide priorities, targets and KPIs • Sets initial areas for standards	• Sets out likely areas for support/ best practice for boroughs • Sets efficiency expectations	• Sets standards for initial areas in service delivery • Develops and tests template for BDP delivery plans	• Adds national priorities to NWL and borough priorities • Issues template for delivery plan	• Lays out support/ best practice offer for boroughs • Sets out allocations for trusts/ collaboratives/ BDPs • Confirms efficiency expectations	• 8 x planning sessions with BDPs to test and support plan • Prioritisation sessions • Iterates allocation • Agrees goals with ICS work streams	• Collates plans to create ICS plan • Submits ICS plan • Finalise contracts
Borough level	• Gathers most recent borough needs assessments/ H&WB strategies (with/ for HWB) • Compiles timetables for needs/ H&WB refresh (if known)	Suggests ICS wide priorities	• Suggests local priorities (which together with NWL priorities give borough priorities) • Participates in further borough needs assessment/ H&WB strategy	• Outlines BDP delivery plan • Discusses delivery plan with acutes	• Updates NWL on borough priorities • Adds national priorities to NWL and borough priorities • Works with trusts/ collaboratives to set standardised interfaces	• Develops BDP delivery plan • Interfaces with acutes on delivery plan	• 8 x planning sessions with NWL/ relevant trusts to test and support plan • Agrees alternation to allocations	• Finalises BDP delivery plan • Finalise contracts
Trusts/ Collaboratives				• Outlines trust/ collaborative delivery plan • Interfaces with BDPs on delivery plan	Works with BDPs to set standardised interfaces	Develops trust/ collaborative delivery plan Interfaces with NWL/ BDP on delivery plan	• Planning sessions with NWL/ BDPs to test and support plan	• Finalise contracts