Public Document Pack

Committee Agenda – Second Despatch

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 30th March, 2023**
Time:	**4.00 pm**
Venue:	**Chelsea Old Town Hall, King's Road, Kensington and Chelsea, London, SW3 5EE**

Members:

Councillor Nafsika Butler-Thalassis	Cabinet Member for Adult Social Care, Public Health and Voluntary Sector, WCC
Councillor Tim Mitchell	Minority Group, WCC
Bernie Flaherty	Bi-Borough Executive Director of Adult Social Care
Sarah Newman	Bi-Borough Executive Director of Children's Services
Anna Raleigh	Bi-Borough Director of Public Health
Judith Davey	Healthwatch Westminster
Steve Inett	Healthwatch Westminster
James Benson	NHS London
Andrew Steedman	NHS NWL
Jackie Rosenberg	One Westminster
Lena Choudary-Salter	Westminster Community Network
Andrew Steeden	Primary Care Representative
Jan Maniera	Primary Care Representative

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Director of Law in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

7. COMPLEX CARE **(Pages 3 - 30)**

This paper and the wider workshop will provide an insight into how the Bi-Borough Place Based Partnership Complex Care programme is developing and how it addresses what is important to our residents and how we are helping to reduce health inequalities across our communities.

8. HEALTH AND WELLBEING STRATEGY CONSULTATION **(Pages 31 - 46)**

To approve.

This report presents the draft Health and Wellbeing Strategy for approval to allow for formal consultation to proceed.

Stuart Love
Chief Executive, Westminster City Council

Maxine Holdsworth
Chief Executive, Royal Borough of Kensington and Chelsea

27 March 2023

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster & Royal Borough of Kensington and Chelsea Health & Wellbeing Board

Date:	**30th March 2023**
Classification:	**General Release**
Title:	Complex Care
Report of:	Adult Social Care and Health
Wards Involved:	All
Report Author and Contact Details:	Andrew Steeden, Medical Director for West London Gareth Wall, Bi Borough Director of Integrated Commissioning Rachel Soni, Bi Borough Director of Health Partnerships

1. Executive Summary

1.1. This paper and the wider workshop will provide an insight into how the Bi-Borough Place Based Partnership Complex Care programme is developing and how it addresses what is important to our residents and how we are helping to reduce health inequalities across our communities.

1.2. Within the programme four priorities (see next section) have been identified including:

- Care Homes,
- Discharge,
- Palliative and End of Life Care,
- Same Day Access.

1.3. Each of these priorities are being delivered by partnership working with local partners across the bi-borough.

2. What residents are saying?

2.1. Throughout the development of the Health and Well Being strategy and through individual consultations relating to service design, the voice of our residents is key. Below are some of the things people are saying, which relate to the areas covered within Complex Care:

- People living with dementia have found it hard to get **consistent access** to support and services they need.
- Our **end of life** services do not reach wide enough, or appropriately support our diverse communities. Additionally, people want to have access to these services **closer to their home** for patients and those important to them who are supporting their care.
- Palliative care services need to take account of cultural/religious/ethnic considerations in the way services are provided.
- There needs to be **better awareness** and use of advocacy services, especially for people with learning disabilities.
- Care Home residents have struggled to get suitable access to **dental** practitioners.
- People want to have their **care personalised** in the way they need. For example, residents' feedback captured by Healthwatch as part of a care homes review included:

"*The main thing is my freedom. My freedom in moving, my freedom in choosing."*

"The most important thing is freedom or independence. If we don't get the right support, we don't have that. We are stuck indoors."

"My local church is opened now. I get to see familiar people. My life is people."

3. What Complex Care Covers

3.1. The Complex Care Programme is broad but is interconnected as it will impact on all residents, in particular the most vulnerable. The programme scope includes:

Care homes

3.2. This area of work aims to:

i. ensure that people living in care homes receive the same quality of physical health and mental wellbeing support they would receive were they living in their own home.
ii. ensure that care homes in the Bi-Borough are attractive places for residents to live and to receive personalised care that meets their social preferences.
iii. demystify/destigmatise the work of care homes and to improve workforce recruitment and retention.

3.3. The focus of this work to date has been implementing the national **Enhanced Health in Care Homes** standard. These national standards are to make sure there is consistent delivery of specialist nursing support into homes to enhance multi-disciplinary nursing case management. We now have specialist nursing support for all care homes and are undertaking a quality review to ensure care provision, multi-disciplinary discussions, and support with assisting with care home training needs are consistently delivered in line with North West (NW) London Integrated Care Board (ICB) recommended standards.

3.4. The programme is also working to improve the availability of enhanced **dementia in-reach** specialist support into homes to support earlier identification, diagnosis and management of people with dementia. Our mental health providers are undertaking a project in six care homes that provides education, dementia-specific psychology-led training and professional development to support care home staff in caring for people with dementia. Our mental health providers are also exploring how they can further enhance local in-reach provision to support earlier identification and management of individuals with behaviours that challenge.

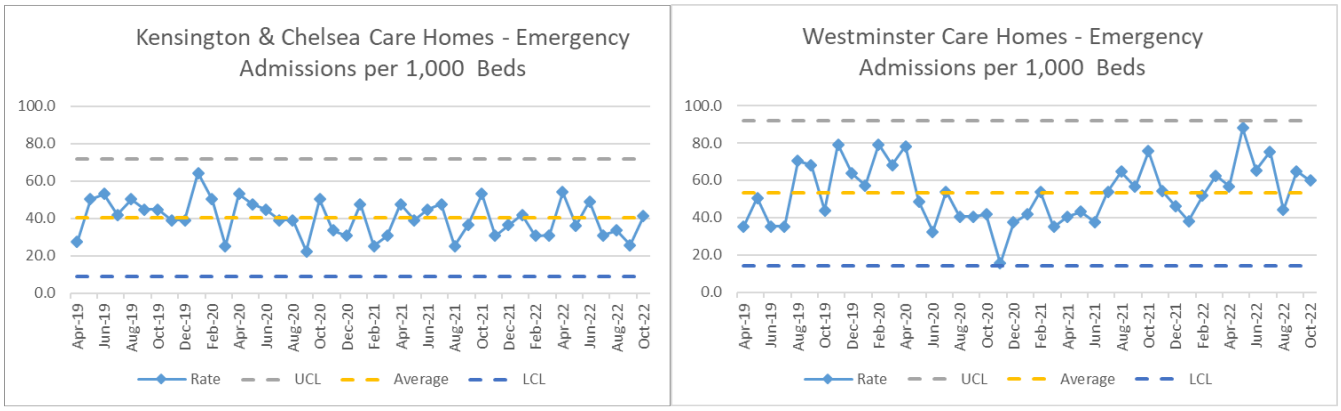
3.5. **Oral healthcare** has been identified as an area of challenge for care homes. To address this, a short-term project has been commissioned from Central London Community Healthcare Trust (CLCH) Specialist Dental Services to improve the oral health of care home residents through training to improve the skills and confidence of staff to supervise, support and assist residents with an effective oral health routine.

3.6. In addition to the healthcare priorities, **social priorities** are equally important for residents in care homes. There is considerable variation in ability of residents to connect with their local communities. To address this point, a user experience research project has been designed to hear from residents about their experiences and preferences.

3.7. A key area of support being led by this workstream is addressing the challenges with consistent staff training, workforce development and high turnover for care home staff. We are delivering a programme to support care home (and home care) providers to attract, train and develop a skilled social care workforce. This includes identifying existing learning and development provision, and challenges around access and uptake to inform a future course design, that will support development of career pathways.

3.7 In terms of performance one key metric tracked is emergency admissions per 1,000 (figure 1). Average performance is in line with plan and there have been no significant changes. Furthermore, ambulance and urgent hospital admissions for Care Home residents has not significantly changed since the outbreak of the Covid.

Figure 1: Emergency Admissions per 1,000



Palliative and End of Life Care.

3.8 This is a relatively new programme that is focused on improving the local delivery of Palliative and End of Life Care services for people who are approaching the end of their life, through improved joint working by all key local health and care partners.

3.9 It is being taken forward through the Bi-Borough Palliative and End of Life Care (PEOLC) forum that has patient and carers representation in addition to key health and care partners. The aim of the programme is to use local knowledge, feedback and joint ownership of our assessment against the national PEOLC Ambitions self-assessment framework.

3.10 This framework sets out recommended standards to evidence the delivery of high quality care against 6 ambitions of:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

3.11 Some emerging themes to address include:

- Improving public and clinical access to PEOLC information to support care delivery and awareness by residents and carers
- Improving access to and utilisation of the new Universal Care Plan (UCP) to support access to up to date clinical and care information that provides better informed care delivery across the system.

3.12 The PEOLC forum also provides a platform to engage with the NW London ICS Community Based Specialist Palliative Care review programme and development of a new model of care. The new model of care is still in development and we are currently awaiting the proposed next steps to support this work.

3.13 The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended

until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate.

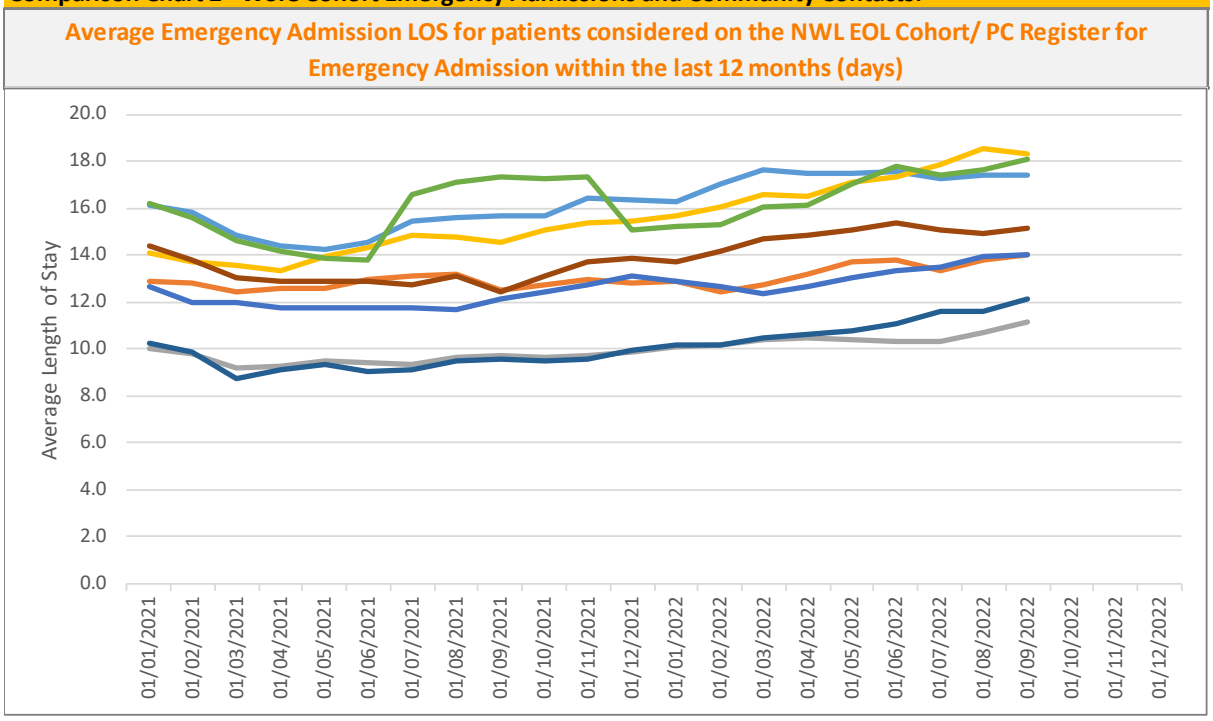
3.14 When Pembridge inpatient unit was suspended in 2019, health committed to completion of the community-based specialist palliative care review prior to any decisions being made on the future of this unit. Whilst acknowledging the local frustrations on the lack of clarity for the future, health remain committed to do a clear process and transparency on next steps and have recently published the engagement outcome report (see www.nwlondonics.nhs.uk/cspc detailing all the feedback received and outlined next steps.

3.15 Health anticipate completing the work to develop a new model of care in the next month. A number of metrics are monitored by NW London to assess the impact of the system in supporting our residents,

- Average LOS for patients on NWL EOL Cohort
- Percentage of deaths that occur in hospital.

Key:			
Brent	Ealing	Harrow	Hounslow
Central London	Hammersmith and Fulham	Hillingdon	West London

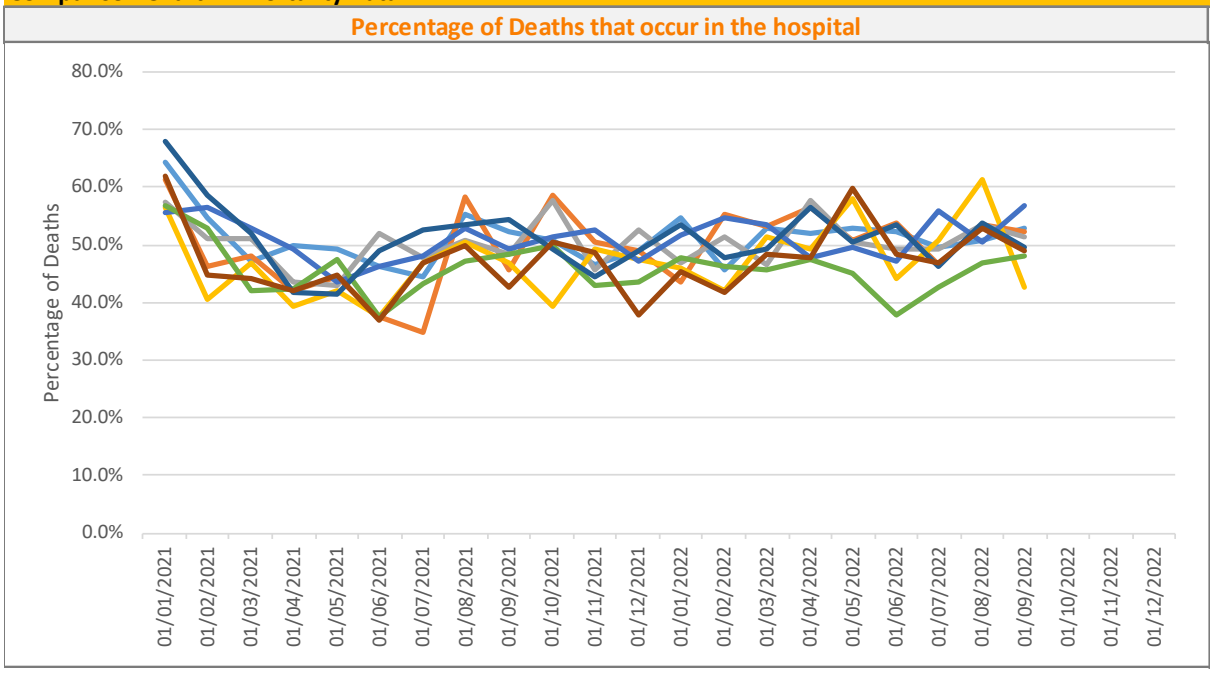
Comparison Chart 2 - WSIC Cohort Emergency Admissions and Community Contacts:



Our Bi-Borough length of stay is in line with the trend seen for other NW London boroughs and continues to be around the mid-range period spent in hospital.

Key:			
Brent	Ealing	Harrow	Hounslow
Central London	Hammersmith and Fulham	Hillingdon	West London

Comparison Chart 4 - Mortality Data:



Our Bi-Borough performance is in line with the trend seen for other NW London boroughs and continues to be lower than at the start of 2021.

Discharge.

3.16 For people being discharged from hospital having the right care, at the right time, and in the right place is critical to improving the outcomes of people. This is important because having people staying in a hospital longer not only reduces the ability of the hospital to treat some else, but it does not help improve the health outcomes of the person with a longer stay. For example, national evidence has shown that 10 days in an acute setting results in in about 10 years of ageing in the muscles of people over 80yrs and a wait of more than two days (in hospital) negates the additional benefit of intermediate care.

3.17 By focusing on reducing discharge delays this will improve outcomes for older people and also reduce the cost of care across the system. However, reducing the number of discharge delays is complex and through this area we are seeking to achieve a sustainable reduction in discharge delays.

3.18 In September 2022 the Bi-Borough changed its approach to discharge to assess and re-enforced social care and multidisciplinary discharge planning with the intention of improving flow in the hospital, reducing oversubscription of care to ensure care capacity is targeted and available where it is needed.

3.19 Over the winter period, often seen as a period of peak demand for admissions and discharges, a number of activities have been undertaken to improve our performance. Appendix A provides a summary of the different work

programmes, whilst appendix B provides a summary of the additional funding and impact received at short notice over winter to support discharge planning.

3.20 The Place Based Partnership have worked together to introduce additional access to local authority reablement care and home care, increased capacity in NHS Home First / Rapid Response services and ringfenced placement capacity in care homes.

3.21 The acute Trusts have reviewed their discharge hubs and recommendations from the review are to be implemented. Specific initiatives such as 'Better Together' at Imperial bring disciplines closer together to plan discharges. Specific events such as Multi Agency Discharge Events (MADE) have brought through themes that require specific action planning, including housing and homeless pathways, mental health discharges, early identification and notification of people with complex discharge care needs and introduction of a new digital monitoring system called Optica.

Same Day Access

3.22 The Fuller Stocktake (see https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) underpins the NHS ambition to improve the health outcomes of the nation and sets out a number of areas where, by working differently across a range of partners, these can be achieved.

3.23 Same Day Urgent Care is a new area but has a number of underlying principles including:

- People need to be able to access same-day urgent care
- GPs need to be able to provide continuity of care to those patients who need it most

3.24 Over the past 3 months the Bi-Borough Place Based Partnership has been working with a range of partners to look at how these principles can be delivered through integrated neighbourhood teams.

3.25 For urgent care to be effective it is important that people can have access in their community, for example from their home through 111 or going to community pharmacy, prior to needing a GP referral. Having sought this advice people may require an immediate referral into emergency care or go online or talk to somebody before walking into a hospital emergency department.

3.26 However, we know people have different needs and for a number of people having access to an in-person GP appointment is a priority for them. If we can design support services around a GP, then it will be possible to prioritise these people and to provide other support to people that do not require or don't need a face to face.

4.0 Complex Care Workshop

4.1 There are two elements to the wider complex care workshop:

Person with Lived Experiences

4.2 A local resident will be talking about her experiences and insights into living within the borough and how she has interacted with the wider health and care system. This is a powerful opportunity for the HWB membership to hear and listen to individual experiences and to understand how these experiences have been supported or impacted on by our services.

Market Stalls

4.3 The market stalls will cover four areas to highlight the need for multi-disciplinary working across partners to address the wider social determinants of health to support residents. The stalls include:

- **Discharge Planning** - this stall will be led by community health and care providers and will provide opportunities to understand the work that is underway to improve discharge planning, especially for people pathway 1 redesign.
- **Care Homes**
- **Good Health –** Opportunity to present new models of care and how these are support the Same Day Access work programme area of complex care. Violet Melchett and Golborne GP practices will be available to talk about their work and ambitions to improve the health of our communities.
- **Community Safety**– keeping people safe at home has been identified as a key priority for our residents. This will be an opportunity to hear about what support is available and how this contributes to improving the health and wellbeing our residents and communities.

4.4 Following the market stalls key issues will be captured and presented back to the HWB in the March meeting and fed into the HWB strategy.

Recommendations

1. To note the report

APPENDICES
Appendix A – Winter Interventions
Appendix B – Summary of additional winter funding
Appendix C - NWL Discharge Leaflet
Appendix D - British Red Cross Winter Poster

Appendix A – WINTER INTERVENTIONS

Summary of winter interventions to support discharge and achieve the following.

- people are supported to return home as soon as they no longer need an acute hospital bed and are supported to make decisions about their future long-term care needs and where they want to be.
- support people to stay at home and remain as independent as possible as long as possible through reablement and care.
- ensure that people's health outcomes improve so more people can live at home for longer, especially if services are designed for discharge home to be the default.
- for those people, where home in not an option we ensure that the assessment of their long-term care needs happens outside of hospital and decisions re long term future care is made with the person and their families.

Measuring Performance

The following targets are used to track progress,

- **Reducing length of stay in hospital.**

  It is recognised that a long length of stay in hospital increases the chance of patients acquiring infections, as well as causing patients to debilitate and become more dependent. There is a target to reduce **by 40% the number of patients staying in hospital more than 21 days.**

NWL Performance – Number of people in a hospital bed by Length of Stay. **(snapshot on first Friday of each month)**	**Dec-22**	**Jan-22**	**Feb-22**	**Mar--22**
LOS over 7 days	1,586	1,727	1,623	1,627
LOS over 14 days	867	1,072	962	965
LOS over 21 days	574	689	646	653

Source: NHS England Weekly Discharge Report

Once Optica, the new information system is in place we will seek to provide borough breakdown and greater detail to allow to understand LA issues.

Continuing Healthcare Targets

- **Reduce the number of CHC assessments** taking place in hospital to **under 15%** [Data to be provided]

- **Reduce the time taken** for long term care decisions to be made so that there is **a maximum of 28 days** between checklist and decision [Data to be provided]

In terms of **reablement** the following indicators are key:

- 85% people (65+) are at home **91 days after discharge** from hospital into reablement /rehabilitation, see table below

WCC				2022-23 Plan	Q1 YTD Actual	Q2 YTD Actual	Q3 YTD Actual
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services			Annual %	89.3%	94.2%	96.3%	94.9%
RBKC				2022-23 Plan	Q1 YTD Actual	Q2 YTD Actual	Q3 YTD Actual
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services			Annual %	89.3%	88.9%	92.5%	93.0%

This measurement below reflects the proportion of those new clients who received short-term services during the year, where no further request was made for ongoing support. Since short-term services aim to reable people and promote their independence, this measure will provide evidence of a good outcome in delaying dependency or supporting recovery.

Reablement Outcomes - WESTMINSTER	**Apr**	**Jul**	**Nov**	**Feb**	**Mar**
% people with no ongoing care (cumulative) Plan 80%	81.5%	76.4%	79.1%	79.9%	

Reablement Outcomes - RBKC	**Apr**	**Jul**	**Nov**	**Feb**	**Mar**
% people with no ongoing care (cumulative) Plan 80%	84.2%	89.8%	88.0%	88.6%	

Programmes

Overnight Care pathway

Additional care and support was commissioned to support people who would have previously been placed in Residential care due to safety issues overnight. The additional support allows people to be discharged home with support overnight until they become more confident and independent.

Although a small number of people have gone through the pathway, approximately 40% have been able to stay at home. Environmental factors, such as the home not being suitable to provide the care, people's need increasing in complexity and meant they were not safe between care calls during the day which was a key criterion for the scheme.

.

Pathway 1: (Discharge Home)

Health and Adult & Social Care have been working together to develop a new integrated, steam lined pathway 1, offering a single pathway for all hospital discharges to a person's home, with the focus on a person's assessment taking place outside of the hospital setting. With the outcome of a more time efficient pathway with less duplication, less potential omissions due to transitions of information, greater safety and more appropriate use of reablement resource and less long-term care hours in ASC. This pilot will continue into 23/24 with the aim of increasing the number of people being discharged through pathway 1 and therefore support discharge.

British Red Cross:

This winter the BRC have been commissioned to provide additional capacity to support discharge in the first 72 hrs and also a community wrap around service for 4 weeks post discharge, with the aim to reduce re admissions and support flow (see appendix D).

Pathway 3

Additional capacity has been made available through the discharge to fund to secure care home placements for people with residential or nursing needs. The Local Authority block purchases beds and Continuing Healthcare placements have been made available. Joint work across the CHC and LA teams is critical in ensuring those with primary health needs are assessed in a timely way for Continuing health care and that eligibility rates and conversion rates are monitored.

This page is intentionally left blank

Appendix B Summary of additional winter funding

National ASC Discharge funding has been agreed from DHSC to support winter pressures to local health and care system. The national conditions include:

- Allocations for specific health and wellbeing boards (HWBs) should be pooled into local BCF agreements (governed by section 75 of the NHS Act 2006) and ICBs should agree the distribution based on agreement with LA partners, dependent on local context and challenges.
- Local authority funding allocations have been determined using the established Adult Social Care Relative Needs Formula (ASC RNF) .
- Funding will be allocated to ICBs and local authorities in 2 tranches. The first tranche (40% of the total allocation) will be in December and the second tranche (60% of the total allocation) in January.

The following table summarises this funding, plus additional funding from NWL ICB to support winter.

RBKC	
National ASC	**£722,338**
National ASC - ICB allocation	**£1,000,000**
NWL winter fund Allocation	**£131,398**
Westminster	
National ASC	**£1,102,633**
National ASC - ICB allocation	**£1,000,000**
NWL winter fund Allocation	**£123,654**

This page is intentionally left blank

North West London Integrated Care System

NHS North West London

Let's talk about discharge

– getting you out of hospital

We understand that you may be worried about leaving hospital, especially if you have been in hospital for a while. When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength and can lead to risk of infection. Leaving hospital as soon, as you no longer require treatment in hospital will benefit your recovery, as well as allowing other patients to receive the care at the right time.

Hospital care is for people who are very unwell. Once you no longer need this, you may be transferred to a community setting to continue your recovery, on a temporary basis, where your longer term care needs and choices can be supported.

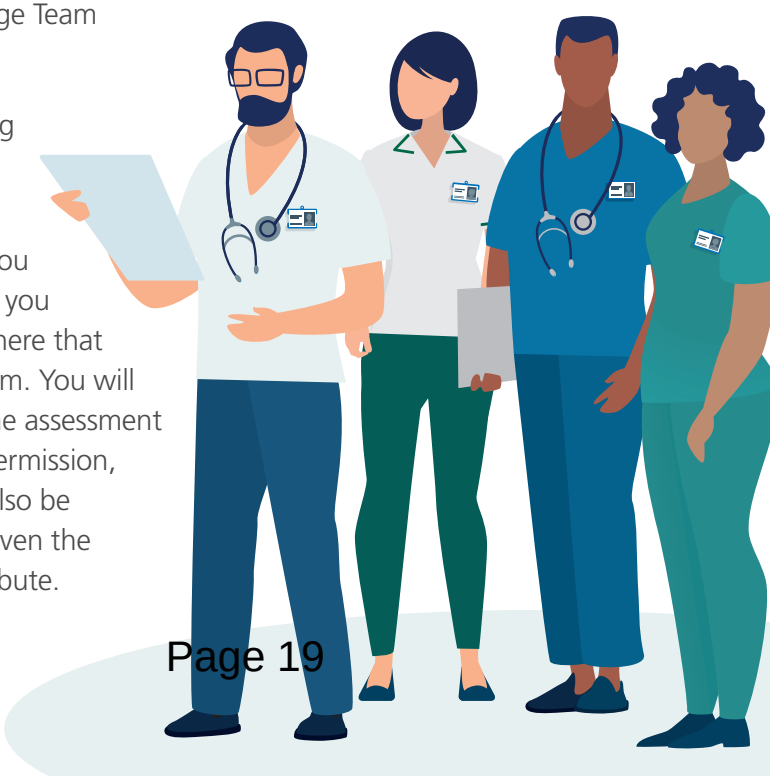
Who will plan my discharge from hospital?

Your hospital will start planning your discharge as soon as is possible. Following your admission into hospital, a case worker will be allocated to support the planning of your discharge. They will act as your single point of contact throughout the planning process. This person may change due to leave and other staff requirements.

It may be necessary to involve other professionals in your discharge planning. Here are some of the professionals who may also be involved:

- Specialist Nurse
- Physiotherapist
- Occupational Therapist
- Dietitian
- Speech & Language Therapist
- Integrated Discharge Team
- Social Worker
- Community nursing

A discharge assessment will determine whether you need more care after you leave hospital and where that care should come from. You will be fully involved in the assessment process. With your permission, family or carers will also be kept informed and given the opportunity to contribute.



The different types of discharge:

1. Discharge home

In most cases, it will be appropriate for patients to be discharged home with no additional support or input required.

1a. Discharge home with informal support from voluntary organisations

Voluntary teams (such as the Red Cross) work with hospitals and provide a level of support that will help you get home. This may include transport, shopping, minor cleaning at home and anything else to ensure you are comfortable at home after discharge. As well as practical help they will support you settle back at home, support you emotionally and highlight organisations in the community where you can access additional support, which might range from services that help with social isolation to welfare advice.

1b. Discharge home with additional support from the NHS community teams: occupational therapists, physiotherapists, community nursing

This support will be organised by the discharge team, in discussion with you and those who care for you, and you will be told who is coming, how to contact them and who to contact if there is a problem.

1c. Discharge home with a care package

This will be identified following a full assessment with your social worker. In most cases, your ongoing care will be organised by the local authority. This is a chargeable service. A financial assessment will be requested, which will be required by your social worker. If you have complex health needs you may be assessed and found eligible for Continuing Healthcare, which is provided by the NHS.

You can choose to not have a financial assessment, however, this means that discharge will proceed on the basis of you self-funding care.

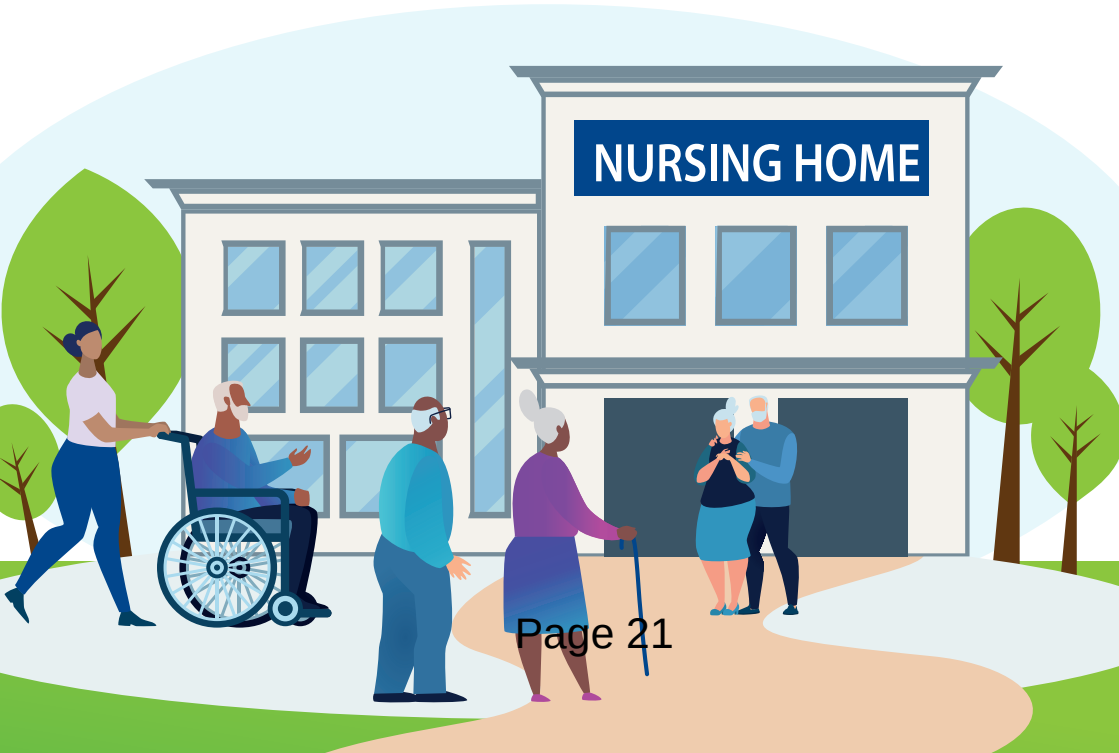
2. Discharge to somewhere other than your home

There may be several reasons why you would not be able to be discharged directly home from hospital. These are identified below:

- Changes in your housing / home environment
- Your home environment cannot meet your rehabilitation needs
- Complex nursing needs
- Your care and support needs can no longer be managed at home.

In any eventuality you will be discharged to the most appropriate accommodation, in some instances on a temporary basis such as:

- Extra care sheltered accommodation
- Community inpatient rehabilitation unit
- Residential care home
- Nursing home



We cannot always guarantee that the destination that you and family request as a preference, is available on discharge. Any changes or proposed suggestions will be discussed with you, family and the discharge and clinical teams.

We aim to ensure that every discharge is safe and completed in a timely way to prevent any potential risks whilst remaining in the hospital. However, sometimes unforeseen delays occur, or new options are provided at short notice. We aim to ensure you are provided as much notice ahead of discharge as possible.

2a. NHS Continuing healthcare

If you require a high level of health or care needs the ward team involved in your care may refer you for an NHS continuing healthcare assessment. If you have been assessed as eligible for NHS continuing healthcare, a package of services to meet your care needs will be arranged and funded by the NHS. These services can be provided in your own home or in a care home with or without nursing. If appropriate, this assessment should take place after you have left hospital and when you are in a care setting that is most appropriate for your care needs.

This may be a temporary placement such as a nursing/residential care home. Whilst every effort will be made to ensure that you are discharged to a temporary placement that is local to your family and friends. Due to availability of beds at the time of your discharge, it may not always be possible to guarantee that this temporary placement is within the location that you and your family would like.

Longer term nursing/residential care home placements will be based on all available local units across North West London.

2b. NHS-Funded nursing care

People with lower nursing needs who require a care home with nursing may be eligible for a weekly contribution towards registered nursing care. Your ward team can advise you on this. For more information, please ask for the leaflet: NHS continuing healthcare and NHS-funding nursing care – public information booklet.

Funding

Care from NHS services are free at point of access. However, discussions about the funding of your care arrangements for when you leave hospital, will be had with you while you are in hospital or with you or your nominated representative.

Local councils are responsible for commissioning social care and they each have their own charging policies. Your social worker will discuss what this means for you in detail.

However, as a general guide:

You will not be entitled to help with the cost of care from your local council if:

- you have savings worth more than £23,250 – this is called the upper capital limit, or UCL, and will rise to £100,000 from October 2025
- you own your own property (this only applies if you're moving into a care home)

You can ask your council for a financial assessment (means test) to check if you qualify for any help with costs.

More information about financial assessment can be found online at www.nhs.uk (Search Financial assessment, means test).

You can choose to pay for care yourself if you don't want a financial assessment. However, this means that discharge will proceed on the basis of you self-funding care.

You can:

- arrange and pay for care yourself without involving the council
- ask the council to arrange and pay for your care (the council will then bill you, but not all councils offer this service and they may charge a fee)
- Find out what care you need

Even if you choose to pay for your care, your council can do an assessment to check what care you might need. This is called a needs assessment.

For example, it will tell you whether you need home help from a paid carer for 2 hours a day or 2 hours a week and precisely what they should help you with.

The needs assessment is free and anyone can ask for one.

Medication

The hospital will aim to have your discharge medication ready on the day of estimated discharge.

Copy of letters

You will receive a copy of the letters sent to your GP relating to your hospital stay.

Therapy

If your hospital multi-disciplinary team decide that you require ongoing input from a physiotherapist or occupational therapist once home, they will ensure this is passed on to your local Therapy Team, who will support you to meet your needs and regain independence.

Below are the types of therapy you may be given:

Therapy on discharge

If a therapy request is required immediately following discharge you will receive a visit from a skilled and competent member of your local therapy team within 48 hours of discharge.

Community therapy

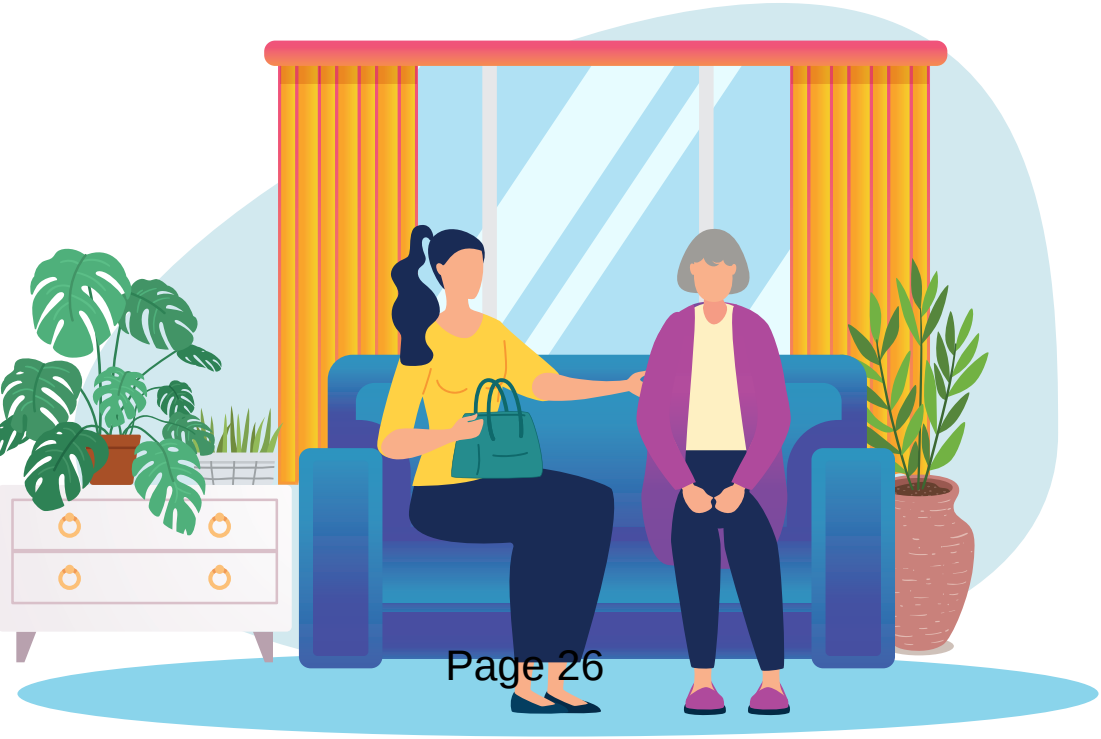
A member of the community therapy team will visit you for a period of up to six weeks. They will work with you on jointly agreed goals to continue your progress and maximise your independence at home, and if appropriate, outside the home. The team can provide any additional advice and support from local agencies and voluntary services to meet any on-going needs you may have.

Being looked after: Informal Carers

An informal carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction, cannot cope without their support.

The role of a carer can encompass a multitude of activities including, helping people to the toilet, helping with washing, dressing or moving around the home, shopping, cleaning, cooking, laundering of clothes, assisting with medication, managing money and taking people to attend appointments. If you are helping someone because they are ill or disabled, then you are a carer.

Carers UK has some very useful information about what to consider when coming out of hospital.



Discharge checklist

This checklist is for you, your designated hospital carer, and your family to ensure you have everything in place for your discharge.

You should make sure that each of these questions is ticked off before you go home; if anything is not checked off then please ask the designated member of your care team to organise what needs to be done to ensure your safe discharge:

- [ ] Have you made your relatives and carers aware of your estimated day of discharge?
- [ ] If you had any cannulas inserted were they all removed?
- [ ] Have you fulfilled all requirements for you to be discharged?
- [ ] Have you been to the toilet?
- [ ] Have you had something to eat?
- [ ] Have you planned where you are going 'home' to?
- [ ] Do you have a key to get into your property?
- [ ] Have you asked the ward staff to return any valuables you may have left in safe keeping?
- [ ] Do you have all of your other personal belongings?
- [ ] Have you made arrangements for your extra belongings to be taken home?
- [ ] Do you have outdoor clothes for your journey home?
- [ ] Have you changed into your personal clothes?
- [ ] Do you need a Medical Certificate to cover your hospital stay?
- [ ] Do you have all of your medication? If you normally receive your medication in a Nomad or Dossette box it is important that you tell us before the day of discharge.
- [ ] Have you arranged transport to take you home?

NHS North West London ICB
Version 1, March 2023

CSS5229 NHS Creative 03/2023

BritishRedCross

The British Red Cross Assisted Discharge Service is here to help this winter

We have implemented extra staff in your hospital this winter to help with added pressures on services. We are here to increase patient flow and ensure safer and faster discharge from hospital. Contact us today to find out more.

Tel: 07834 525352 or 07708 295657
Email: WinterPressureSupport@redcross.org.uk

The power of kindness

This page is intentionally left blank

Agenda Item 8

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date: 30 March 2023

Classification: **General Release**

Title: Health and Wellbeing Strategy

Report of: Rachel Soni – Bi-Borough Director of Health Partnerships

Wards Involved: All

Report Author and Contact Details: Aaron Hardy, Principal Policy Officer
ahardy1@westminster.gov.uk
Grant Aitken, Head of Health Partnerships
Grant.aitken@rbkc.gov.uk

1. Executive Summary

1.1 The Joint Westminster and Kensington and Chelsea Health and Wellbeing Board (HWBB) agreed in 2021 to undertake a refresh of their individual strategies to reflect learning from Covid 19 and to set out a direction of travel that would have an impact on health inequalities in our boroughs.

1.2 This report presents the draft 10-year Health and Wellbeing Strategy (HWBS) and seeks approval to consult for the next 8 weeks on the strategy.

2. Key Matters for the Board

2.1 The Board is asked to:

- Note the work carried out to date to develop the draft 10-year health and wellbeing strategy.
- Approve the draft strategy for consultation and
- Endorse and promote the consultation through your local networks and partnerships.

3. Developing the Health and Wellbeing Strategy

3.1 When agreeing to the development of a new joint Strategy the Board Members set out several principles, including:

- The strategy statement/vision covers a chosen 10 years with medium term organisational plans providing the detail and the delivery focus.
- Keeping residents at the heart of what we do
- Taking an evidence-based approach using local data sets, quantitative and qualitative
- Being accountable to residents with shared ownership of decisions in an open and transparent way through the HWB board
- Working across organisation boundaries in a collaborative way by focusing on residents and not the organisation
- To challenge inequalities by sharing, disseminating, and championing learning and evidence.

3.3 Additionally, the HWBB requested that the strategy development utilises existing evidence and engagement findings. This work involved a comprehensive literature review (Appendix A) to identify priorities and best practice to address health inequalities and to identify areas and issues that would impact people's lives by addressing the wider determinants of health.

3.4 The strategy has been informed by evidence throughout through the development of the he Joint Strategic Needs Assessment (JSNA) "Borough Stories" and other engagement activities with residents and partners. This information has provided much of the evidence informing the drafting of the strategy.

<u>Planning Workshops</u>

3.4 After the initial research period a working group of HWBB partners was established with representatives drawn from the local authorities, NHS and VCS organisations. Following a series of workshops, 10 Ambition statements / policy areas covering the wider determinants of health and wellbeing were agreed and developed.

<u>Engagement</u>

3.6 To test the emerging priorities and ambition statements a programme of wider engagement with residents, business and other partners was carried out. The key aim of the objectives of the engagement and consultation has been to:

- Understanding the voice of residents.
- Share information and understanding.
- Be collaborative in the development of the HWB strategy.

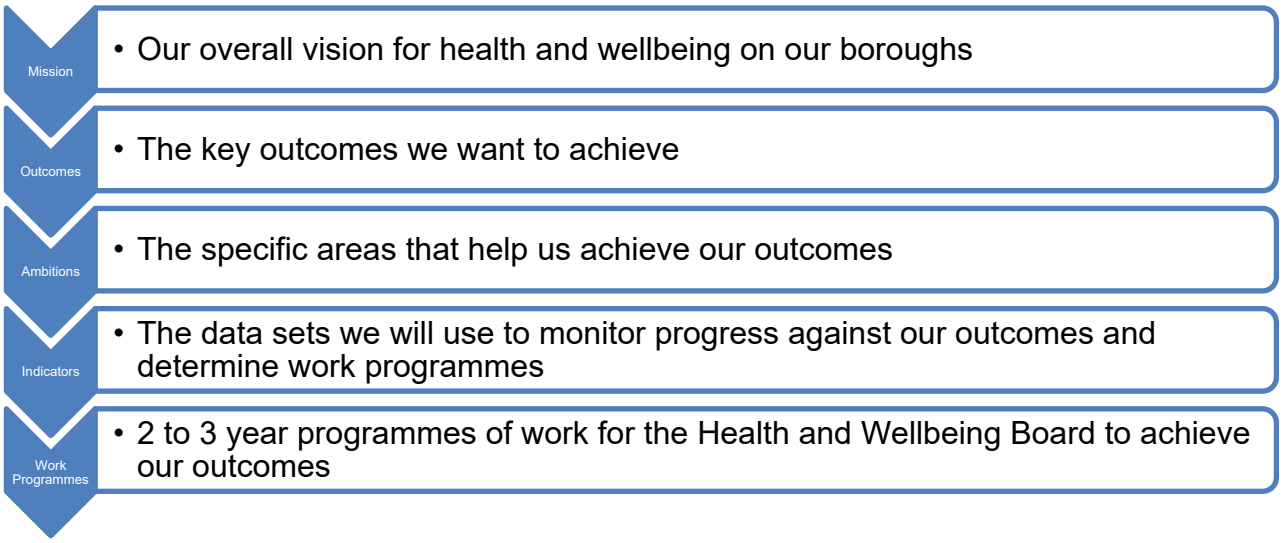
3.7 The development of the Strategy used a variety of engagement methods to reach as many people as possible to further develop the ambition statements of the strategy (see below). This has involved a mix of quantitative (feedback forms/ surveys) and qualitative (focus groups/ deliberative events/ workshops), for example,

- Workshops - to identify the priorities, structure and themes of the strategy.
- Summer Inequalities Programme engagement.

3.8 This was supported by an online survey. 51 responses were received made up of:

- 23 Westminster Residents.
- 13 Kensington and Chelsea Residents.
- 10 people who work in either borough.
- 9 other.

4. Draft Health and Wellbeing Strategy



4.1 The draft strapline for the Health and Wellbeing Strategy is '***Healthier and Happier Lives***'. This encapsulates our aims to tackle health inequalities, improve health and wellbeing and make sure everyone can live happy fulfilling lives.

4.3 Our co-produced vision outlines our approach to working with communities and across partners to make a difference to people's lives.

"People live healthy and happy lives to their fullest and in ways they choose in communities that are fair and safe."

4.3 Supporting the vision are the outcomes that matter to people and to be what we are all working to achieve.

- Residents live longer and in a way that allows them to fulfil their lives.
- Residents have their mental wellbeing seen as important as their physical health.
- Residents live in communities that are healthy, safe and with good quality schools, housing and environment.
- Residents have access to good quality and fairer services that meet their needs.

4.4 These outcomes will be how the HWBB measures its success in achieving the strategy's vision. An outcomes framework is being developed that will facilitate the principle that we are accountable to residents with shared ownership of decisions in an open and transparent way through the HWB board.

4.4 Following the HWBB meeting on 15 September 2022 feedback on the draft ambition statements have been incorporated to form the basis of the strategy. The 10 ambition statements are the specific policy areas that contribute to the outcomes:

1. Our children and young people are healthy, safe and happy and can achieve their full potential.
2. We can all be active in our health.
3. We support people to look after their mental wellbeing.
4. We have a good quality home.
5. We feel safe and part of our communities.
6. Our boroughs are healthy environments.
7. We have access to the best services when and where needed.
8. We are all treated with fairness and able to shape the decisions that affect us.
9. We are all financially stable and have access to enriching opportunities and good jobs.
10. We are supported and empowered to live as independently as possible.

4.5 Following the last discussion at the board of the strategy on 24 November 2022 a series of workshops were held on each of the 10 ambitions with colleagues from the Health and Wellbeing Board Members to test and refine the content of each statement.

4.6 Addressing health inequalities is complex and in the HWB Strategy there was a commitment to visualise what good health and wellbeing means for people. A visual artist was commissioned to work with a range of people and organisations to develop this visual including:

- Session with local residents identified through the Local Account Group and partners.
- Session with local organisations working across our boroughs.
- Session with young people.
- Session with senior managers.

4.7 The visual is within the document and helps to tie in the 10 ambition statements to reinforce how we all need to work collaboratively and with our residents to make a difference to the lives of local people.

4.7 The strategy commits to developing an outcomes framework that will include a two-to-three-year work programme setting out what the board will focus on during that period. These decisions will be based on a set of indicators – data sets that will show the progress we are making towards achieving our outcomes. The development of this framework will take place once the strategy has been approved.

5. Consultation

5.1 Subject to the board's approval, the Health and Wellbeing Strategy will be consulted on for 8 weeks. The draft consultation plan is attached at appendix C.

5.2 The consultation plan is built around 6 key activities/channels:

- In-person workshops across each borough
- Virtual workshops
- Online survey (including easy-read version)

- Hard copy survey (available in libraries, GPs etc)
- Attendance at strategic partner meetings and community groups
- Comprehensive comms plan to promote the consultation

5.3 The key audiences identified in the consultation are:

- Residents
- VCS and community organisations
- Strategic Partners
- Staff.

5.4 The consultation plan has been presented to the Westminster Quality Improvement Board and is currently going through the RBKC consultation gateway. Feedback received so far has focused on the need to make sure that we target the consultation at groups that are particularly affected by health inequalities and who are typically underrepresented in consultation responses.

6. Financial Implications

6.1 There are no direct financial implications arising from this report. Implementing our plans to achieve our strategy ambitions requires resources and investment over the long term as part of business and budget planning.

7. Legal Implications

7.1 The Health and Wellbeing Board has a statutory duty to prepare a joint health and wellbeing strategy under s116A of The Local Government and Public Involvement in Health Act 2007.

8. Carbon Impact

8.1 Health and Wellbeing outcomes include environmental impact. It is believed that there is no direct carbon impact as a result of this report, however the strategy will aim to bring positive indirect impacts.

9. Consultation

9.1 The Health and Wellbeing Strategy will be subject to formal consultation before being agreed by the Health and Wellbeing Board.

10. Equalities Implications

10.1 The Health and Wellbeing Board must have due regard to its public sector equality duty under Section 149 of the Equality Act 2010. In summary section 149 provides that a Public Authority must, in the exercise of its functions, have due regard to the need to:

(a) eliminate discrimination harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

(c) foster good relations between persons who share a relevant protected characteristics and persons who do not share it.

10.2 Section 149 (7) of the Equality Act 2010 defines the relevant protected characteristics as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

10.3 An initial screening has been completed. The Council believes there are no negative direct equalities implications arising from this report. An Equalities Impact Assessment will be undertaken as part of each policy review and is underway for the strategy.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:
Grant Aitken, Head of Health Partnerships
gaitken@westminster.gov.uk

Appendices

- Appendix A – Literature Review
- Appendix B – Summary of engagement activity to date
- Appendix C – Consultation Plan

Appendix A: RBKC & WCC Health and Wellbeing Strategy Literature Review

Strategies	Reports	Insight/Engagement
• Fairer Westminster Strategy 2022-2026 • RBKC Council Plan • Our strategy for Special Educational Needs and Disabilities 2021-2024 Kensington and Chelsea Council • Our strategy for Special Educational Needs and Disabilities. 2021-2024. City Of Westminster • Autism Strategy • WCC Emerging Corporate Strategy • Cultural Strategy • Best practice Health and Wellbeing Strategy Examples • ICS Priorities • Active Westminster Strategy • Air Quality Action Plan • RBKC and WCC SEND Strategies • NHS Long Term Plan • Biodiversity Action Plan • Children and Young People's Plan	• Kensington and Chelsea Health Report October 2021, Public Health Intelligence • Westminster Health Report October 2021, Public Health Intelligence • The Mosaic Community Trust Annual Report 2021-2022 • Active Westminster Active • Communities Report • Church Street Youth Voices Project Report • Bi-Borough Vaccine Sentiment Paper • CP Summary Review • SWIM Covid-19 Assertive Outreach Report • SWIM Project Closure Report • Mosaic Vaccine Hesitancy Report • BMEHF Vaccine Report • Fuller Report • The Marmot Review • The Marmot Review 10 Years On • BMEHF Social Isolation Report • My Care My Way • Children and Young People's Plan Engagement Report • Doing Things Differently - A strategy for embedding voluntary and community action in the health and care system to address health inequalities (January 2023) • Access to care: identifying the barriers for Bangladeshi	• CYPP Engagement Review (Summary of recent consultation activities with children and young people across the Bi-Borough (2018-2022) • COVID-19 Student Voice Survey collected 126 responses from primary schools, 374 from secondary schools and colleges and 42 responses from pupils with SEND (Bi-borough, 2020) • Grenfell – Children and Young People's Emotional Health and Wellbeing Services with parents and carers, children and young people, schools, and residents or members of the wider North Kensington community (RBKC, 2021) • Community Safety Survey with residents, businesses, and other stakeholders (RBKC, 2021) • Here to Listen Event (WCC, 2021) • Churchill Garden Estate Survey May 2021 • Active Westminster Strategy Engagement session 2022 • Service User Feedback – Mental Health Strategy Kensington and Chelsea • Stakeholder Engagement – Mental Health Strategy Kensington and Chelsea • Virtual Wallet User Findings • Persona Profiles and Findings • Youth Wellbeing Feedback

	communities in West London (2023)	• Young People Covid Concerns • City For All – Resident Engagement Findings • Youth Outreach British Red Cross – Bi-Borough • Covid Sentiment Survey 2020 & 2021 • North Kensington Health and Wellbeing Survey • Older People's Day Services consultation • Grenfell EHW Adults Consultation • WCC City Survey

Appendix B: Summary of Engagement Activity to date for the WCC & RBKC Health and Wellbeing Strategy Development

Stakeholder/Event	Activity
Residents	
RBKC Citizen's Panel	Market Stall
Health Champions	Presentation and discussion
Community Champions	Presentation and discussion
Young People	
Youth Action Alliance	Workshop
Youth Healthwatch	Workshop / Presentation
RBKC Youth Council	Workshop / Informal Discussion
RBKC Youth Council	Visual artist coproduction session
WCC Youth Council	Workshop / Informal Discussion
Health and Social Care	
Youth Hubs	Presentation and discussion
Healthwatch – RBKC and WCC	Meeting and discussion (Virtual)
Health and Wellbeing Board	Various meetings
NW London ICB	3 x staff workshops
NWL ICB Primary Care Executive Committees-both boroughs	Presentation and discussion
NWL ICB Engagement Team	Meeting and discussion to promote engagement
BME Health Forum	Met with officers and attended Social Isolation event to incorporate comments
BME Health Forum	Public Event linked with JSNA to promote
RBKC Mental Health Partnership	Presentation and meeting to support engagement
Westminster Mental Health Partnership	
VCS / Community	
One Westminster	Survey and overview of the HWBS was provided to One Westminster for distribution in their newsletter.
Kensington and Chelsea Voluntary Sector Council	Presentation to KCSC CEOs across VSC to encourage engagement with development
Action Disability Kensington and Chelsea	Presentation and discussion
Mosaic Trust	Meeting / workshop
RBKC Council Plan Engagement	3 x presentations and market stall
The Advocacy Project	Presentation and discussion
Abbey Centre	Attended Needs Assessment Focus Group Attending South Westminster Neighbourhood Network*
North Kensington Volunteer Centre	Visual artist coproduction session
Local Action Group	Visual artist coproduction session
VCS and Business Partners	Visual artist coproduction session

Council	
IGXU	Met with officers and collated with feedback
Active Westminster Partnership	Meeting and workshop with ActiveWestminster
Portobello Business Centre	Market stall as part of the summer events programme (17 organisations)
RBKC Healthwatch Advisory Group	Presentation and discussion
Grenfell Recovery Teams	Met with North Kensington Recovery Team
Bi Borough CYP	Presentation and wider discussion to ensure links across partnerships

Health and Wellbeing Strategy
Engagement and Consultation and Communications Plan
Westminster City Council
Royal Borough of Kensington & Chelsea Council

Overview

The aim of this Health & Wellbeing Strategy (the draft Strategy) consultation and communications plan is to set out how we will promote the consultation and receive and respond to feedback on the draft Strategy.

The Joint Westminster and Kensington and Chelsea Health and Wellbeing Board (the Board) brings together the Councils, NHS, the Voluntary and Community Sector (VCS) and other local partners to promote integrated health and social care to improve residents' health and wellbeing. The draft Strategy sets out our ambitions for improving health and wellbeing and tackling health inequalities in our boroughs.

The engagement and consultation will be run across both local authorities in partnership with NHS, VCS and wider partners.

Background

The development of the Strategy began in 2022 and has used a variety of engagement methods to ensure the strategy is evidence based and reflects residents' priorities. This has involved a mix of quantitative (feedback forms/ surveys) and qualitative (focus groups/ deliberative events/ workshops).

Aims and Objectives of Consultation

The key objectives of the engagement and consultation are:

- **Information sharing** – We will explain what is happening across the place-based partnership and the work done so far to develop the draft Strategy
- **Consultation** – We want comments on the approach of the strategy and the draft ambitions.
- **Feedback Loop** - This consultation will engage with those that have already contributed to the strategy development. This will provide reassurance to stakeholders that their voice has been heard and shaped the strategy.
- **Collaboration** – This is the start of a longer-term development of the Board to ensure it represents the resident voice and through this consultation we will raise awareness of the work of the board and how people can engage in its work.

Consultation Methods

Audience	Method and Purpose	Timing, Location, resources
Residents	In-person workshops to seek feedback on the strategy. Link into family hubs and other existing programmes and community groups and events	2 x 90 min workshops in each borough (north and south) Link with community champions 5pm - 7pm
	Virtual workshops to seek feedback on the strategy	2 x workshops

	Promoting consultation and events	Throughout the consultation period Small leaflets – dates and QR code Social media Attendance at events
	Online survey to gather feedback	Two formats of survey Abridged and full Different languages, Easy Read (Nick Marchant) Ask EQIA question
	Hard copy survey to gather feedback	Available in libraries, leisure centres GPs etc. Free postage code
	Visiting specific services	Care Homes, Day Services, Hubs etc.
VCS Partners	In Person workshops to get feedback on the strategy	2 in each borough
	Virtual workshop to get feedback on the strategy	1
	Online survey to gather feedback	As above
Strategic Partners	Presentations, partners to promote the consultation and survey links	Partners to deliver presentations
Staff	NHS	2 'Blended' workshops across bi-Borough NHS providers/ ICB Re-engagement via PCEC/ Clinical Directors- 1 for each place SMT engagement
	Local Authority	Loop Live SMTs RBKC Scrunty - May RBKC internal comms - (Jo Birch RBKC)

In addition to the above, a pack will be developed to present at any existing events if the opportunity arises. Previous experience shows that specific and targeted events regarding health and wellbeing are required as standalone, as well as attending existing events (where time can be restricted). Attending existing events will primarily be used as an opportunity to promote the above opportunities. We will focus on events where there are already compelling reasons for residents to attend.

Consultation questionnaire

The consultation will ask people to provide their comments via an on-line form that will be accessible on the council's website, the full survey will be supplemented with an easy read survey. Hard copies of the survey will be made available at libraries, GPs and other locations.

Aims and Objectives of Communications

The communications objectives are as follows:

- Residents and partners understand what the health and wellbeing board and strategy are and what our priorities are in relation to consultation.
- Residents and partners understand how they can feedback on the draft strategy

- Residents and partners know how they can engage with the Health and Wellbeing Board in the future.

Messaging

- This is our 10-year strategy to address health inequality and improve health and wellbeing across our boroughs.
- The consultation on a new strategy begins on XXXX and closes on XXXXX and residents, businesses and statutory groups are being encouraged to take part. www.xxxx.westminster.gov.uk.

Campaign audiences and key communications channels

This section sets out the main communications channels that will be utilised to reach key audience groups.

Audience	Communications channel
Kensington and Chelsea residents	• Screens in GP surgeries • Screens in leisure centres and Kensington Town Hall • Screens on Council estates • Council publications: North Ken News, Our Borough, Housing Matters, K&C Life • Website • Social media • Council A1 Poster sites • Posters in Libraires • Existing service user / patient groups
Westminster residents	• Council publications: MyWestminster, YourWestminster, Families First, YourHome, Westminster Plus • Website • Licensing newsletter • Social media • Media • Screens in GP surgeries • Existing service user / patient groups
Partners	• BIDs • Business newsletter • Website • Social media • Media • Licensing newsletter
Statutory authorities	• Series of emails during eight-week consultation period with links to website
Ward councillors	• Briefing note • Briefing session • Links to website

Inclusive Engagement

For this consultation we are looking at underrepresented groups in two ways:

1. Groups that are affected by health inequalities.
2. Groups underrepresented in consultations.

Health Inequalities

Health inequalities are cross-cutting, there is no one group that is solely affected by health inequalities, different groups suffer unfair injustices across the range of wider health determinants. However, where we know that a health inequality exists we will target the affected groups as part of our consultation.

Analysis is being undertaken using the Joint Strategic Needs Assessment (JSNA) to identify groups that should specifically be targeted as part of the consultation.

Groups underrepresented in consultations

We will do more to target groups that are historically underrepresented in Local Authority consultations. These groups are:

- Young people and young adults (under 35s).
- Those whose first language is not English.
- Residents living with a disability.
- Digitally excluded residents.

EQIA

- Initial screening in complete. An EQIA is being completed and will be published with the strategy. There will be a question as part of the consultation on the EQIA.

Feedback to residents

In order to close the feedback loop the results of the consultation exercise will be presented in three ways:

- A comprehensive report published and presented to the Health and Wellbeing Strategy
- The consultation will inform the 'What our residents tell us' section of the strategy
- Top line results will be published on the Health and Wellbeing webpages as a 'you said, we did'.

.

Project Plan

Week	Comms	Consultation
-3		Make sure venues are booked Ward Member Briefings to cover: • The strategy • How residents can get involved
-2	Draft Materials • Updated webpage with consultation • Media release and reactive FAQs • Social media posts • Email to partners • Ward councillor briefing note • Publication content	
-1	Share posters/leaflets/hard copy surveys with partners	
1	Webpage goes live Materials in libraries/surgeries/notice boards Social Media Posts (twice a week) Notice Boards go live Email stakeholders list MyWestminster newsletter YourHome newsletter Westminster Reporter Westminster Plus Email briefing to Ward Councillors WIB	Consultation launches Online surveys go live
2	Social Media Posts (once a week)	
3	Social Media Posts (once a week)	
4	Social Media Posts (once a week)	
5	Social Media Posts (once a week)	
6	Social Media Posts (once a week)	
7	Social Media Posts (once a week)	

8	Social Media Posts (once a week)	
9	Social Media Posts (once a week)	
10	Social Media Posts (once a week)	
Post Consultation	Update webpage – consultation now closed A response table and our consideration and decision on consultation comments/ suggestions will be published on the website. Email key stakeholders with summary of responses and next steps.	
TBC		In-person resident workshops x 2 in each borough Virtual resident workshops x 2 In-person partner workshop – 1 in each borough Virtual partner workshop Canvassing events

Outstanding Actions			
Action	**Owner**	**Update**	**Deadline**
Find workshop venues			
Produce comms products			
Identify comms channels for RBKC residents			
Identify service visits			