Public Document Pack

City of Westminster

Committee Agenda

Title:	**Adults and Children's Services Policy and Scrutiny Committee**
Meeting Date:	**Tuesday 20th October, 2020**
Time:	**7.00 pm**
Venue:	**This will be a virtual meeting**

Members:

Councillors:
Iain Bott (Chairman)
Margot Bright
Nafsika Butler-Thalassis
Maggie Carman
Angela Harvey
Eoghain Murphy
Tim Roca
Selina Short

Elected Voting Representatives
Ryan Nichol, Parent Governor
Vacant

Co-opted Voting Representatives
Alix Ascough, Church of England Diocesan Representative
Marina Coleman, Roman Catholic Diocesan Representative

Non-Voting Co-opted Representatives
Sam Green, Principal, Pimlico Academy
Vacant

This will be a virtual meeting and members of the public and press are welcome to follow the meeting and listen to discussion to Part 1 of the Agenda.

This meeting will be live streamed and recorded. To access the recording after the meeting please revisit the link.

If you require any further information, please contact the Committee Officer, Tristan Fieldsend: Senior Committee and Governance Officer.

Tel: 07812 760 335 Email: tfieldsend@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

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 Head of Committee and Governance Services in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1.	**MEMBERSHIP** To note any changes to the membership.	
2.	**DECLARATIONS OF INTEREST** To receive declarations by Members and Officers of the existence and nature of any pecuniary interests or any other significant interest in matters on this agenda.	
3.	**MINUTES** To approve the minutes of the meeting held on 8 September 2020.	**(Pages 5 - 12)**
4.	**CABINET MEMBER FOR CHILDREN'S SERVICES - PORTFOLIO UPDATE REPORT** Update to the Committee on current and forthcoming issues in this portfolio.	**(Pages 13 - 24)**
5.	**CABINET MEMBER FOR ADULT SOCIAL CARE AND PUBLIC HEALTH - PORTFOLIO UPDATE REPORT** Update to the Committee on current and forthcoming issues in this portfolio.	**(Pages 25 - 30)**
6.	**THE FUTURE OF THE GORDON HOSPITAL** To receive an update on the current status of closed inpatient wards at the Gordon Hospital and CNWL's plans and approach for the future of the site.	**(Pages 31 - 38)**
7.	**WESTMINSTER OUT OF HOSPITAL RECOVERY PLAN** To receive an update on the Westminster Out of Hospital Recovery Plan.	**(Pages 39 - 76)**
8.	**2020/21 WORK PROGRAMME AND ACTION TRACKER**	**(Pages 77 - 84)**

9. REPORTS OF ANY URGENCY SAFEGUARDING REPORTS

Verbal Update (if any).

10. ANY OTHER BUSINESS

To consider any business which the Chairman considers urgent.

Stuart Love
Chief Executive
12 October 2020

This page is intentionally left blank

CITY OF WESTMINSTER

MINUTES

Adults and Children's Services Policy & Scrutiny Committee

MINUTES OF PROCEEDINGS

Minutes of a virtual meeting of the **Adults and Children's Services Policy & Scrutiny Committee** held on **Tuesday 8 September 2020.**

Members Present: Councillors Iain Bott (Chairman), Margot Bright, Nafsika Butler-Thalassis, Maggie Carman, Angela Harvey, Eoghain Murphy and Tim Roca

Co-opted Members: Ryan Nicol

Also Present: Councillor Tim Mitchell (Cabinet Member for Adult Social Care and Public Health)

1. MEMBERSHIP

1.1 Apologies for absence were received from Councillor Peter Freeman and co-opted members Marina Coleman and Sam Green

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

3. MINUTES

RESOLVED:

3.1 That the Minutes of the Adults and Children's Services Policy and Scrutiny Committee meeting held on 15 June 2020 be approved.

4. CABINET MEMBER FOR ADULT SOCIAL CARE AND PUBLIC HEALTH – UPDATE

4.1 Councillor Tim Mitchell (Cabinet Member for Adult Social Care and Public Health), provided a briefing on key issues within his portfolio. The Committee also heard from Russell Styles (Deputy Director of Public Health), Senel Arkut (Director of Health Partnerships) and Dr Neville Pursell (Central London CCG – Chair).

4.2 The Committee received the update and held detailed discussions on the following topics:

- Covid-19 – The Committee was updated on the number of Westminster residents who had tested positive for Covid-19. The infection rate in Westminster was currently below the level requiring any further action to be taken however this would continue to be monitored closely.

  Details on how the Council was supporting the national Test and Trace programme was provided which involved using local data and knowledge to profile the spread of Covid-19 in the borough and to help prevent and manage any outbreaks and clusters. The Committee noted that there were no particular areas within the borough which had seen any concentrations of the virus however this would be monitored. A mobile testing station was operating two days a week in Hyde Park in addition to the other testing sites available. Alternative sites had also been identified if the rate of infection increased in the future to ensure sufficient capacity would be available.

  The groups experiencing the highest levels of infection were those in the 18-29 age bracket and people returning from holiday. Specific communication campaigns had been instigated targeting younger people using social media in order to disseminate information regarding following government guidelines. Ongoing work had also been undertaken with institutes of higher education to ensure returning students were provided with safe environments to study and encourage them to adhere to social distancing rules.

  It was confirmed that the Police were responsible for enforcing the wearing of face masks on public transport. The Committee requested that an update be provided on the number of fines issued to people not wearing face masks on public transport.

  The Committee provided its thanks to the Cabinet Member for Adult Social Care and Public Health and those officers in Adult Social Care and Public Health for all their hard work in extremely challenging circumstances.

- Gordon Hospital Consultation – The Committee was provided with an update on Central North West London (CNWL) NHS Trust's decision in

March 2020 to temporarily close the Gordon Hospital as a key part of their response to the Covid-19 pandemic. It was explained that the proposal was part of the NHS Long Term Plan to support people at home and shift care from inpatient to community-based settings where clinically possible. It was anticipated that there would be further consultation on its potential permanent closure, but concern was raised the impact this would have on the local Mental Health inpatient provision. The Committee requested that a further update be provided by CNWL providing a full background on why the closure had taken place. A breakdown was also requested detailing which facilities Westminster patients were now having to be admitted to, including if any of these were located in outer London. In response to a question it was confirmed that the Police would be liaised with on the closure of the hospital to ensure they were involved in the consultation process.

5. CABINET MEMBER FOR CHILDREN'S SERVICES – UPDATE

5.1 Councillor Tim Barnes provided a written update on key issues within his portfolio including: the Covid-19 response and recovery activity, operational updates, libraries and registration services. The Committee was requested to submit any questions on the update in writing.

6 PROPOSED NORTH WEST LONDON CCG MERGER

6.1 Jo Ohlson (North West London CCG – Accountable Officer) introduced the report outlining the proposal to merge the eight CCGs in the North West London Integrated Care System into one CCG. The Committee also invited Jules Martin (Central London CCG – Managing Director), Dr Neville Pursell (Central London CCG – Chair), Louise Proctor (North West London CCG – Managing Director) and Jenny Greenshields (North West London CCG – Chief Finance Officer) to join the discussion on this item.

6.1 The Committee was informed of the reasons for the proposed merger and how it was proposed to submit the application in 2021/22. If it was agreed to implement the proposals a number of commitments had been made, including:

- Retaining strong borough teams and relationships;
- Retaining primary care funding at a local level; and
- Increasing investment in primary care

6.2 In response to questions from the Committee it was acknowledged that potentially Westminster's financial allocation would reduce. However, across North West London the proportion of investment in out of hospital services would be increased, with a first step of levelling up investment in primary care services

outside the core contracts. This would ensure consistent services were offered to patients. It was also explained that core primary care commissioned services would be assessed over the next few months in order to develop plans of levelling up primary care provision across NWL over time.

6.3 Concern was expressed that merging the eight CCGs in North West London into one CCG would lead to a loss of voice for local residents. The Committee was informed that it was envisaged that having one CCG taking strategic decisions across the whole area with smaller PCNs at a local level would result in an even closer local focus, whilst at the same time enabling more effective commissioning of services. Patients and GP member practices would continue to be involved in the single CCG and at a local level. Decision making would be devolved on delivery and integration of services to the neighbourhood and borough level as the integrated care partnerships developed. Work was already being undertaken with Healthwatch and local stakeholders to develop proposals for how patient and public involvement would work in practice. The single CCG would also retain a strong local presence, including responsibility to work with local people and stakeholders, to listen to their feedback and to involve them in shaping services. The Committee was informed that the aim was to enhance patient and public involvement and engagement in the new system to ensure the patient and resident voice was consistently heard and listened to.

6.5 The Committee still expressed concerns over the proposals and how they impacted on the residents of Westminster. The Committee thanked the witnesses present for answering its questions but highlighted the importance of continued consultation on the proposals in order to receive reassurances that they would benefit local residents.

7 COVID-19 SUPPORT TO ADULT SOCIAL CARE PROVIDERS

7.1 Gareth Wall, Director of Integrated Commissioning, provided the Committee with an update on Covid-19 support to Adult Social Care providers. It was explained that central to the response had been to ensure support was in place for Adult Social Care providers, both Residential Care Homes and Home Care (Domiciliary Care), to guarantee that they were able to provide safe effective care to residents. Support had included daily calls with providers from March 2020, the provision, guidance and training for Personal Protective Equipment (PPE) and a package of financial support measures designed to mitigate some of the financial impacts that they had experienced due to Covid-19.

7.1 The Committee was interested to learn about staffing levels at care homes during Covid-19. It was confirmed that some staff had to isolate during this period and as part of the programme of daily calls to care homes staffing levels were monitored. In the majority of cases care homes and home care providers were able to cover any staff isolating through their existing staffing quotas. In some

instances, additional recruitment was required and an update on staffing levels would be provided to the Committee. In response to a query regarding agency workers working at multiple care homes it was explained that there was a type of funding made available to care homes titled the Infection Control Fund. One of the conditions of the fund was to limit the use of agency workers and ensure there was a consistency of staff. For the funding to be released assurances were required by the care homes confirming that consistent staffing was provided.

7.2 Concern was expressed over whether there were sufficient levels of PPE in care homes considering there were fears of a winter spike in Covid-19. The Committee noted that levels of PPE and the type of PPE each care home had was being monitored. Supply lines were now stable and currently there was at least three month's supply available. Stocks were available to supplement levels when required and the Council had secured supply routes to access PPE through a national portal.

7.3 An update was provided on what provisions had been made to ensure residents of care homes were able to receive visitors. Work had been undertaken with care homes and the NHS to develop safe ways of conducting visits. This included meeting outdoors, using social distancing measures and through the use of technology. Care homes had been requested to develop plans on how visits would be undertaken but following the recent restrictions imposed by the Government on the number of people able to meet advice on visits may have to be amended.

7.5 The Committee expressed its thanks to all those involved in the early action undertaken to protect care homes during the Covid-19 pandemic and all the hard work that was continuing to be undertaken in this field.

8 MATCHING PROCESS FOR ADOLESCENTS IN CARE

8.1 Nicky Crouch, Director of Family Services, presented a report outlining Westminster Children's Service's (WCC) matching process for adolescents in care. Following an outstanding OFSTED inspection in September 2019 the only action arising was to improve the formal matching and panel approval of adolescents in long term foster placements. The Committee was updated on what considerations were factored in when placing children and the actions taken to ensure the Council was formally matching older children to their carer's to ensure 'permanence' was being achieved in a timely way.

8.2 The Committee was informed that matches took place on several different levels with the mantra of "right placement, first time," being the priority. Wherever possible extended family or friendship networks would be assessed first, however if this was not viable, it would be endeavoured to match children to 'in house' foster carers before exploring spot purchased external resources. The Committee

noted that when a child's care plan was confirmed and they were placed in a long term placement where they were expected to remain for the remainder of their time in care, efforts were made to formally match the child and placement, giving the child a sense of 'permanence' and security.

8.3 The Committee was interested to note that during the Covid-19 pandemic it was expected that there would be an increase in need of placements as a result of an increase in safeguarding issues, however this did not materialise. What was observed was a reduction in referrals whilst looked after numbers remained settled and stable. This small decrease was as a result of a reduction of unaccompanied minors arriving, although increases were being identified again.

8.4 A detailed discussion was held on the challenges of finding appropriate placements for unaccompanied minors which was often complicated by a lack of information about the child. Efforts were made to place the child to reflect ethnicity, language and religion and there was a diverse foster pool to help enable this. Members also discussed help available to foster carers and requested an update be provided on this area including whether they were provided with council tax relief.

8.5 The Committee expressed its thanks for all the efforts and hard work undertaken in this particularly challenging area. Members supported the efforts made to enhance the matching process and ensure it was even more robust going forward.

9 2020/21 WORK PROGRAMME AND ACTION TRACKER

9.1 Lizzie Barrett, Policy and Scrutiny Officer, presented the Committee's 2020/21 Work Programme and Action Tracker.

9.2 The Committee reviewed the draft list of items and suggested potential future topics including the future of the Gordon Hospital and school exclusions could be included on the work programme.

RESOLVED:

1) That the Work Programme be noted; and

2) That the recommendation tracker be noted.

10 REPORTS OF ANY URGENT SAFEGUARDING ISSUES

10.1 The Chairman requested that an update be provided on the reported increase in serious youth violence following the easing Covid-19 lockdown measures.

The Meeting ended at 8:53pm.

CHAIRMAN: _____ DATE: _____

This page is intentionally left blank

City of Westminster

Adults and Children's Services Policy & Scrutiny Committee

Cabinet Member Update

Date:	20 October 2020
Briefing of:	Councillor Tim Barnes, Cabinet Member for Children's Services
Briefing Author and Contact Details:	Charlie Hawken chawken@westminster.gov.uk

1 SCHOOLS REOPENING

1.1 **Attendance**: in Week 4 (28th September to 2nd October), primary schools in WCC showed a rise in attendance from Monday through to Wednesday with a slight decrease on Thursday and Friday. Attendance was at 90% at the end of the week, slightly below the national average but above the average for London.

1.2 In terms of secondary schools, figures have shown a slight decline in the 4th week with attendance at 84-86%, compared to weeks 2 and 3 where the figures were between 88-92%. Thursday and Friday showed a decrease in attendance compared to the rest of the week. Westminster secondary schools were at 84% by the end of the week which is below the national average but above the London average.

1.3 Data on attendance is obtained by the Council from the DfE online portal. The Education Service has also established a by exception reporting system. Schools with below 85% attendance are asked to provide details to the School Standards team. Schools are then contacted by their lead adviser to discuss whole school attendance and the information is also shared with Early Help. The reason for the slightly low primary attendance is due mainly to children being absent due to the usual colds and childhood illnesses where parents are anxious and not sending them in. Schools are working with parents to ensure they understand the symptoms of Covid.

1.4 Early Help is working closely with all schools, supporting individual cases where there are concerns about attendance. With the return to statutory attendance in September, the usual referral process is in place, although the Council is

sensitive to the current situation and would not issue any warning letters or penalty notices unless it was felt appropriate.

1.5 In line with government and public health guidance, schools have put into place appropriate controls. This has included staggered start and finish times to the school day and the setting up of controlled 'bubbles' for teachers and class groups.

1.6 New admissions to Reception in September have held up well, with schools not experiencing any significant drop that might have been expected following the lockdown period. These figures are encouraging. However, long term trends remain poor with low numbers reflecting changes in London's demographics. This presents a significant financial threat to the long-term ability to provide for the education of our young people at the standards we expect. Schools have been engaged through the Schools Forum to consider solutions to meet this challenge, which will likely mean a need for total capacity within Westminster schools to decrease further over time, particularly at Primary level.

1.7 **Emotional Wellbeing and Mental Health Support Offer:** it is widely acknowledged that Covid-19 is having a detrimental impact on the emotional wellbeing and mental health (EWMH) of many children and young people. In spite of this, referrals into local EWMH services (including CAMHS) dropped significantly early in lockdown. They have increased over time. However they are currently still at a lower level than they were pre-lockdown. This follows the same pattern seen in many services.

1.8 Headteachers have recognised the need to support the social, emotional and behavioural wellbeing of children as they have returned to school. Over the past couple of years there has been a key focus on developing and embedding a whole school approach to EWMH and this has meant that our school-based support offer has adapted well to meeting evolving needs during the last 6 months. We have delivered support and training to school staff focused on the resilience and wellbeing needs of children coming back to school after lockdown. We have had specialist input from the Education Psychology Service with webinars on transition, recovery and learning, various bespoke training courses focused on topics such as building resilience, dealing with loss and bereavement, and emotional coaching.

1.9 Mental Health Support Teams (MHSTs) provide additional support in 43 schools/settings in Westminster. The Teams' tailored whole school offer in each school (focused on low to moderate mental health needs) has continued to evolve to meet needs during lockdown. The support of these teams extends beyond pupils to also include parents, teachers, headteachers and governors as part of a genuinely whole school approach. We are aware of the significant impact Covid-19 is having on school staff. To support this, the School Standards Team commissioned a Headteacher Coaching Circle focused on supporting emotional wellbeing and providing the opportunity to

reflect and learn from peers. In addition, the MHSTs are providing a variety of staff focused support.

1.10 Going forward, we will shortly be rolling out the DfE's Wellbeing for Education Return initiative locally. This will take the form of delivery of additional training to school staff across the borough and an enhanced menu of EWMH school support that schools which don't have MHSTs can draw on. This flexible menu of support will be designed to meet schools where they are in terms of their whole school approach to EWMH journey. In addition, we will be delivering further Trauma Informed practice training to school staff and will be delivering EWMH training for school governors to increase their awareness of the key role that they can play in supporting pupil and staff wellbeing as part of an effective whole school approach.

1.11 **Outbreak control process and data:** schools have been sent a Unique Organisation Number (UON) by DHSC which they can use to order tests. Schools have been informed of this via the weekly schools bulletin as well as through Heads meetings which are attended by colleagues from Public Health. We have provided them with the link they need to request tests and these kits are supplied in boxes of 10, with one box per 1,000 pupils or students. Schools are able to order additional tests should they need them. In consultation with the local Director of Public Health, where an outbreak in a school is confirmed, a mobile testing unit may be dispatched to test others who may have been in contact with the person who has tested positive. Testing will first focus on the person's class, followed by their year group, then the whole school if necessary, in line with routine public health outbreak control practice. To date (week of the 5th of October), since September there have been 16 positive cases among staff and 35 positive cases among pupils. The early years and schools outbreak management team (OMT) process has allowed us to have "real-time" intelligence.

1.12 **Congratulations to Max Haimendorf,** Principal of King Solomon Academy, who has been made an OBE in the Queen's Birthday Honours 2020 for his services to education.

2 WORKING WITH CHILDREN, YOUNG PEOPLE AND FAMILIES

2.1 **Family navigators and wrapping support around primary schools:** the new role of the Family Navigator has been central both in terms of the integration of services that makes up the Family Hub and in terms of supporting a family's early access to services. The role was tested in Bessborough and has recently (April and May 2020) been extended to the hubs in the NE and NW. The skilled practitioners build bridges to and from local schools and GP practices, helping these providers support families into the services they need and then coordinating the network around a family. This was a major topic of discussion with Vicky Ford MP, the Minister for Children, during a virtual visit of the WCC Family Hubs services on 15

October. Westminster was elected for the visit having been identified as a beacon of excellence for family service provision.

2.2 Since the role began the navigators have worked with over 170 families and more than 310 children and young people. The two most common reasons for referral have been housing issues and children with SEND. Approximately 50% of the families referred meet at least two of the wider Troubled Families criteria. From end of March until the end of June 2020, the Family Navigators undertook around 500 contacts per month with families. Currently the Navigators are supporting schools by visiting families who are nervous about sending their children back to school.

2.3 **Our parenting offer:** the parenting offer to families has continued to develop and is now delivered on-line; many offered in the evening. The programme - between September and December this year - includes delivery of the following evidence based programmes:

- **Circle of Security** - A 10 week attachment based parenting group ideally suited to parents with children under 7 years.
- **Non-Violent Resistance** - A 12 week group for parents with children 11yrs+ who are displaying challenging or risky behaviour
- **Who's in Charge** - A 9 week child to parent violence (CPV) programme aimed at parents whose children are being abusive or violent toward them or who appear out of parental control
- **Freedom Programme** - An 11 week programme for women who have experienced domestic abuse in any of it's forms, providing a reflective space and tools to identify abusive behaviour in the future.
- **Triple P** - An 8 week positive parenting programme ideally suited to parents with children under 11yrs.
- The Building Relationships for Stronger Families sessions (funded by DWP) continue to be delivered by Tavistock Relationships and like us, they are providing these programmes remotely.

2.4 **Safe spaces for direct contact:** social workers have continued to have face to face contact with children and their families throughout the pandemic, including routinely seeing children alone. Risk assessments are completed to consider whether family members have any Covid-19 symptoms ahead of visits. Social workers have been provided with PPE and have been given guidance around social distancing. Direct contact with children is generally completed in the family home or at an alternative safe space such as the child's school, a park, library where the child feels able to talk freely. Social workers are provided with tools and training to support their direct work with children. Monthly audits review the quality of direct work and that the child's voice is at the centre of practice.

3 SUPPORT TO CHILDREN WITH SEND

3.1 **Returning to school:** following support provided to families during lockdown, the Bi-Borough Inclusion Service continues to be available to support children

and young people with special educational needs. The service is working closely with schools to establish the best way to provide support to meet the needs of children and young people with SEND while also minimising risks to public health.

3.2 To support the planning for the return of all students this September, the service undertook a survey of over 500 children from across Kensington and Chelsea and Westminster City Council to understand their experience of lockdown and their thoughts, both positive and negative, about returning to school. The results of this survey were shared with local schools and partners. The service will be undertaking a follow-up survey towards the end of the autumn term to understand how things have gone and any further development of our offer that is required.

3.3 Schools are working on ensuring that there is a contingency in place for learning at home if there is any local outbreak in the future. The borough's SEND Local Offer website continues to have a specific COVID-19 page, which provides the latest updates on service provision for children and young people with SEND.

3.4 Below are some of the ways in which our Education Psychologists are supporting pupils in transitioning back to school:

- Provision of Resource Booklets
- Staff Workshops in schools and staff webinars
- EP Involvement in transition meetings for Year 6 pupils with Education Health and Care Plans (EHCPs) and supporting the transition to secondary schools
- Consultations with parents and carers where the child or the parent is anxious about the return to school
- Consultations with Special Educational Needs Coordinators (SENCOs) and teachers
- Webinar series on emotional coaching, early years and social development, resilience, and supporting our children to be anti-racist
- We have also regularly updated the Services2Schools website – with the latest resources, links to materials, booklets, and signposting for SENCOs to download and share with parents and families e.g. mental health, anxiety, sleep, bereavement, supporting children and young people with autism, sensory issues, homeschooling and supporting the Muslim community. The website had enormous number of hits and web traffic both locally and internationally.

3.5 **Short Breaks:** our Short Breaks Service encouraged families to start coming back to the Playschemes to get their children out of the house and to get used to seeing and playing with other children. This was well-received by families and has given them the confidence they need to send their children back to school.

4 PATHWAYS TO EDUCATION, TRAINING AND EMPLOYMENT

4.1 **WCC Supported Internship 2020/21:** after a successful first year, we are delighted to be hosting the Westminster City Council Supported Internship (for young people aged 16 to 24 with SEN and/or disabilities) for a second year, in partnership with City of Westminster College and Westminster Employment. A dual cohort will run this autumn, consisting of nine returning interns from the 2019/20 cohort and six new interns who successfully underwent a virtual recruitment process. A blended learning approach is being taken this year from City of Westminster College's Maida Vale site, online and staggered starts to physical and remote work placements commencing throughout October. The Westminster Employment job coach team are working closely with council teams and our employer partners (Planet Organic, Elior, Unity Kitchen, Veolia, Bouygues, Ricoh) to finalise and redesign work placements to deliver remotely where teams are not office based.

4.2 **Employment Outcomes of young people with SEND:** our SEND Local Offer and Employment Pathways Lead works to improve the pathway planning we do so a greater number of young people with SEND who want to get a job are better able to progress to achieve their employment ambitions. Based in Children's Services and working closely with the Economy Team, she works to support casework and develop accessible training and employment opportunities.

4.3 **Bi-borough Supported Employment Forum:** this is our multi-agency strategic network that has the objective to improve the employment outcomes of our young people with SEND. An action plan was co-produced by members and includes a number of priorities identified by young people themselves. Activities have started to be delivered including: Access to Work workshops in schools, production of a Supported Employment Directory and designing of Preparing for Adulthood themed parent/carer events.

4.4 **Reskilling for Recovery:** the Westminster 'Reskilling For Recovery' workstream is working to address the economic impact of covid-19 on specific vulnerable groups in relation to skills and employment. A number of specific project proposals have been developed with young people with disabilities in mind.

4.5 **EET Panel:** the Virtual School host an EET Panel supporting children in care and care leavers to access Education, Employment and Training opportunities. This includes working closely with WES and partner agencies and supporting access to training, employment and apprenticeship opportunities. 69.5% of our children in this group aged between 19-21 (DfE measure) were EET at the end of Q2.

5 YOUTH OFFENDING AND CONTEXTUAL SAFEGUARDING

5.1 **Developing a substance misuse strategy:** Public Health presented a paper to the Youth Crime Prevention Partnership Board in August 2020 outlining: what the current problems are in relation to substance misuse, what young people are telling us, what the current provision is and where the gaps are. It was agreed at the Board to develop a drug strategy to achieve harm minimisation and suppress violence. It was also agreed to adopt actions from the JSNA related to this area to develop the strategy. This is currently been explored with Public Health and the policy team.

5.2 **Working with Wilmott Dixon:** in conjunction with Wilmott Dixon, Westminster YOT launched our first mentoring programme to bridge the gap between young people and businesses and to support young people to choose positive career paths. The mentoring programme has been developed to provide opportunities for young people to be mentored by an individual employed currently by Wilmott Dixon. As part of this programme a bespoke training programme has been developed for young people as well as their mentors and they have benefited from Trauma-Informed and Safeguarding Training delivered by the Educational Psychologist and Speech and Language Therapist within the YOT. To date 11 young people have been matched to a mentor while 2 young people have gained employment.

5.3 **Preparing for Inspection:** the YOT has worked hard over the last year to prepare for the HMIP inspection. The evidence in advance and supporting documents are ready and the team are prepared. There have been various workshops delivered to discuss the domains within the inspection framework, preparing staff to meet with inspectors and to best to showcase their work. In addition, over the last year, there has been a focus within the management team on improving standards within assessments, quality assurance and recording.

5.4 **The Work of the Integrated Gangs and Exploitation Unit (IGXU):** the IGXU is a multi-agency co-located team comprised of Children's Social Care, Community protection, Police officers and other specialist roles such as a family therapist and a specialist sexual violence worker. The IGXU supports young people affected or exploited by gangs to exit this lifestyle through swift identification, one-to-one work, family work, group work, street work and community work. We have an engagement rate of 70-80% and we see 60-70% of those seeking support with education, employment and training successfully placed in jobs or vocational courses. The IGXU holds 80+ cases and last year saw over 1000 young people in schools, over 200 parents in parents' group as well as undertaking street work across the borough three times a week.

5.5 We originally saw a decline in activity in March and April. We adapted our service delivery to accommodate the needs of the young people and we created virtual meetings using Zoom, WhatsApp etc. As lockdown eased. we went back out in late April doing 'ride outs' to drive to the areas young people are congregating to meet with them. The pattern of gang activity has changed

during this period: the focus has returned to local areas and we have seen an increase in tensions between groups in WCC and the borders and in particular between Mozart and Lisson Grove Men (LGM). Sadly in July we had three murders in 24 hours, all of young adults know to the IGXU. The staff worked to create messages of de-escalation for our young people. Since this time tensions remain quite high however activity has lessened and the team remains actively engaged in analysing intelligence and working to disrupt activity and promote young people's positive engagement in their communities.

6 CAPITAL PROGRAMMES

6.1 **Hallfield Primary School:** the works to provide a MUGA and a related Pavilion will start on site as soon as the Planners' pre-commencement conditions are discharged. The contractor is expected to complete both facilities in the spring of next year. The small works to provide a nursery for children with Autistic Spectrum Disorder are currently the subject of a planning submission and it is hoped to open the nursery in the summer term of 2021. The College Park Satellite, to be established in an unoccupied building on the site, is scheduled for opening in the Autumn of 2021. This will provide room for two classes of children with autism.

6.2 **King Solomon Academy:** on the Older Years' Site the works scheduled to be handed over on 12th October are running to schedule. Foundations are complete and steelwork is being erected for the new dining hall. Listed Building Consent has been received for the remaining works on the Older Years' Site. The contractor started work on the Younger Years' Site on September the 1st.

6.3 **Millbank Academy: Windmill Centre:** expanded and much improved provision for children with Autistic Spectrum Disorder is being planned for the resource base The Windmill at the Academy. Work is due to start on site in the summer of 2021, for completion by the autumn.

6.4 **St Marylebone Bridge School:** the Stage 2 Tender Report will be issued imminently and the Final Business Case is expected to be sent to the DfE at the end of October.

7 LIBRARIES AND REGISTRARS

7.1 **Virtual library:** libraries already offered a strong digital resource collection but from the start of lockdown they have been enhancing their online offer to provide a seamless integrated offer. In addition to an extensive collection of e-books and magazines for loan, digital resources such as reference materials, learning resources and business information, and an app allowing users to view the catalogue and reserve items have been created. A phase 1 Virtual Library includes interactive events such as rhymetimes and stories for children, author visits, local history talks and other resources. Improvements include:

- Phone helpline for library users needing information, advice and recommendations
- Social media engagement improvement plan in progress
- Improvements to current web pages for ease of navigation
- Main phase of commissioned website discovery project (which will identify user needs for development)
- Procurement/commissioning/design of new website based on discovery recommendations by late 2020

7.2 **Westminster registration service:** since the resumption of marriage and civil partnership ceremonies on 4 July 2020, officers have conducted 584 ceremonies, at Old Marylebone Town Hall and reopened venues across Westminster. This is a 32% reduction in ceremonies in comparison to 2019, but is significantly higher than anticipated at the resumption of the service. It is also double the average number of ceremonies per local authority in England and Wales. Whilst many couples have postponed ceremonies into 2021 and beyond, the service has retained significant numbers of bookings as well as seen new bookings made, particularly in October and November (which is up on 2019 by 38%). This is mainly due to good availability and a large ceremony room which can accommodate the maximum number of guests (currently set at 15 including the couple) and maintaining social distancing.

7.3 The service hosted a visit by Andrew Dent, the Deputy Registrar General for England and Wales on 22 September, who wanted to see how the service had adapted during the pandemic and to thank staff for their hard work. A number of topics were discussed with him, including: registration of deaths by telephone (allowed temporarily under Covid-19 legislation), the need to extend to birth registrations in the event of further waves of coronavirus and the Law Commission's review of marriage law, which is likely to result in changes to how and where people can get married. The Deputy General Registrar wrote after the visit: "I was impressed by your collective flexibility and innovation through a very challenging period, and by the evident high morale and commitment from everyone I met. Your results speak for themselves; well done".

7.4 **Library usage**

Since entering lockdown in March, library use has changed significantly. The Virtual Library, developed quickly in response to the lack of any face to face library service except a basic access to PC offer at two libraries, quickly gained users by simplifying processes making it much easier to join, and building on the already-extensive offer of e-books, reference and information resources and online IXL learning content, by providing interactive activities – rhyme times and story sessions for children, author visits, book groups and conversation classes, and classes in real time and available to stream.

Use of eBooks, eAudiobooks, eMagazines and Newspapters

Compared to pre-lockdown, use of these resources – downloadable by anyone with a Westminster Libraries card, increased by:

- 133% during lockdown period (from 839 to 1,956 average per day)
- 73% during post-lockdown (from 839 to 1,447 average per day)

The service provided additional e-resources to boost the offer including a wider range of titles.

7.5 Events

Before lockdown, libraries were running on average 92 face-to-face events per week with average 22 attendees per event. During lockdown, there was an average of 9 virtual events per week with 87 attendees per event, a tripling of attendance per event, although fewer were run during lockdown. Contributing to increased attendance was greater reach of virtual events via Teams/Zoom compared with events in physical library spaces

7.6 Limited PC offer

During lockdown, two libraries – Church Street and Victoria – offered a limited PC service with internet access, particularly aimed at residents without their own online access or broadband at home. Sessions were offered for 45 minutes and there were restrictions on what people could use it for eg no streaming. Occupancy was high at around 90% of available slots and once the service was fully operational around 200 sessions per week were being taken up at each site. To comply with government guidance requiring the closure of libraries, no other services were on offer eg no book loans or returns.

7.7 Resumption of face-to-face library services

Since reopening on 4 July, use has been increasing slowly month-by-month, though it remains significantly down at about half the number of visits to pre-lockdown figures. Officers have been promoting the resumed service through social media and the council website, and more activity, such as rooms for hire and classes, is being reintroduced as it is safe and permitted to do so. The maximum number of individuals or families allowed in the buildings at any one time is lower due to space required for social distancing (for example the limit is 15 people in Church St library compared to a normal working figure of 50) and there are fewer PCs and study spaces available. Each site is different due to its physical layout and space. The service is also operating on slightly reduced hours, with most sites open for two hours per day less than normal.

Comparative figures

Total visits
July-Sept 2020: 199,562
July-Sept 2019: 446,468
55% down

Average daily visits
July-Sept 2020: 2,169
July-Sept 2019: 4,853
55% down

Average hourly visits
July-Sept 2020: 294
Juy-Sept 2019: 556
47% down

This page is intentionally left blank

Adult Social Care and Health in Bi-borough

City of Westminster

Adult Social Care and Public Health

Cabinet Member – Policy & Scrutiny Update

Title:	Cabinet Member Update for Policy and Scrutiny
Division:	Adult Social Care and Public Health
Briefing Date:	20 October 2020

1. COVID-19 Update – Adult Social Care & Health

1.1 1,524 Westminster residents have tested positive for Covid-19 as of 12 October 2020[1]. The accumulative rate of infection is lower in the City of Westminster than the regional and national average.

1.2 In line with the national and regional trend, the rate of infections has seen an increase in recent weeks.

1.3 Local Outbreak Management Plans continue to be implemented to reduce the spread of the virus and ensure the most efficient use of local Mobile Testing Units and Local Testing Sites.

1.4 Public Health and Communications colleagues continue to work closely in delivering the council's Coronavirus communications strategy which aims to provide clear, prompt, and easy to understand information to residents, staff, volunteers and business owners, so they can stay safe, access any support they might need, and help each other. Colleagues have been working quickly to ensure that the latest Coronavirus advice and guidance is explained clearly, and in languages spoken by our communities. Colleagues have been working with local businesses, community groups and the interfaith forum, as well as providing information across council channels. This ranges from the latest advice and

[1] Public Health England. Coronavirus (COVID-19) in the UK. Accessed 12th October 2020.

information, to where and when testing is available and the latest case rates within our borough.

1.5 National research to date, including that published by Public Health England, has confirmed that Covid-19 has disproportionately impacted certain people and communities, and has exacerbated existing inequalities. Local data and intelligence suggests that this pattern is being reflected in Kensington and Chelsea. Specifically:

- A higher proportion of deaths from Covid-19 are among people from a BAME background compared to non Covid-19 deaths.
- Deaths are higher in more deprived areas with the pattern mirrored, not exacerbated, by Covid-19. Those from a BAME background are more likely to be at risk due to higher prevalence of diabetes, hypertension and obesity.

1.6 In relation to co-existing conditions, of those residents who have died from Covid-19 and had their death registered in WCC, 89% had an underlying health condition. Our One You and Change4Life services are addressing these risk factors however we are reviewing how services can reach out to BAME groups and others that have been disproportionately affected by Covid-19.

2. **Community Champions**

2.1 The Community Champions delivery approach has been adapted to continue to reach and support vulnerable residents in each project area during the pandemic, with many activities provided online. Many residents have been supported through Champions' contributions to food distribution networks across the borough, helping to alleviate food poverty created or exacerbated by the Covid pandemic. Phone line, WhatsApp, and socially-distanced face to face doorstep support has also been provided.

2.2 Champions have been successful in reaching a diverse range of community groups that council services often find more difficult to engage, and have helped to find ways of mitigating the disproportionate impacts of Covid on BAME communities in particular. Projects have become actively involved in supporting or leading local partnership responses with other voluntary and community sector, council and NHS services. Champions have continued in their role as a conduit for residents' concerns and worries; providing information in accessible ways from reliable sources and helping to dispel myths and fake news. They are valuable sources of reliable community intelligence for the council and CCG on the many challenges Covid19 has presented.

3. **Flu update**

3.1 There is a high emphasis being placed on the national flu vaccination campaign this year in order to minimise the risk of both flu and Covid19 co-circulating in communities with the consequent risk to individuals and the health care system.

3.2 The national NHS England ambition is to have 100% of health and social care workers and 75% of all eligible groups vaccinated by December 2020.

3.3 Public Health teams are working with BAME networks, community champions and community engagement leads to ensure that the flu vaccine is promoted effectively to all communities, and that there is an opportunity for communities to raise questions and have them answered.

3.4 There have been challenges with vaccine supply which are being resolved, and all partners are working closely together to monitor and support uptake amongst the most vulnerable groups.

4. Beachcroft House

4.1 All residents completed their moves into the new Beachcroft House earlier than planned, and were moved-in safely and comfortably by 29 September. The timeline was brought forward partly to minimise any risks associated with the increasing infection rates across the borough, but also because our residents and their families were excited about the move to new accommodation. Feedback from residents has been very positive.

4.2 Prior to the transfer to the new site, the Westmead and Carlton Dene homes were closed to new admissions meaning that there are around 12 vacancies to fill at Beachcroft. We will work with the provider to fill these places from the end of this month once everyone is settled in to new accommodation. This will, of course, be done strictly in line with infection control protocols. For information – there are 84 beds at Beachcroft in total.

4.3 Residents at Beachcroft will also be trialling some of our new technology in the community spaces as part of our Smart City ambitions. This includes exercise bikes that are linked to virtual routes on a television screen, and competitive leagues for those who like to put the miles in. We are also trialling a Scandinavian innovation called Toval Tables or “magic tables” - mobile machines that project animated, interactive games onto a table surface that residents can play for leisure and fun. These have been tested in other homes to date and proved popular with residents, so we are pleased to be able to test them further in Beachcroft.

4.4 As with other residential settings, visits from family and friends in the building are not possible due to current safety restrictions. However as soon as it is safe to do so, family visits will recommence, and a full opening ceremony will be held.

5. Development of Carlton Dene and Westmead

5.1 Following the opening of Beachcroft House, the sites for Carlton Dene and Westmead are due to be redeveloped.

5.2 Carlton Dene is due to include a 65-bed extra care housing scheme for older people, as well as an increased number of affordable housing. The second phase of public consultation was open between 28 September and 18 October.

5.3 The online consultation sessions that took place on 1 October and 7 October can be viewed on the consultation website: https://www.westminster.gov.uk/carlton-dene

5.4 The Westmead site is also scheduled for redevelopment as part of the housing development programme.

5.5 The consultation phase for the new Westmead proposals has closed and we are currently reviewing feedback before submitting a planning application.

6. Support to Care Homes

6.1 We continue to provide daily support calls to care homes, as well as supported accommodation schemes and homecare organisations working in the City. Our support and advice includes the following areas:

- Access to, and use of, Personal Protective Equipment. The government is now making PPE available for free to most providers of social care via a national online portal. We are supporting organisations to access this and continue working with other Boroughs to ensure we have sufficient stock and supply for urgent situations.
- We are following up on a recent announcement by the Minister for Social Care, Helen Whatley MP, that there will be a pilot scheme for treating family members of care home residents as staff. The proposal is that they will become part of the testing regime and trained in the use of PPE, so that they can visit their loved ones within the home.
- We have helped care homes and other care providers to move across from our local testing regime (which was through local primary care) onto the national testing portal. The portal is now in a more stable position and both the logistics and results are being returned in a timely way. Staff continue to be tested weekly, with residents tested every four weeks. If there are any positive results, all staff and residents are tested immediately and then re-tested within seven days.
- There has been a small number of positive results for staff in recent weeks. Fortunately there have been no positive amongst residents during this time, and providers are doing all they can to maintain strict infection control measures, using the national Infection Control Fund distributed by Council staff, to ensure that staff can work with discrete groups wherever possible to minimise risks.

7. Winter Planning

7.1 On 18 September 2020 the Department for Health and Social Care (DHSC) published a National Social Care Plan for Winter 2020-21, focusing on managing the ‘second wave’ of the coronavirus pandemic. Although local health systems are already required to produce winter plans each year, this is the first time the Government has produced a national plan outlining actions that local authorities, NHS organisations and social care providers must take ahead of the winter.

7.2 Winter presents numerous challenges to the health and care system through increased demand on front line services. Covid 19 will be also be circulating, alongside seasonal flu and other viruses, and transmission is predicted to increase over the winter period. These pressures will create risks to the health and wellbeing of both people who need care and support and the health and social care workforce.

7.3 The Bi Borough and West London and Central London CCG are working together to develop a winter plan, along with other system partners to support the management of flow through local acute settings.

7.4 The winter programme has two broad priorities in supporting the local health and Care system:

- manage demand pressures on the NHS with reference to seasonal winter pressures e.g. reduce admission to acute settings by supporting people to receive their care closer to home or in community settings
- support timely and safe discharges from hospital, with the appropriate support in place, to help promote people's independence and choice.

This page is intentionally left blank

City of Westminster

Adults' and Children's Services Policy and Scrutiny Committee

Date:	20 October 2020
Classification:	General Release
Title:	The Future of the Gordon Hospital
Report of:	Central and North West London NHS Foundation Trust
Cabinet Member Portfolio	Cabinet Member for Adult Social Care and Public Health
Wards Involved:	All
Policy Context:	City for All
Report Author and Contact Details:	**Jo Emmanuel- Medical Director, Jameson Division CNWL** **Ade Odunlade – Managing Director, Jameson Division CNWL** **Ela Pathak-Sen, Director for Mental Health Services Westminster** jo.emmanuel@nhs.net ade.odunlade@nhs.net ela.pathak-sen@nhs.net

1. Executive Summary

1.1 The aim of this paper is to update the Policy and Scrutiny Committee on the current status of closed inpatient wards at the Gordon Hospital and CNWL's plans and approach for the future of the site. It will outline the background and rationale for its' temporary closure, impact, and the alternatives that are available to ensure continued care for Westminster residents.

1.2 In March 2020, the inpatient wards at the Gordon Hospital were temporarily closed as part of CNWL's COVID-19 response primarily due to serious concerns regarding infection control in the building, along with the need for rapid flexibility of our service provision to support mental health care during the pandemic. The Trust is planning to publicly consult on the future of the Gordon Hospital once the emergency status is lessened.

1.3 The paper outlines the extensive transformation and strategic work already underway to assure the provision of quality mental health care that meets the needs of Westminster patients, supporting care closer to home in the least restrictive setting as per national direction, and ensuring when admission is required this is through timely access and in therapeutic settings.

2. Background

Initial Gordon Hospital closure:

In March of 2020, the inpatient wards at the Gordon Hospital were rapidly closed as a key part of CNWL's COVID-19 response. Due to the level 4 emergency status caused by COVID-19 and its impact, as with many frontline partners, CNWL found it necessary to make this decision rapidly and was not able to fully consult with local partners as per normal practice. This need to close one of our inpatient sites was to enable staffing flexibility to cover for sick and isolating staff, to temporarily redeploy staff to meet service pressures, and to offer emergency response alternatives to A&E.

The Gordon Hospital was chosen as the place to close temporarily as part of this response for two key reasons, both linked to quality of care provision. Firstly, we had serious concerns following assessment of its risk for infection prevention and control (IPC), e.g. lack of en-suite bathrooms. This issue regarding IPC risk was a key quality driver for the decision to close the Gordon inpatient wards given the particular vulnerabilities facing those with mental health disorder, both due to being in a confined space (with heightened risk of infection spread) and also the high physical comorbidities in our patient group meaning they are at particular risk of the consequence of infection. Furthermore, The Gordon Hospital is a standalone site (i.e. not co-located with an acute hospital), which raises associated risks of not being able to access rapid physical health support for inpatients, which is particularly important given the risk of COVID-19.

Proposal for the future of the Gordon:

Provided national guidelines surrounding emergency state allow, we aim to consult on the future of the Gordon Hospital next calendar year exploring the option to not reopen the site. We propose keeping the wards closed from this point and throughout the process to enable staffing flexibility for possible future COVID-19 spike(s), in light of the identified IPC risk, and to support the move towards a long-term shift in care to the community to support providing care closer to people's homes.

The key drivers for this approach include:

1. *National and Regional Policy*: Supporting the delivery of the NHS Long Term Plan & Five Year Forward View for Mental Health which centres on local community provision of services to support people at home as well as aligning with standards for providing care in a therapeutic and fit-for-purpose environment for all patients.

2. *Local Vision and Clinical Objectives:* Aligning our estates strategy/portfolio with existing transformation work and priorities to provide care in the least restrictive environments and move care closer to home in the community.

3. *Quality of the Estate:* Ensuring the best provision for our local patients in a therapeutic environment that is fit-for-purpose. The Gordon inpatient wards do not comply with standards around fit-for-purpose physical environments for care, and have posed long-standing challenges including safety issues for patients and the public. The COVID-19 pandemic has heightened the need to urgently address these and explore much more modern approaches to providing inpatient care when needed.

3. National and Regional Policy

CNWL has major transformation work underway to deliver against national expectations whilst responding to local needs in Westminster. This has already seen the launch of new services and offers for Westminster residents, as well as its neighbouring boroughs (detailed under section 4 of this paper).

The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, reported that the current reliance on acute beds means that it is often difficult for people to access care near home and that this is exacerbated by a lack of community services, particularly Crisis Response and Home Treatment Teams (CRHTTs).

The NHS Long Term Plan also supports the shifting of care from inpatient to community-based settings where clinically possible and appropriate as laid out in several objectives:

> ***3.94.*** *New and integrated models of primary and community mental health care will support adults and older adults with severe mental illnesses [will give them] greater choice and control over their care, and support them to live well in their communities.*
> ***3.96.*** *The NHS will ensure that a 24/7 community-based mental health crisis response for adults and older adults is available across England by 2020/21. Services will be resourced to offer intensive home treatment as an alternative to an acute inpatient admission.*
> ***3.98.*** *We will also increase alternative forms of provision for those in crisis. Sanctuaries, safe havens and crisis cafes provide a more suitable alternative to A&E for many people experiencing mental health crisis*

4. Local Vision and Clinical Objectives

Looking forward and in line with these national asks, locally we recognise that care for our local people should be provided in the least restrictive setting and closer to home, by shifting provision to a more community-based offer. This includes expanding existing, and developing new, provision available within the community to ensure care, support, and interventions are available and accessible locally.

CNWL is currently investing in and delivering transformation work in the below areas, with the aim to develop further to provide the best possible care for Westminster residents.

- Moving care closer to home wherever clinically possible and appropriate
- Working with local VCSE, facilitating a broader offer to our population
- Working to prevent admissions unless no clinical alternative
- If admission is needed, it will be purposeful and in a therapeutic environment with dedicated identified beds within the NWL system for Westminster patients, including building on existing bi-borough co-location of beds at St Charles. Long-term, we want this consolidation to be within modernised facilities that enhance the delivery of high-quality treatment.

Figure 1. Our Care Closer to Home Vision & Model Overview

CNWL is using Long Term Plan and locality investment to take forward:

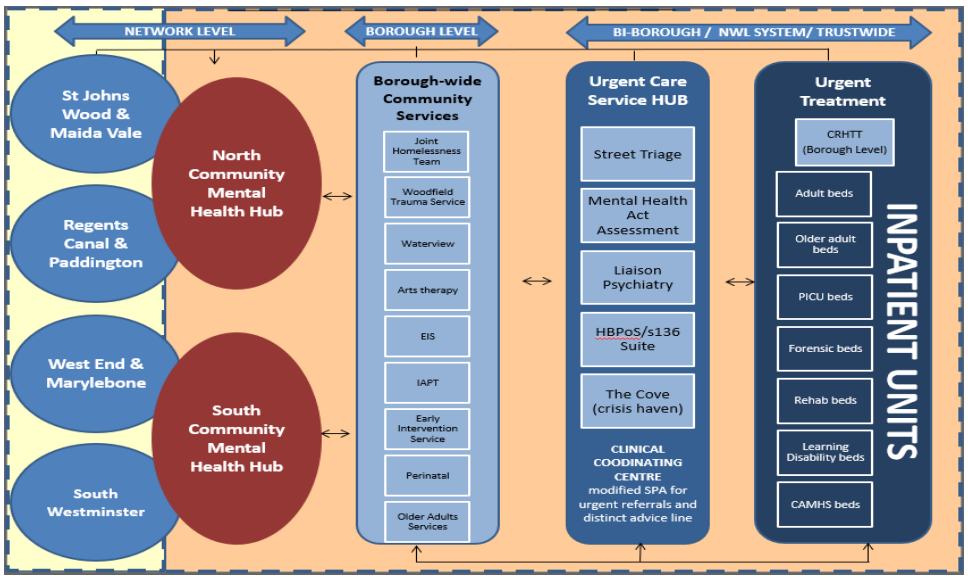
- New **First Response Service** offering 24/7 assessment to our residents, wherever they are in the community. In KCW, the soft launch of this service is complete with a full go-live in mid-October.
- "**The Cove**" crisis haven for KCW population has launched, offering a crisis alternative and intervening upstream to avoid escalating acuity, providing 365 days a year for a non-clinical evening offer.
- If a bed is required, a new **Central Flow Hub** will find a suitable bed in a timely way and is supporting the elimination of the use of beds out of area through external providers (Out of area placements – OAPs) via improved flow management.
- New community offers provided by the third sector, which for Westminster residents includes specific support to people with coexisting MH and substance use problems, specialised Arabic outreach workers (Oremi centres), additional BAME support workers in the community, and further investment in the Single Homeless Project for support to Westminster patients post-discharge.

- Inpatient admission is supported by new investment embedding **Trauma Informed Approach** for all patients admitted to CNWL beds.
- Investment in a new "**Community Access Service**" to ensure our patients do not stay longer than clinically required on wards and are supported through re-enablement to live as independently as possible, due to go live in the next few weeks.
- Develop and improve our **Home Treatment Team** (HTT) model to:
  - Refocus function to ensure fidelity to a recommended model that offers a genuine alternative to admission, 24/7, 365 days a year.
  - Make HTT responsible for staying within their local bed allocations and enabling HTT to in-reach to wards to facilitate early discharge.
  - Support increased productivity and new ways of working (including significant investment in new technology to enable mobile working).

Community Mental Health Hub (CMHH) – Westminster received transformational funding through NHS England as an early implementer site of a new model of care for the provision of community mental health care. After partnership development work across health, social care, and local community partners for over a year, the Community Mental Health Hubs North and South for Westminster launched 1st September. It has been described by national teams as a "truly transformational model", and is based on these agreed principles:

- Enhance patient experience: intervention emphasis > assessment
- Enhance professional/staff/provider experience: conversations & 'tasks'
- Minimise primary and secondary care divide: no thresholds
- Minimise bureaucracy & optimise use of community-based resources
- Maximise 'One Team' feel: camaraderie, communication, relationship building
- Encourage shared responsibility for patient & encourage shared responsibility for resource
- Maximise support for MH professionals, GPs & other providers
- Establish an effective framework to measure meaningful outcome measures

Figure 2. Community Mental Health Hub (CMMH) Model for Westminster



The hub offers integrated care to Westminster residents and investment has included recruitment of new staff including an additional two Community Navigators, two family therapists, a Lived Experienced 'Personality Disorder' pathway specialist and a senior 'Personality Disorder' Nurse, a GP based Eating Disorder specialist, four newly developed graduate mental health worker roles, and two new Social Prescribers through a partnership with One Westminster. Westminster is also part of a community pharmacy pilot in the hubs. These new staff provide the offer shown below.

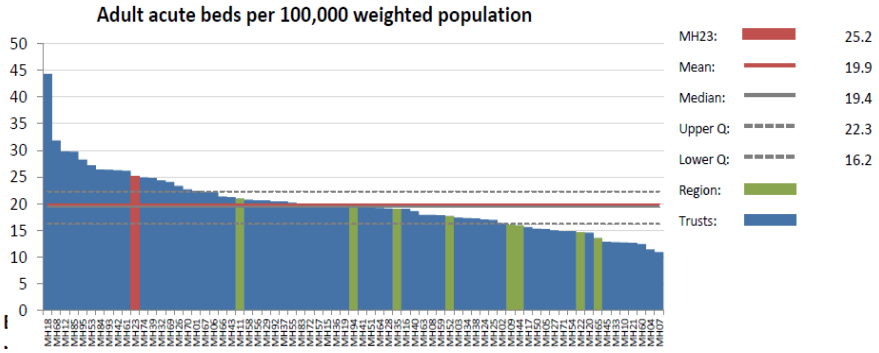
Figure 3. Community Hub Offer in Westminster

5. Maintaining Within This Bed Base

Right balance of acute to community

We know from various reports, including a recent deep dive from the Getting it Right First Time national team (GIRFT) and NHS Benchmarking, that CNWL has a higher than expected bed base and number of admissions for our population. The graph from 18/19 benchmarking data (NB. 19/20 data not yet available) shows CNWL (MH23) at 25.2 beds per 100,000 weighted population, above the national and regional average. Accounting for the closure of Gordon wards, CNWL remains higher than five neighbouring London trusts and above national average for beds per weighted population and the number of available beds for Westminster remains above the average per weighted population.

Figure 4. Acute beds per 100,000 weighted population



Since closing the Gordon Hospital 242 Westminster patients have been admitted to inpatient wards across CNWL, with the majority (over 70%) being placed at St. Charles Hospital where they are given priority based on its proximity to Westminster. Westminster has always had access to the beds at St Charles, including a designated ward - now Westminster patients are looked after on all the acute inpatient wards at St Charles, with better flows between the Health Based Place of Safety to PICU beds should these be required. To ensure timely discharge to Westminster patients placed in our CNWL beds in the outer London boroughs, we have appointed additional discharge support including dedicated consultants. Additionally, the caseload for Westminster's Home Treatment Team (HTT) has seen on average an increase of over a third in the past Quarter, with a steady decrease in admissions, indicating that our new 24/7 model and skills mix is embedding and we are seeing more patients in their homes and the least restrictive environment.

Over the COVID-19 period all patients on the CMHT caseload, including those recently discharged, have been contacted and all discharged patients have received 72-hour follow-up as per our CCG CQUIN scheme. Those discharged to HTT have been provided continued support closer to home as an alternative to admission. We are tracking all patients in this cohort using a patient flow tool and only five have been readmitted to an inpatient ward as of 1st October 2020.

6. Quality of the Estate

The inpatient wards at the Gordon do not comply with the Royal College of Psychiatrists standards relating to "a physical environment that is fit for purpose". National guidance for mental health acute inpatient environments[iii] includes outlining the need for:

- En-suite bedrooms
- Direct access to an outdoor garden space
- A welcoming and therapeutic environment with decoration, furnishings and fittings chosen to provide a pleasant atmosphere, minimise institutional features and encourage activity and social interaction
- Spaces (particularly unsupervised spaces e.g. bedrooms and toilets) are designed, constructed and furnished to create a homely atmosphere and limit the opportunities for harm and self-harm

- Ensuring that inpatient environments promote the sexual safety of people using the service

CNWL has worked with our estates colleagues to try and address estate pointers at the Gordon, however the following remain:

- No outside space and not possible to create
- No en-suites to the bedrooms and the infrastructure won't allow for installation
- Extremely difficult security issues with the building, which will be technically difficult to overcome
- Building is within a conservation area, so fully modernising the facility would not be appropriate in its location– in addition the plant and infrastructure needs a capital investment of approximately £25m, just to bring up adequate H&S standards

7. Summary and Next Steps

The wards at the Gordon currently remain closed and we are proposing to consult formally on its future next year depending on the status of the National Emergency.

We are working across the system to embed the changes articulated above to support Westminster residents getting access to care in the community wherever possible through a broadened community offer. We recognise that an essential part of providing good quality mental health care is also to facilitate timely access to modern inpatient services when community alternatives are not possible, preferably as close to home as possible. Without in anyway predetermining the outcome of the proposed consultation, we are exploring planning to consider development of a potential alternative inpatient site within Westminster.

The temporary closure of the Gordon Hospital is a significant change which has been forced upon us at considerable pace due to the COVID-19 pandemic and the need to respond rapidly to ensure quality of care for all our patients was maintained within this context. This has inevitably raised challenges and we are keen to listen to and respond to concerns. We are committed to working with our patients and their families, our communities, and our partners to not just monitor and respond to these challenges but also to work collaboratively to plan for the right inpatient service to meet the mental health needs of Westminster residents.

---

[i] *MHA Review report/recommendations*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/763547/Modernising_the_Mental_Health_Act___increasing_choice___reducing_compulsion___summary_version.pdf

[ii] *DHSC Health Building Note 03-01: Adult acute mental health units*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147864/HBN_03-01_Final.pdf

Adults' and Children's Services Policy and Scrutiny Committee

Date:	20 October 2020
Classification:	General Release
Title:	Westminster Out of Hospital Recovery Plan
Report of:	Central London CCG
Cabinet Member Portfolio	Cabinet Member for Adult Social Care and Public Health
Wards Involved:	All
Policy Context:	City for All
Report Author and Contact Details:	**Central London CCG** **ebarrett@westminster.gov.uk**

1. Executive Summary

As part of the Covid-19 response, NHS England asked all areas across the country to very quickly produce plans setting out what they had changed over the COVID-19 period and how they will be planning to recover – embedding any learning as well as continuing to deliver effective health services in future. Each borough was asked to produce a plan for their borough covering specifically the 'out-of-hospital' services, and to align this with the plans being developed at the ICS level (NWL level) and also at regional level (London).

The Westminster plan was co-produced as a partnership by the local Mental Health provider Trust (CNWL), the Community Trust (CLCH) Primary Care Network leaders, Westminster City Council and Central London Clinical Commissioning Group. The plan is in draft format currently and we are engaging with our public and patients via the CCG Patient Reference Group and Healthwatch to help us further improve it.

The report highlights the following in more detail:

What we did for the first wave and what we learnt

- **Specialist homeless hub** within Westminster led by specialist primary and community teams

- Provides **health and care input to 35 locations** across GLA and local authority site (supporting 1005 individuals) housing homeless people during the Covid-19 pandemic
- Training in **covid-19 rehab:** fatigue management, adapted pulmonary rehab, post intensive care syndrome, screening for delirium, executive dysfunction, emotional wellbeing incl. anxiety and depression, social isolation and creative virtual rehab
- **Sharing of data** across organisations to identify high risk populations
- Virtual first model in all GP practices with **significant reduction in need for face to face**. Increasing focus on proactive care management of most vulnerable
- **Improving discharge support via** close working between providers to **pool staff** in discharge hubs
- **Opportunities to trial digital technology** in community services to maintain care, including as an enabler for MDT working – e.g virtual geriatrician support

What we need to sustain and/or do differently for second wave and other services

- All providers working together to **develop rehab pathways** to avoid duplication, reduce gaps and ensure joined up transfers of care.
- Enhanced support into all care homes from primary care through **lead GP model** and **proactive virtual ward rounds and MDT working**, building on the frailty nurse support currently in place
- **Testing** on acute discharge prior to care home admission
- **Improving discharge support** including ensuring that **capacity and demand** reflect changing need
- **Homefirst staffing model transformed** to provide 8am-8pm, 7 days a week service
- Maintain the local **Mental Health Emergency Centre** to support alternative to A&E and a CAMHS centre operating across all 5 NWL boroughs to support options for de-escalation and offer space to explore admission alternatives
- **Integrated care for shielded patients and patients with Long Term conditions** through MDT working

What we need to think about for the future

- Maintain focus on redesigning pathways around **population health** need
- Digital Strategy i.e. roll out a **virtual ward model** using technology for remote monitoring for patients as part of the package of care
- **Flexible use of teams and resources to meet the needs of the population -** cross-organisational teams will act as “one team” providing seamless care that is more proactive
- **Integrated clinical leadership at a borough level** - lead change on Programmes of work
- **Joining up support/corporate functions across partners -** to support partners to come together and operate in a seamless and integrated way
- **Increased investment in prevention** funded through the releasing of savings delivered through pathway transformation and clinical efficiencies

- Working with the local authority to ensure **wider determinants of health** are reflected in pathways and models to support **reduction in inequalities**

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact ebarrett@westminster.gov.uk

APPENDICES:

The full Westminster Out of Hospital Recovery Plan is appended

This page is intentionally left blank

Westminster

Response: what we did for the first wave and what we learnt

- **Specialist homeless hub** within Westminster led by specialist primary and community teams
- Provides **health and care input to 35 locations** across GLA and local authority site (supporting 1005 individuals) housing homeless people during the Covid-19 pandemic
- Training in **covid-19 rehab:** fatigue management, adapted pulmonary rehab, post intensive care syndrome, screening for delirium, executive dysfunction, emotional wellbeing incl. anxiety and depression, social isolation and creative virtual rehab
- **Sharing of data** across organisations to identify high risk populations
- Virtual first model in all GP practices with **significant reduction in need for face to face**. Increasing focus on proactive care management of most vulnerable
- **Improving discharge support via** close working between providers to **pool staff** in discharge hubs
- **Opportunities to trial digital technology** in community services to maintain care, including as an enabler for MDT working – e.g virtual geriatrician support

Rebalance: what we need to sustain and/or do differently for second wave and other services

- All providers working together to **develop rehab pathways** to avoid duplication, reduce gaps and ensure joined up transfers of care.
- Enhanced support into all care homes from primary care through **lead GP model** and **proactive virtual ward rounds and MDT working**, building on the frailty nurse support currently in place
- **Testing** on acute discharge prior to care home admission
- **Improving discharge support** including ensuring that **capacity and demand** reflect changing need
- **Homefirst staffing model transformed** to provide 8am-8pm, 7 days a week service
- Maintain the local **Mental Health Emergency Centre** to support alternative to A&E and a CAMHS centre operating across all 5 NWL boroughs to support options for de-escalation and offer space to explore admission alternatives
- **Integrated care for shielded patients and patients with Long Term conditions** through MDT working

Renew: What we need to think about for the future

- Maintain focus on redesigning pathways around **population health** need
- Digital Strategy i.e. roll out a **virtual ward model** using technology for remote monitoring for patients as part of the package of care
- **Flexible use of teams and resources to meet the needs of the population -** cross-organisational teams will act as “one team” providing seamless care that is more proactive
- **Integrated clinical leadership at a borough level** - lead change on Programmes of work
- **Joining up support/corporate functions across partners -** to support partners to come together and operate in a seamless and integrated way
- **Increased investment in prevention** funded through the releasing of savings delivered through pathway transformation and clinical efficiencies
- Working with the local authority to ensure **wider determinants of health** are reflected in pathways and models to support **reduction in inequalities.**

Safety first	Virtual first in all services which reduces F2F and improve proactive care. SPA for MH services conducted virtually . ehub to support SPA /digital front door for primary care. Temporal and spatial segmentation of F2F care
Working with and through communities	Utilise social prescribing as part of case management to address specific issues and maximise the potential of volunteering and community support – particularly to reduce social isolation
One team approach	Working to a common purpose via integrated teams providing seamless care e.g. shielding patients /community hubs
Market intelligence, data & digital support	Using WSIC to identify populations requiring proactive care management and integrate the workforce to ensure patients receive coordinated care which meets their needs in a holistic way. Improve digital first model for wider access to health and wellbeing incl. smoking cessation, tackling substance misuse, managing weight, increasing physical activity and improving mental wellbeing . Utilise remote monitoring capabilities within our care models
Outcomes that matter to populations	No Health without Mental Health - physical and mental health services are truly integrated , eliminating unwarranted variation and improve LTC management and achieve better outcome and experience for Older people, improve prevention, health and wellbeing

This page is intentionally left blank

NW London Out of Hospital Recovery Plan: Westminster

2nd June 2020 submission

Engagement slide 2nd June 2020

The borough plan, set out in these slides, has been produced in collaboration with our partners and we have gratefully received specific written input from:

- CNWL
- CLCH
- Primary Care Network CDs and Chairs
- Westminster City Council

We have also worked with our Inner North West London colleagues to ensure alignment across Central London, West London and Hammersmith and Fulham CCGs. At various stages in its development, the borough plan has been discussed at a range of meetings including PCN Clinical Directors and Chairs meetings; workstream meetings (i.e. shielded patients); bi-lateral local authority meetings and the CCG's Leadership Executive Committee and Joint Leadership Team;

To review and finalise our borough plan, we held a range of meeting with partners on 2nd June to support this submission to NWL. The following representatives gave their time to be part of these meetings:

- Jo Davies and Kathleen Isaac (CLCH)
- Dr Rishi Chopra, Dr Saul Kaufman, and Dr Sheila Neogi (representing Primary Care Networks)
- Matthew Reade, Faye Rice and Ade Odunlade (CNWL)
- Grant Aiken and Sarah Crouch (Westminster City Council)

Contents

Principles for how we work

In 2019, the local system agreed principles for how we will work together based on learning from our relationships and approaches over the last few years. We continue to use these principles as the golden thread for how we will work together to transform care for our patients.

- **Co-production, communication, relationship building and trust** as the most important principle the system needs to develop.
- A **local** focus driven by local clinicians, leaders, staff and the public. Patient and service user involvement from the start is crucial.
- Proposals to reduce variation will be balanced against the large differences across parts of the borough requiring **differing approaches.**
- We will build on and learn to better use **existing work**
- A focus on **people development** – change is only going to happen through effective relationships and adopting a bottom-up approach.
- **Releasing capacity** and investing time. This requires each partner to identify named individuals from their organisation to lead work streams. Everyone needs to invest time to grow and track lessons learnt.
- Move away from **behaviours** that are competitive.
- All work needs to be coordinated and "not bite off more than we can chew".
- A focus on **prevention** – including sustained investment into preventative services and away from reactive responses to proactive support.
- Articulating a compelling **case for change and future vision** to generate enthusiasm, energy and address scepticism.
- Building **resilience** in teams that supports frontline staff and clinicians and in patients to support them to manage their own care.
- The need to develop **long-term financial sustainability** of Westminster health and care services is a **collective challenge**.
- **'Open book'** sharing of performance, benchmarking and value for money to guide decision making based on quality and effectiveness
- Moving to "**no physical health without mental health**", with a focus on bringing mental and physical health transformation together.

We are mindful that this local borough plan has been written at extreme pace as part of the NHS recovery planning process. We will take a "test, learn and evolve" approach to the plan – listening to and learning from all partner and patient feedback and measuring the impact on demand within the system as we adjust pathways and adopt changes. Wider patient and public participation on the borough plan must be undertaken as we continue to develop more detailed proposals to ensure that our plan meets the needs of our population.

Managing population health and tackling inequalities

Covid-19 has had and will continue to have a disproportionate health impact on some groups and tackling the variations in health care and the wider determinants of health which underly these trends will need to be key element of implementing our borough plan. Covid-19 has disproportionately affected:

- Older people and people with long term conditions.
- Men working in lower skilled occupations compared to those in higher skilled occupations (ONS)
- People from BAME backgrounds who have a greater risk of developing coronary heart disease, high blood pressure and type 2 diabetes.
- Predicted rise in all forms of Violence Against Women and Girls (VAWG) based on experiences during other public health emergencies disproportionately affecting black and minoritized women and girls

The covid-19 pandemic is expected to also have an impact on wider health and wellbeing needs, including:

- National evidence suggests during lockdown, 1 in 5 drinkers (21%) are drinking more frequently and that around a third of adults are less active than before the Covid-19 restrictions (while the same amount are doing more). Locally, people are reporting not going out at all and not letting their children out, with physical activity dropping completely. There is an opportunity to review joint approaches to influence the four biggest risk factors for health – smoking, excessive alcohol consumption, poor diet and lack of exercise
- Increasing evidence around the impact of mental health and wellbeing, including anxiety and fear, bereavement, stress and felling lonely or isolated. Evidence suggests that common mental health disorders such as depression or anxiety are more prevalent in people of mixed ethnicity and so there may be potential implications for our BAME communities given the disproportion direct impacts of Covid-19 mentioned above (Mental Health and Wellbeing JSNA). The impact of loneliness and social isolation may be significant given high proportions of people living alone locally.
- Missed immunisations. Childhood vaccinations particularly MMR are already low and further decrease in vaccination coverage could have major implications for public health

A universal approach to health service delivery but with a more intensive focus on the most vulnerable populations with the greatest needs will help to mitigate the disproportionate impact of covid-19. As a borough, we also recognise the need to do more to tackle wider inequalities. The 10-year on Marmot review published in February shows improvements to life expectancy have stalled and the health gap between wealthy and deprived areas has grown. There is an opportunity to tailor whole system interventions that will address health service need alongside improvements in resident's economic, environmental and social circumstances by considering 'integration' in the broadest sense – integration across health, social care, housing, employment and other social determinants services. The following slides set out some initial thoughts on our approach to population health management and tackling inequalities across our population groups.

Managing population health and tackling inequalities

As a borough partnership, we have been developing and testing approaches to delivering care across population health groups for the last two years. Our population groups are children and young people; adults with long term conditions, Homeless people, adults with mental health conditions and older people, including Frailty Basic. Using the Whole Systems Integrated Care dashboard we undertake population segmentation and population health analysis to understand these key groups, their needs and their resource use. Our PCNs have identified a priority population out of these cohorts, so that they can lead on behalf of all PCNs on the development of new models of care for that population.

Our experience over the last few months has enabled us to gain greater traction on reorganising care around specific populations as well as increased the sharing of records and functioning interoperability within networks which must not be lost where permitted by IG requirements. We will continue with business as usual processes, such as practices using the WSIC dashboard to inform proactive care planning, including using the “rising risk” dashboard to identify and response to patients with changing needs.. However, we will also develop new ways of working, such as widening the scope of our Integrated Community Team model to support shielded patients and developing new multi-agency responses to patients with long term conditions. We will want to explicitly recognise that mental health will now be a part of all workstreams and population group work so that physical and mental health services are truly integrated.

Our PCNs will retain responsibility for, and management of, areas of unwarranted variation leading to clinically improved outcomes for patients. Improvement plans and peer to peer review will be introduced for practices where unwarranted variation is highest. PCNs will continue to be responsible for delivering the requirements of the Demand Management Strategy which has been effective at dampening down both urgent and planned care demand within Central London over the last year. We need to increase our focus on prevention, both primary and secondary, and want to use the opportunity of this borough plan as a way to ensure that all services and pathways we redefine bring prevention to the fore.

Managing population health and tackling inequalities

Population Group	Areas of inequalities*	Our approach to reducing inequalities
Mainly Healthy	• Cancer screening – breast, cervical and bowel • NHS Health Check • % people in employment	• Develop a PCN-level approach to increasing cancer screening working across the system to ensure all opportunities are maximised to offer screening and increase uptake. • Implement “C the signs” in all practices to support identification of potential cancer patients. • Increase the virtual opportunities available to our population to support behaviour change and health and wellbeing, including smoking cessation; tackling substance misuse; managing weight; increasing physical activity and improving mental wellbeing • Identify specific cultural cohorts and tailor our services to improve access and address specific needs. This will include reviewing the impact of digital first on access for these cohorts and working with community groups to mitigate any barriers to access. • Consider how our models may need to change to support patients affected by the economic impact of Covid-19 and support them to retain mental wellbeing
Adults with Chronic or Complex Long Term Condition	• Flu vaccination • Diabetes • Social isolation	• Use Whole Systems Integrated Care to identify populations requiring proactive care management and integrate our workforce to ensure that adults with multiple long term conditions receive coordinated care which meets all of their needs in a holistic way. • Ensure that secondary prevention and mental health support are key components of our integrated approach to care planning and case management • Utilise social prescribing as part of case management to address specific issues and maximise the potential of volunteering and community support – particularly to reduce social isolation • Maintain improvements in discharge support and rehabilitation as business as usual ways of working and ensure that patients with rising risk are actively supported via our community models • PCN level responsibility for, and management of, areas of unwarranted variation in practice and clinical delivery. Improvement plans and peer to peer review will be introduced for practices where unwarranted variation is highest. PCNs will continue to be responsible for delivering the requirements of our Demand Management Strategy which ensure that patients are managed in-line with NWL pathways.

* These are some areas of inequalities, not all. Areas have been taken from PHE Fingertips and the Westminster Borough Profile (www.jsna.info)

Managing population health and tackling inequalities

Population Group	Areas of inequalities*	Our approach to reducing inequalities
Frail Elderly and End of Life	Flu vaccination Social isolation Emergency admissions within 30 days of discharge	• Embed flu vaccination into out integrated community models, to ensure that patients receive this as part of their personalised care plan and case management response • Maintain improvements in discharge support and rehabilitation as business as usual ways of working and ensure that patients with rising risk are actively supported via our community models • Increase access to remote monitoring via our virtual ward for our most at risk individuals and for our care homes. • Utilising NHS Volunteer Responders to help vulnerable patients with tasks such as delivering medicines from pharmacies, driving them to appointments, bringing them home from hospital and regular phone calls to check they are ok. They have recently added an additional voluntary role the 'Community Response Volunteer Plus' which is an enhanced role for patients with cognitive impairments or significant vulnerabilities
Children, Young People and Families including Maternity	Vaccinations/ immunisations Obesity Children in low income families Dental decay	• Build on pilot approaches tested during out Covid-19 response to offer vaccinations, immunisations and child health checks at-scale via a single face to face location. We will also test alternative approaches, such as drive through and curb-side child vaccination clinics. • Build on our excellent partnership across children' services to identify and support vulnerable families. This will include working with voluntary groups and borough resources to take a family approach to primary prevention and tackle multi-generational health inequalities e.g. obesity in children and adults who then may be an increased risk of diabetes, hypertension, high cholesterol.
Mental Health and learning disabilities	Higher prevalence of mental health Higher admissions to hospital for mental health	• Move forward at pace with out existing community transformation programme which will ensure mental health services are wrapped around PCNs. As part of this programme we will improve access to Mental Health information, tools & advice, plus specific work on Complex Emotional Needs (CEN – formerly Personality Disorder) pathway to be accelerated • Increase access to Talking Therapies (IAPT) and Counselling including online therapies • Approaches for Learning Disabilities and their families and carers - service recovery planning incl. anticipating surge in demand for known patients plus prepare for any backlog in LD Eligibility & Autism Diagnostic assessment; where needed, remote advice & consultation to non-specialist services (e.g. GP Practice) to make reasonable adjustments for PWID & Autism; KCW intensive support team mobilisation

* These are some areas of inequalities, not all. Areas have been taken from PHE Fingertips and the Westminster Borough Profile (www.jsna.info)

Managing population health and tackling inequalities

Population Groups	Areas of inequalities*	Approach to reducing inequalities
Homeless	Life expectancy General Health Successful completion of drug treatment TB incidence	• Our **Homeless Integrated Care Network (HICN)** has existed for a number of years and this model, led by specialist primary care, has had significant impact both at a delivery and strategic planning level. The borough partnership will use the HICN as a platform to build upon for future planning in order to tackle health inequalities amongst this population. • Rough sleepers requires a multifaceted and multiagency response beyond what healthcare can provide and this will include combining a **'housing first-health first approach'** • Mobilising our **Psychological informed environment (PIE)** model of care working with up to 240 hard to reach rough sleepers with underlying trauma and MH issues. Data from this project will be used to inform future thinking for homelessness provision in Westminster • Continue to provide step-down intermediate care beds for homeless patients and health clusters established within hostel to support those recently discharged from hospitals with move on accommodation factored into model to support sustained changes in behaviour and prevent a return to the streets
Patients with more complex social needs	- Health outcomes are poorer - Social isolation	• Embed the work of our 5 new PCN Social prescribing Link Workers, and 2 that are linked to the CNWL Mental Health Hubs, to support our most vulnerable patients. Our social prescribing link workers have been trained to better support patients with learning disabilities; and have also received training on emotional listening, dealing with loss and bereavement and dementia. Link workers will provide more holistic care and personalised support by supporting patients on a 1:1 basis and helping them identify the wider issues that impact their health and wellbeing.
Shielded Patients	- Social isolation - Mental Health and Wellbeing	• CNWL Check in and Chat phone service - This is for patients who have been advised to 'shield' and other vulnerable patients that are self shielding. A team of trained volunteers and staff telephone vulnerable and shielding patients who have been selected by services as needing some additional contact to essentially 'check in on them'. The team will signpost patients to services or support within the local community as well as talk to them about any concerns they have and raise them with the service the patient normally sees. • Westminster Connects and national volunteering programmes provide support to shielded patients, including befriending calls

* These are some areas of inequalities, not all. Areas have been taken from PHE Fingertips and the Westminster Borough Profile (www.jsna.info)

Working Together and Learning from Covid-19

Ways of working
- Bi-weekly meetings with the local authority allowing **joined up thinking** (i.e care homes)
- Silver command structures led by **PCN Clinical Directors** to organise primary care response
- Intense focus on redesigning pathways around **population health** need
- **Sharing of data** across organisations to identify high risk populations

Virtual First (all sectors)
- Virtual first model in all GP practices with **significant reduction in need for face to face**. Increasing focus on proactive care management of most vulnerable
- **SOP in place** and appointments being conducted virtually within MH services whilst retaining patient choice
- **Opportunities to trial digital technology** in community services to maintain care, including as an enabler for MDT working – e.g virtual geriatrician support

At-scale working in primary care
- At a PCN level, some **practices have "folded" into other sites** to release resources for Covid-19 response, including estates and staffing for the hot hub
- One PCN has also tested **delivering child health services at scale** (immunisation and checks) as well as crucial face to face services for patients with long term conditions

Rehabilitation
- Training in **covid-19 rehab:** fatigue management, adapted pulmonary rehab, post intensive care syndrome, screening for delirium, executive dysfunction, emotional wellbeing inc. anxiety and depression, social isolation and creative virtual rehab.
- All providers working together to develop rehab pathways to avoid duplication, reduce gaps and ensure joined up transfers of care.

Care homes
- Significant **expansion of acute frailty team** support into all care homes, 8am – midnight 7 days
- Enhanced support from primary care through **lead GP model** and proactive bi-weekly (as a minimum) virtual ward rounds
- **MDT arrangements** for each care home in mobilisation
- **Testing** on discharge from the acute prior to care home admission
- Online training resources (including training from CIS on PPE)

Escalated Care Centre
- **8am – 8pm, 7 day a week** service for all patients with confirmed or possible Covid-19 infection in the community
- Provides telephone and **face to face treatment** (inc. home visiting)
- **Patient transport** solution in place reflecting the needs of our central London population
- Ready to role out **testing for staff and patients** – via drive-in or home testing – if required.

Ensuring care for the most vulnerable
- **Specialist homeless hub** within Westminster led by specialist primary and community teams
- Provides **health and care input to 35 locations** across GLA and local authority site (supporting 1005 individuals) housing homeless people during the Covid-19 pandemic
- **Organisation of food and care packages** to hostels as well as care homes and community bed locations

Digital Innovation
- Roll out a **virtual ward model through Medopad** as part of NHSX/I pilot
- **Remote monitoring of Covid-19 patients** managed as part of the package of care provided by the ECC
- In process of **expanding to shielded patients** with LTCs
- Planning to **increase the range of remote monitoring and diagnostics** which can be undertaken

The North West London health and care partnership

Working Together and Learning from Covid-19

Integration of specialist workforce

- Specialist nursing staff have been **redeployed into the District Nursing** teams to provide enhanced services and **support a more complex caseload** – e.g. diabetes, Tissue Viability and Continence care This has also supported the upskilling of DNs in these specialist areas.
- The **rapid response team have coordinated specialist resources** to support clinical decision-making including Geriatricians, EoL and respiratory

Improving discharge support

- Close working between CNWL and CLCH to **pool staff** to create the discharge hubs
- **Homefirst staffing model transformed** to provide 8am-8pm, 7 days a week therapy responders shifts. Coordination aligned to each hospital / area to coordinate referrals, discharges, therapy response
- **Clinical training delivered for all staff** by the Homefirst team, including video training sessions on discharge home assessments, taking physiological observations and NEWS2 scoring, clinical escalations and SBAR for communicating concerns
- System utilisation and **management of community beds to meet surges** in demand
- Acute team **undertaking virtual follow ups for post COVID ICU patients** post discharge, with community teams attend the MDTs to assist in the management of any requiring follow up to ensure they are not lost

Harnessing community support

- There has been an **unprecedented outpouring of support** from both individuals and voluntary and community groups who want to help during this crisis.
- Alongside the national volunteering programme, Westminster City Council set up **Westminster connects** which coordinates this support to input into local public services
- We have also received **significant donations of food and hygiene products** for patients and staff which we have been distributing to our most vulnerable
- **Social prescribing link workers** are in place through a PCN and One Westminster partnership which is helping us to ensure our patients social and wellbeing needs are a core component of our care response.

Mental Health

- Mobilised a **Mental Health Emergency Centre** based at St Charles to support alternative/from A&E and support options for de-escalation. There is also a CAMHS centre at Northwick Park Hospital which operates across all five NWL boroughs. These centres aim to reduce time spent inappropriately in A&E and offer space to explore admission alternatives
- **Consolidated inpatient units** to ensure they are safely staffed despite increased levels of sickness whilst enhancing community offer to safely manage patients in the community including 24/7 CRHT and 7 day a week community offer.
- **Enhanced offer of psychological support for Covid-19 related anxieties** via IAPT and SPA

Support for shielded patients

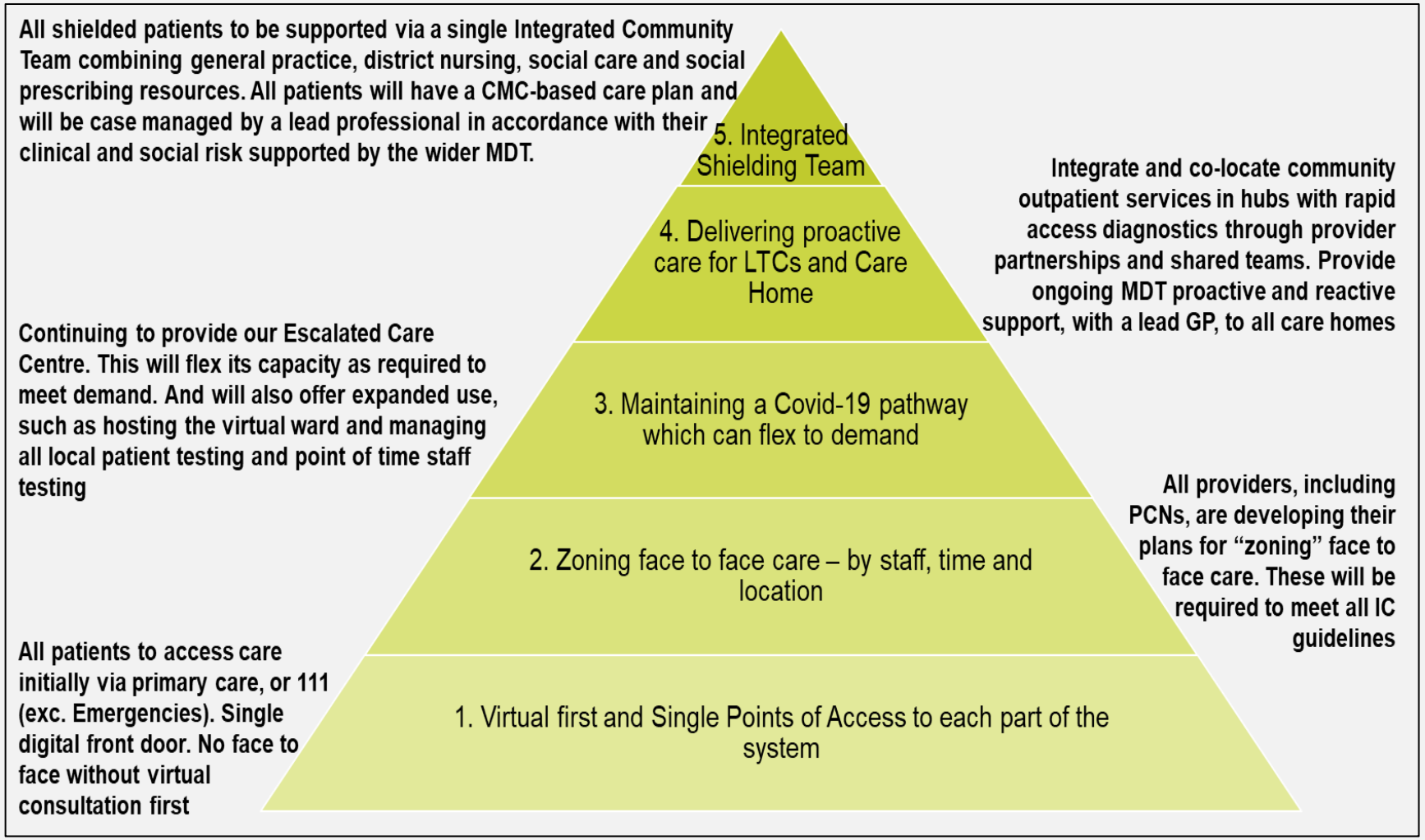
- **Regular phone support** from primary care, community, mental health, social care and voluntary services to all vulnerable and shielding patients
- Feedback from patients on the shielding offer highlighted a that many patients were receiving a **large volume of contact** from different organisations which needed coordination
- This has led the borough partnership to **develop a cross-organisational integrated model for this cohort** going forward, which is outlined in this plan

Planning for Recovery and 2nd Wave - Delivering segregated care

Our five point strategy for segmented care

Our out of hospital borough plan builds on the response work to date and working in partnership to deliver against pathway design needs. This includes implementing the new models of care needed locally to meet the changing needs and demands of patients over the next 6-8 months.

As a borough partnership we are following a five-point strategy to ensuring the high-quality care we deliver remains segregated for the safety of staff and patients whilst becoming increasingly integrated.



Planning for Recovery and 2nd Wave - Delivering segregated care

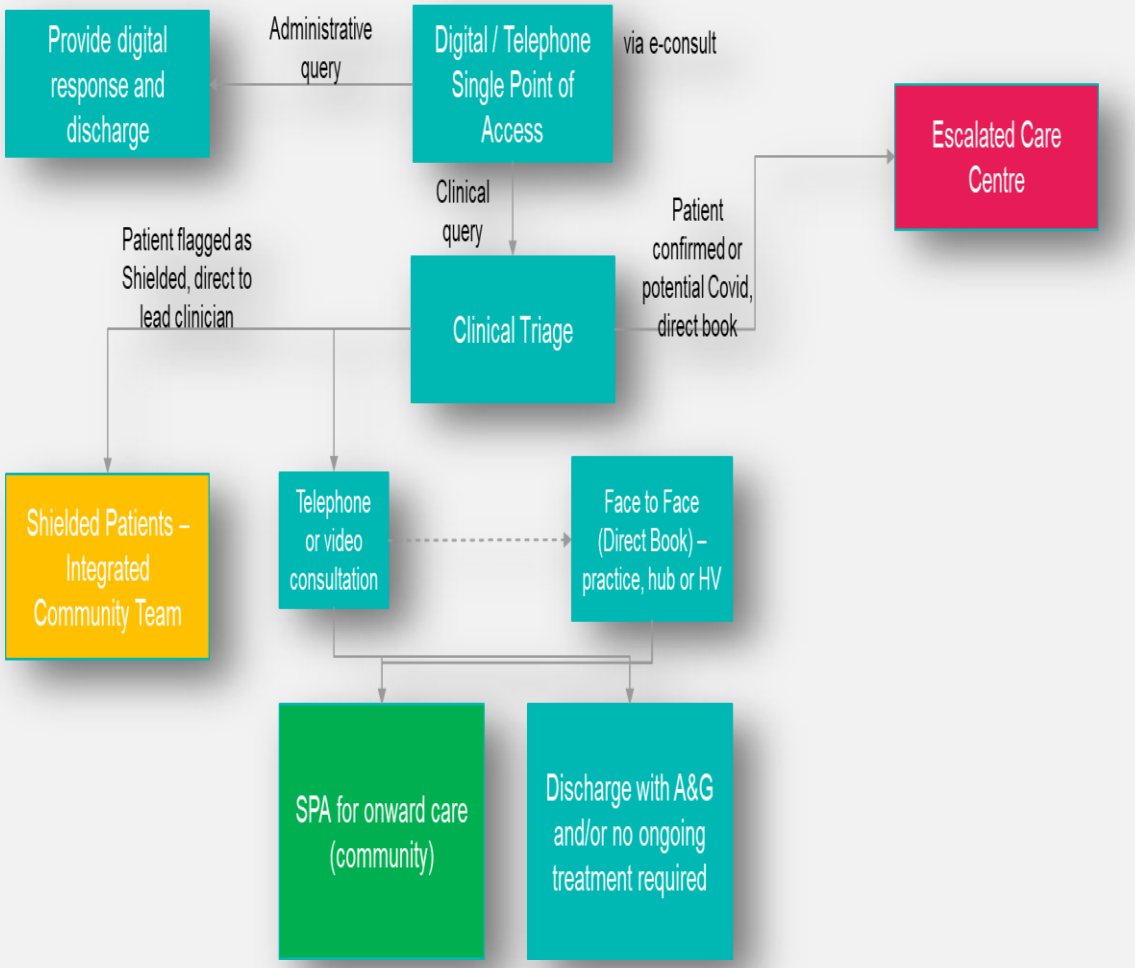
Step One: Virtual first through a single point of access

Prior to the pandemic an average of 5% of primary care consultations were completed virtually, this is now at 95%. Community, mental health and acute providers have also all embraced the use of digital technology to offer virtual solutions to care deliver. As demand for services increases once again, face to face will also increase – but the borough partnership are committed to fully embedding and sustaining "talk before you walk" through virtual first and single point of accesses at each stage of care. We have a strong desire to continue to transform our virtual offer and expand the use of digital technologies in the delivery of care, particularly remote monitoring of conditions.

We are mindful that this shift to virtual contact brings huge opportunities, but also real challenges both in terms of workforce development and in ensuring equal access for all patients. Our plans will focus on how digital transformation can reduce health inequalities rather than exacerbate them. We will also remain mindful of the need to tailor a "virtual first" model for our most vulnerable patients where continuity of care is particularly important to keep them well. We currently have several "Single Points of Access" in our system and recognise that these words can mean different things to partners. As such, our aim will be working collectively to define the most appropriate pathways for our patients and ensure that these have easily navigable access routes.

In terms of primary care access, our PCNs are in the process of developing a robust, electronic hub to be delivered at scale to ensure a consistent model of care and pathway is in place across all practices.

A possible pathway for patient access care via a digital SPA



The North West London health and care partnership

Planning for Recovery and 2nd Wave - Delivering segregated care

Step 2: Zoning face to face care as part of strict infection control procedures

PCNs have led on plans to develop a consistent approach to how general practice can continue to offer face to face services in a way which keeps staff and patients safe. This plan segregates patients through spatial zone, where currently possible, and temporal zoning

Practices are in the process of self-assessing their ability to meet the PCN approach as well as national infection control guidelines. The results of this self-assessment will guide further work with practices on delivering core general practice face to face activity at scale if required.

It is recognised that there are some areas where an at-scale face to face model could be particularly helpful, i.e children, LTC management and shielded patients. However, having tested approaches to at-scale delivery of services during Covid-19, we are aware of the challenges that this can bring. We are committed to building on existing local best practice as well as learning from our ways of working over the last as part of implementing our borough plan.

We also need to give thought to how face to face care can be delivered to more vulnerable populations – such as our homeless patients.

Spatial Zoning

- Some practices able to do this within their own premises, with separate entrances, waiting areas and clinical rooms for "high risk" and "low risk" patients.
- Some larger practices may be able to provide full zoning into 2 or even 3 separate zones.
- "Hubs" for core primary care would be on a "flexing" basis only.

Temporal Zoning

- Spacing out of patient appointments such that the minimum number of patients are in the building at any one time
- Maximisation of work that can be done remotely prior to patients' arrival, reducing F2T to minimum
- Staggering clinics with highest risk patients in morning and lower risk later in the day
- Workforce segmentation with clinicians in recent contact with known Covid19 cases avoiding seeing high risk patients at F2F.
- Escalation at PCN level with move to spatial zoning if required.

Shielded patients (i) All F2F services at home if possible, through an integrated community team across primary, community and social care services, iii.) Strict Temporal Zoning (iv) Referral to the 'Hub" practices when unable to do any of above.

Patients over 60 and/or with one or more LTC, plus pregnant women. To be seen in the high-risk temporal zone, or the high-risk spatial zone.

Children – Provide a perceptibly safe environment through temporal zoning in practice, with a specific child clinic time 12-1.

Low risk - Anyone not in above groups can be seen, when needed, in the afternoon session.

Covid-19 confirmed or suspected – Through Escalated Care Centre.

PCNS are also being asked to consider how they could delivery "cold" hubs either across the PCN or the CCG to offer choice to patients. These could be overlain across the above model and would provide a route for all patients who may require additional comfort to attend for face to face care. Perception of the safety of local services will change over time, but fear will be considerable or some after the initial easement of each peak.

Planning for Recovery and 2nd Wave - Delivering segregated care

Step 3: Maintaining and optimising a hot pathway

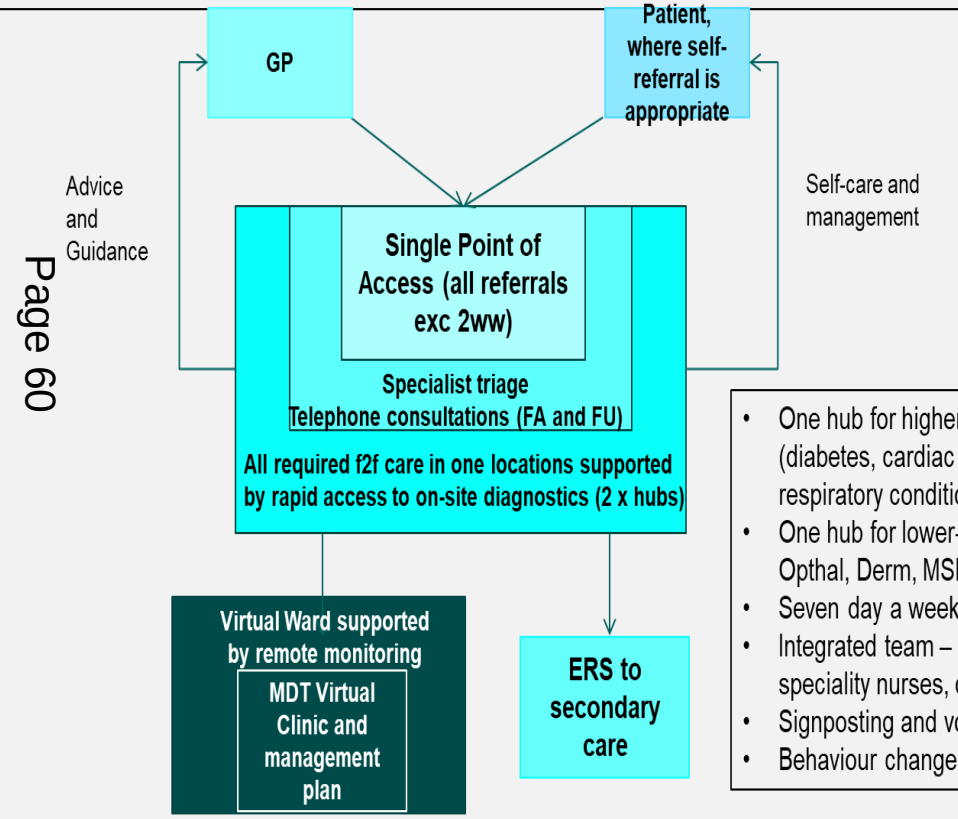
Local “hot” pathway is valuable in managing patients with confirmed Covid-19 or potential Covid-19 in a way which protects both staff and patients and which provides assessment, monitored symptom control as well as rapid access to care in a safe and effective way. However, there are challenges with this pathway which we will resolve as part of our borough plan. This includes how to make the pathway cost effective, whilst retainingg flexibility to scale capacity in-line with demand.

Challenges and Opportunities	Transforming the model through the borough plan
Challenge: Variable demand which can impact on VfM	• Increase role of hot pathway to provide additional support for patients and the health and care system • Review capacity and demand and flex existing staffing to meet current demand • Consider sharing hubs across boroughs.
Challenge: Sustainability due to cost of operation	• Utilise existing commissioned capacity which is underutilised to support delivery – such as extended access services • General Practice to play a more active role in supporting the pathway through provision of salaried sessions – as part of workforce zoning approaches • PCNs to consider use of additional roles as part of the model where clinically appropriate.
Opportunity: Offers a virtual ward service with existing training, resources and SOPs	• Monitoring of care home patients (risk-based) • Remote monitoring of shielded patients and highest-risk non-shielded patients • Offering increasing long-term condition management for Covid-19 patients to enable care to continue • Support earlier discharge from hospital via integration with rehab and intermediate care
Opportunity: Infrastructure in place to offer testing	• Can be mobilised quickly as required for “test, track, trace” • Can be mobilised quickly as required to deliver testing for staff and patient

Planning for Recovery and 2nd Wave - Delivering segregated care

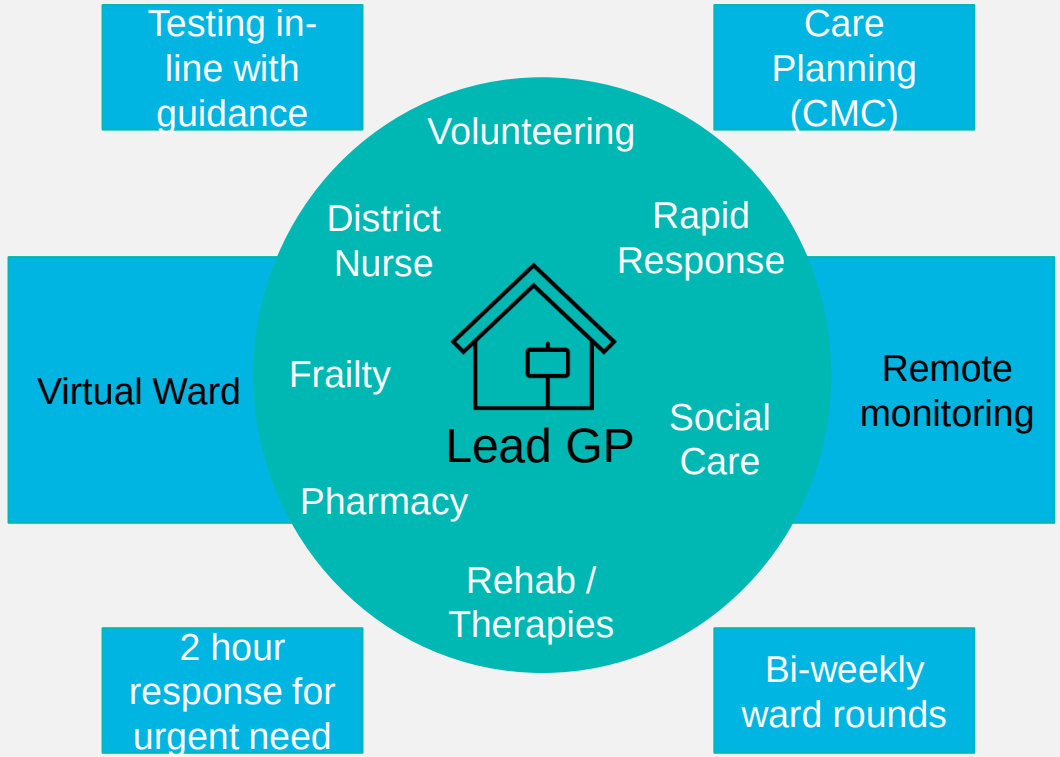
Step 4:Proactive care for long term conditions and care homes

Build on our existing planned care strategy and model of care for long term condition management, by ensuring onwards referrals for community and acute specialist treatment are managed through a SPA, enhanced triage and specialist advice model.



- One hub for higher-risk conditions (diabetes, cardiac conditions and respiratory conditions)
- One hub for lower-risk conditions: Gastro Opthal, Derm, MSK, Gynae and Uro
- Seven day a week service
- Integrated team – GPs, Nurses, therapies, speciality nurses, other HCPs, consultants
- Signposting and volunteering support
- Behaviour change

Proactive support for care homes, via an MDT with a lead GP for each care home. Supported by consistent standards of care including holistic care planning, ward rounds (increasing with need) and comprehensive IC measures, including testing as appropriate

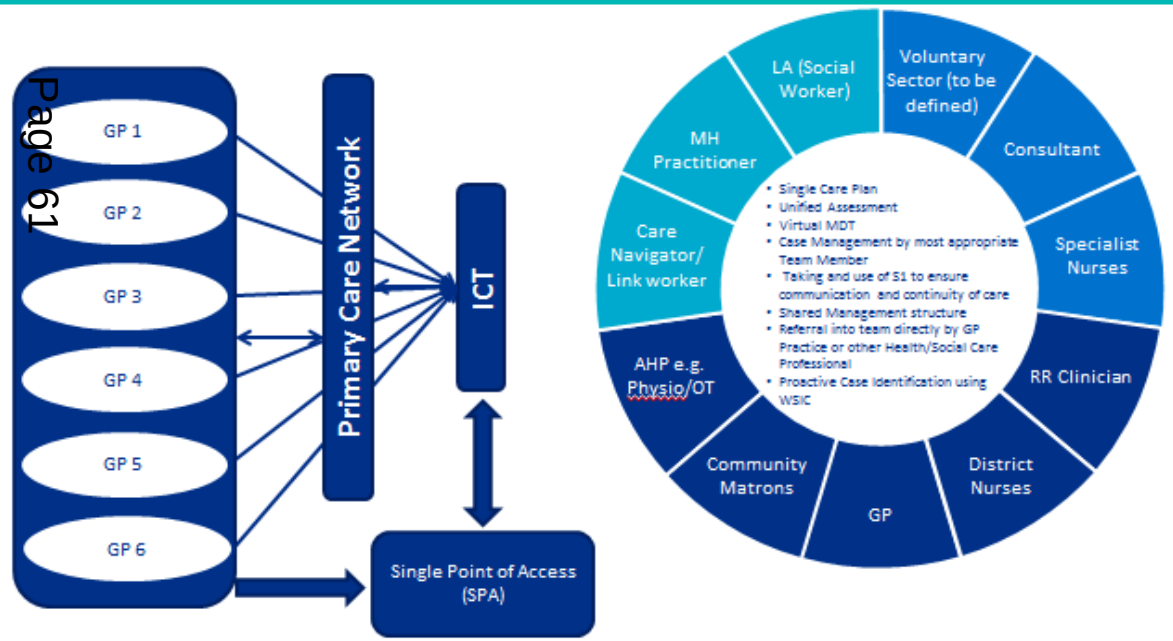


Delivering segregated care

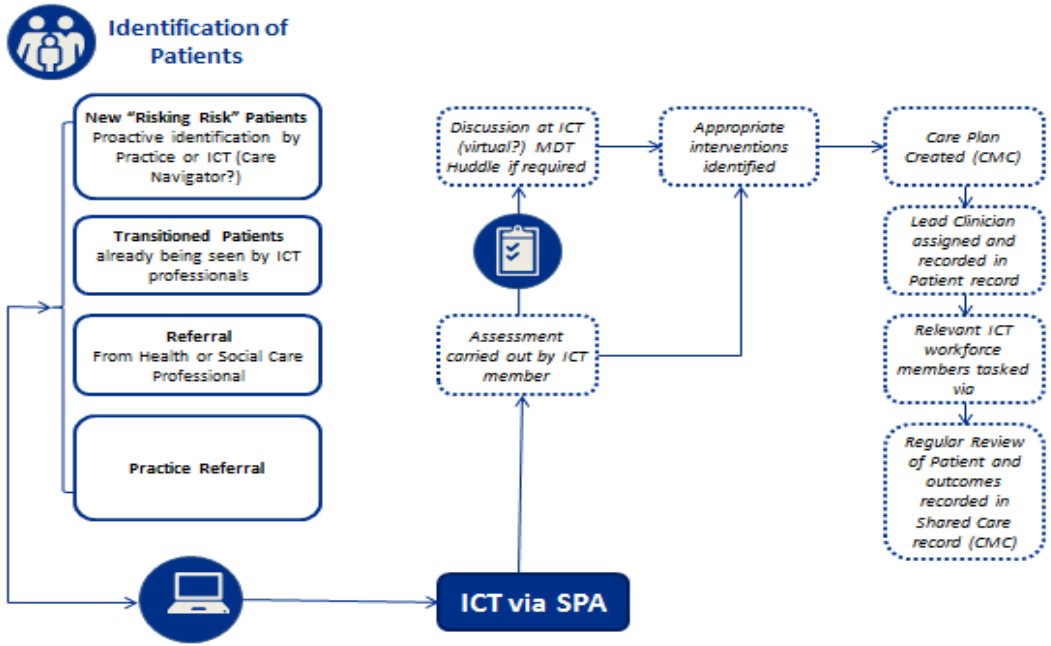
Step 5: An integrated community team for shielded patients

All partners in the system – primary, community, social and voluntary – have been worked extremely hard to support shielded patients. Most partners have introduced regular check-in calls with patients to ensure that any support needs are being identified and acted on quickly. Patients have fed back to us that while this support is appreciated, they receive a large volume of contacts which can be difficult to manage. As a borough partnership, we are developed an integrated community model which will bring together and pool all staff in the system to ensure we can deliver proactive and coordinated care for shielding patients. This builds on pilot approaches tested in 2019 to improve care for our most complex frail and elderly patients.

Integrated Shielded Model



Patient pathway



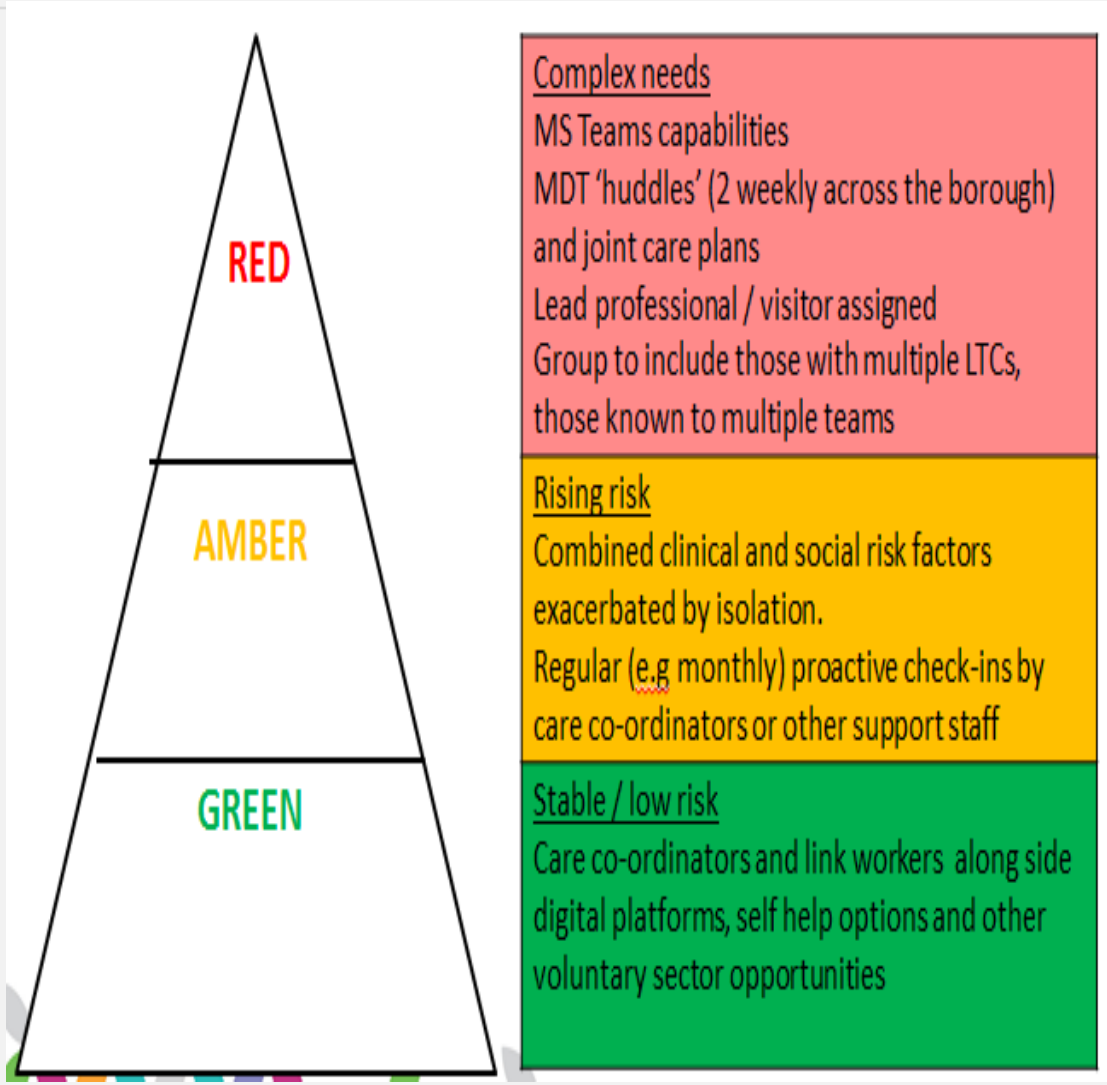
The North West London health and care partnership

Planning for Recovery and Wave 2 - Support to shielded patients

Building on learning from our support to shielded patients to date, including the large volume of contact received by patients, we are developed an integrated community model which will join up care for this group across community, mental health, social care, pharmacy, hospital and voluntary services in Westminster. The integrated community model will offer more personalised, coordinated health and social care to shielded patients living in Westminster.

The integrated team will work together to keep patients well and safe in the community through early identification, risk segmentation and holistic proactive care planning which will reduce the likelihood of deterioration and hospital admission. It is anticipated that the majority of people with 1 or more long term conditions or with challenges in life impacting on their health and wellbeing will be stable and maintained in primary care. However, there will be some people with more complex needs who will require on-going case management by the integrated team with additional support from specialists e.g. specialist nurses, consultants and geriatricians. The diagram opposite sets out the offer for each population segment.

It is important to note that this would represent a new way of working to support these patients and therefore will need to follow our “test, learn and evolve” approach to delivery. Areas already identified as needing monitoring are the frequency and make-up of MDT huddles and the value these deliver; and engagement with patients and clinicians on the role of CMC as a care planning tool outside of end of life care planning.



Planning for Recovery and Wave 2 - Support to shielded patients

Identification and Segmentation	Integrated Community Model	
• System partners will share data and intelligence to agree a shared list of shielded patients • The list will be held by GPs. • Shielded patients will be segmented by level of risk, supported by shared data and WSIC • Every patient will have a holistic care plan (CMC) to support or treat those with complex needs • The care planning process will be multifaceted and multidisciplinary and take into account both health and social issues such as isolation, housing, finance etc • Stronger links to the voluntary and community sector.	• All patients will be reviewed or triaged virtually. Proactive reviews for lower risk patients will be undertaken monthly via virtual "check-ins" by care coordinators and other support staff. • The most complex patients and those with exacerbating need will be reviewed by a virtual "huddle" which will meet 2 times per week. The huddle will support them until they are stable and can be returned to self care and supported maintenance in primary care. The multidisciplinary huddle will include LA, MH, AHP, GP, 3rd sector, specialist community services such as HF, diabetes, respiratory) and consultant Geriatrician etc • Remote monitoring will be available through the virtual ward	• As a principle, the aim is for F2F to be done in peoples home (including flu vaccination and phlebotomy) where appropriate and if required, in-line with shielded guidance • If a F2F is required, the GP will choose the best clinician first time to visit e.g. phlebotomist, practice nurse, GP, DN, community matron, therapist, pharmacist, specialist nurse, mental health, social care. • All HCPs will work at the top of their licence and will deliver all care requirements possible within their skills set • Patient will be proactively offered virtual IAPT services where required. • If diagnostics are required; then patients will be booked into integrated community hubs which will bring together community services and community diagnostics (see slide 15)

Page 93

The North West London health and care partnership

Planning for Recovery and 2nd Wave - Support to care homes

Care Homes in CL*	Type	Provider	Lead GP / Clinician	Beds	Enhanced clinical support elements
Garside	Nursing	Sanctuary	Dr. Muir, Dr. V. Muir's Surgery	40	• Frailty Nurses – daily contact, 7 dpw; single point of contact 8am-10pm, Resident testing • GPs – DNAR and CMC reviews, multi-practice MDTs where necessary. • Clinical pharmacy – Meds Optimisation team • CIS and CLCH community teams: proactive and reactive support, education and training and relationship building. • NWL care home team – Infection control and general clinical support
Butterworth	Nursing	Sanctuary	Dr. Abouzekry, Lanark M/C	42	
Forrester Court	Nursing and Residential	Care UK	Dr. Simons, Newton Road M/C	113	
St George's	Nursing	Independent	Dr. Chukuezi, Victoria M/C	44	
Norton House	Residential	Anchor	Dr. Maneira, Millbank MC	39	

***CL GPs also provide primary care services to the following homes in WL: Athlone House, Chelsea Court, Harrow Road Flats A,B and C.N.B. This list does not include sheltered housing or supported living facilities**

Our borough partnership have been focussed on two priorities to date:
1.) Delivering national and NWL requirements for enhanced clinical support (June – Sep 2020)
2.) Develop integrated Covid prevention and outbreak response
The slides overleaf provide detail on our progress in achieving these two priorities. We currently have a large number of teams and professionals providing support to care homes. Our learning from our progress to date to is that, over the longer-term, there is **further work we must do to improve the communication between these services** (in-line with the developing model for shielded patients) and to tackle longer standing issues which care homes need support to address. This will include **working as a system to improve clinical leadership, particularly nursing leadership, within our care homes** and to **improve access to training, education and support for the care home workforce**. There is also a need for us to **review our care home provision against demand for nursing and residential patients and the changing needs that this provision needs to meet.**

Planning for Recovery and 2nd Wave - Support to care homes

Priority 1: Delivering national and NWL requirements for enhanced clinical support (June – Sep 2020)		
Area	**Responsible**	**By (status)**
GP clinical Leads established	CCGs / PCNs	01/05 (complete)
MDT – basic components established	CCGs, GPs, ICHT Frailty team, NWL	15/5 (complete)
MDTs expansion / formalisation, including: - Simple access to specialist services / support - Prevention of admission advice - Care planning and clinical quality input	CCGs / Provider partners	Summer
Care planning -Review coverage of advanced care plans and increased use of CMC	CCGs / GPs	01/05 and ongoing
Clinical Pharmacy input / support programme agreed	Meds Mgt / CLH	01/06
Priority 2: Develop integrated Covid prevention and outbreak response		
Establish regular monitoring and response protocols between partners, including categorisation of risk levels	LAs, CCGs	15/04 (complete)
Complete initial testing of all residents and staff in care homes	CCGs, GPs, ICHT Frailty team, NWL	01/05 (complete)
Improve prevention and outbreak response including communications to care homes	LAs / CCGs	29/05 and ongoing
Ensure testing undertaken in-line with PHE advice and NWL agreed processes.	LAs / CCGs / NWL	29/05

Proactive planned care (1/3)

Area	Approach
New approaches to long term conditions	Building on our existing planned care strategy we will ensure that primary care is fully supported to manage long term conditions out of hospital. This involves clear pathways for all onward care needs, enhanced clinical triage and advice and guidance from a joint team of primary, community and acute specialists with rapid access to community diagnostics and support from the VCS. The team will determine management plans, provide virtual clinics, manage exacerbations and offer face to face treatment if required. We aim to co-locate services within two community hubs, alongside community diagnostics – one for patients with higher-risk conditions and one to focus on specialities with higher activity but lower risk.
Population health	Population health and prevention will drive pathway design. We recognise that patients with long term conditions are not a homogenous group. We will use WSIC to prioritise groups or conditions that are currently not well managed out of hospital. For each group we will define what we are trying to improve, and use patient and clinical input to define pathways. All pathways will focus on primary and secondary prevention; not just treatment working with the VCS.
Case Management through shared workforce	Patients will be case managed through a risk-stratified approach, with those at high risk of exacerbation receiving comprehensive proactive review, with remote monitoring of conditions at home to prompt increased support if a patient's condition is deteriorating. We will look to develop a shared workforce model by defining the functions required to support each cohort and the workforce required to deliver those functions. We will align existing workforce from across the borough, including specialist teams and identify gaps in capacity. PCN level partnerships will then develop workforce plans including exploring how best to utilise additional roles. We will also look to build on peer to peer support and apply this to new populations – for example diabetes
Advice and Guidance	Advice and guidance will be provided from a condition-specific team of primary, community and acute specialists – building on existing models in place locally for dermatology, cardiology, respiratory and diabetes specialties. These local models will be supported by virtual access to specialist acute advice and guidance available via phone and ERS. Our MDT team will be co-located with diagnostics including bloods, ECG, ABPM, Echo-cardiogram, ultrasound and X-ray to support provision of Advice and Guidance in more complex cases.
Personalisation and self care	Care plans will be developed with patients, families and carers using virtual consultations. Care plans will be holistic and personalised and will support patient's to work towards their personal goals. Care navigators and social prescribers will ensure a prevention focus to all care plans and refer to social and voluntary resources to support delivery of goals. The CCG will look to secure increased digital resources to increase access to self-care.
Memory Services	Clinical Directors across WLT and CNWL are working together to align approach on delivery of memory services post COVID-19 due to the risks inherent in face to face appointments with older vulnerable individuals. This includes modelling staffing numbers required to open services to all new referrals; developing a remote working policy to conduct remote cognitive assessments either by remote consultation and reopen groups; working consistently to manage change processes to enact above operationally, so that the services re-open to routine referrals on 1st July 2020

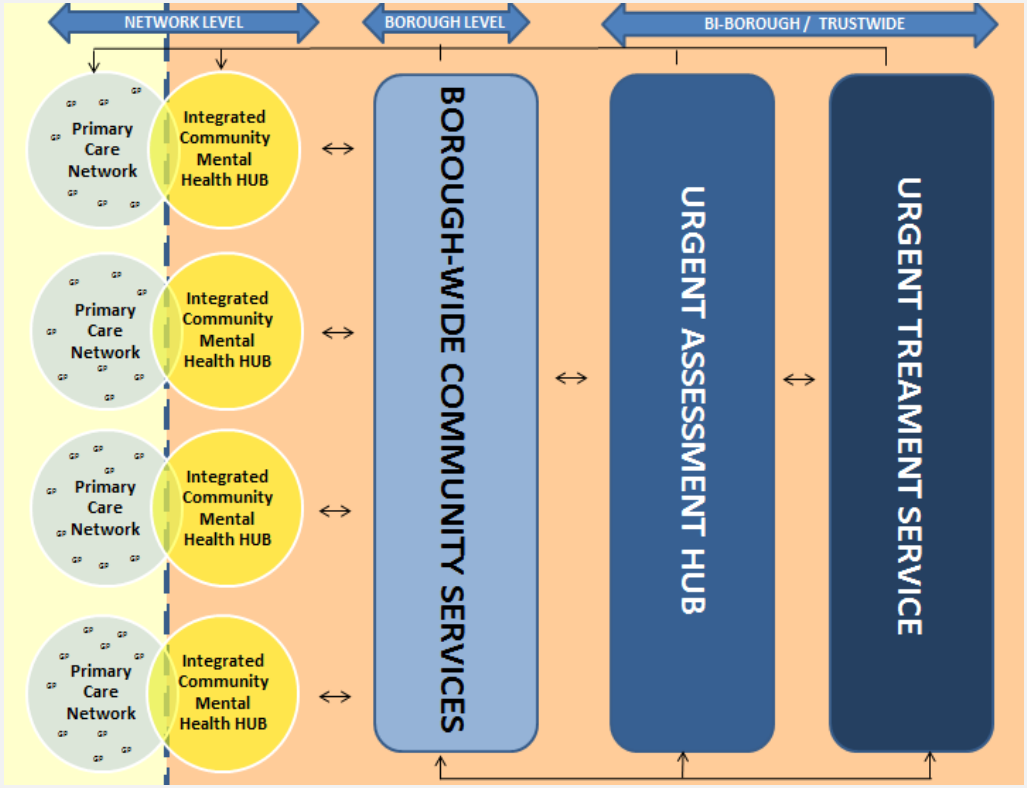
Proactive planned care (2/3)

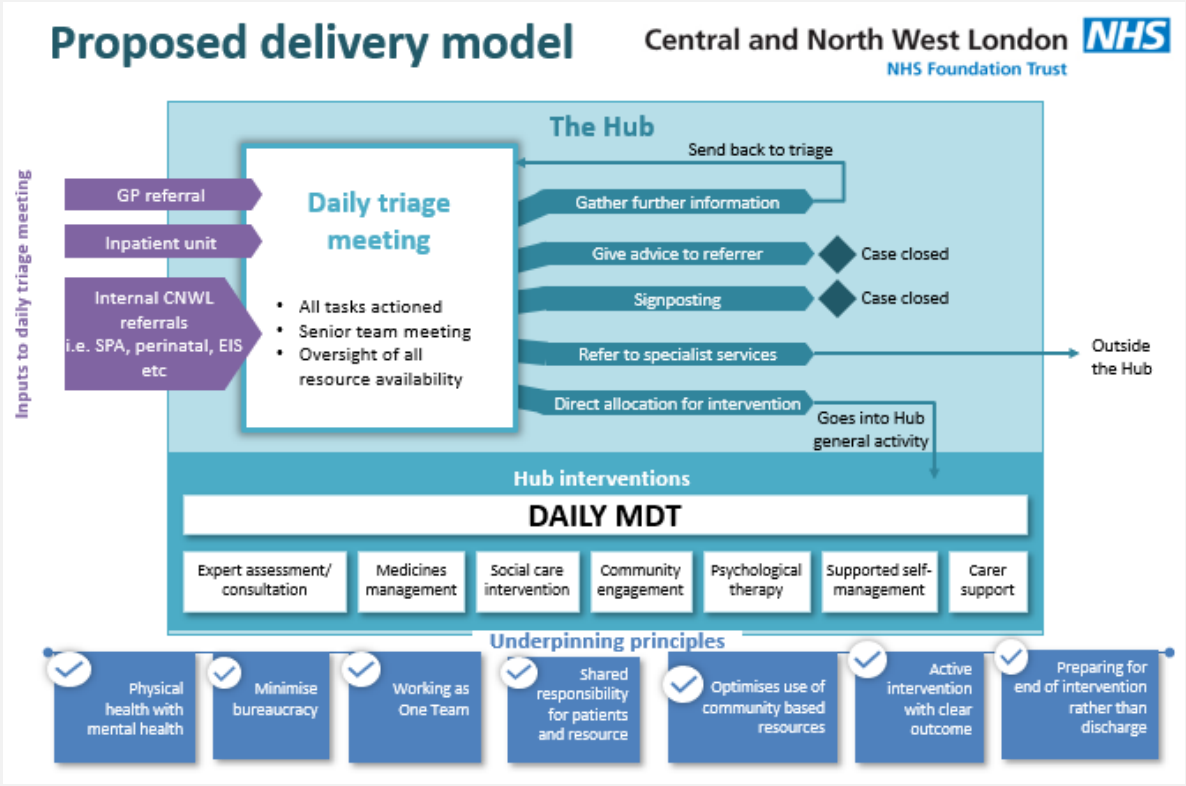
Area	Approach
Cancer and Palliative care	We will roll-out “C the signs” in all practices to improve identification and screening of potential cancer patients. Access to community-based support from cancer specialists and palliative care specialists has been identified as an area of learning. As a result, we will work with wider partners to improve access to specialist cancer and palliative care workforce as part of our integrated community models in way which is sustainable for those providers. We build on the progress made with Coordinate my Care uptake during Covid, to ensure that patients with palliative care needs are using respected tools such as the gold standard framework. We will work with PCNs to improve uptake of training and support available at NWL level and reduce existing variation in practice.
Discharge	We will build on, and embed as business as usual, work of our community and acute providers undertaken to improve discharge to access processes and the emergence of joint discharge hubs. There is a risk that demand may be over and above previous service and staffing levels, therefore redeployed staff may be essential for ongoing provision and there is a competing priority for staff within the service with stepping up essential community rehabilitation services. This risk will need to be managed proactively via the borough partnership and the ICS. Step down COVID and non-COVID pathways will be formalised, learning from our utilisation of temporary beds / units during Covid-19 and considering longer-term need for interim and short-stay beds as well as ensuring our ability to ramp up and ramp down capacity as required.
Rehabilitation	We also need to provide effective rehab support for a new cohort of patients who are likely to require lengthy and intensive rehabilitation, they are likely to be on average younger than the usual cohort of patients seen by community therapy services, and because of this they are also likely to need rehabilitation back to a higher baseline than the majority of the patients on our therapy caseloads. This patient cohort may also require an MDT approach with specialist teams such as Neurology, Respiratory, IAPT, Older peoples mental health, SLT, Podiatry, TVN, etc. CIS has set up and complex case virtual clinic with IAPT for psychological therapies specialist advice. CIS has engaged with MSK colleagues in MSK connect for H&F and MSK healthshare for biborough to develop a pathway from CIS for those able to engage in virtual sessions
Child Health and Wellbeing	School nursing services are proactively linking with schools to support them in reopening including re-establishment of immunisation programmes. CNWL have introduced a child health and wellbeing duty line: managing key health development checks and immunisations. All services will work closely together to maintain all essential healthy child contacts as per community guidance and provide support and advice as required. We recognise that parents and children have significant concerns about receiving face to face care during this time. We will review pilot approaches undertaken during Covid-19 to deliver child health in primary care at scale, as well as pilots undertaken in other areas (like drive-through immunisations) to develop a plan which ensures patients and children have options for how they can receive necessary face to face care and to increase their confidence.
CAMHS	Working with local partners to implement Thrive model across all boroughs including early identification of concerns with children and upskilling partners including schools, local authority, voluntary sector and parents to ensure children have a comprehensive support network skilled and able to support their individual needs. Local transformation plans to be revisited and re-baselined. Consideration being given to how we ‘live with Covid’ and increase service provision and footfall on site at the current time while managing social distancing and infection control across the CAMHS estate. Bereavement support currently under review and development with learning from Grenfell being utilised

Proactive planned care (3/3)

Mental health: *Integrated community MH model working across partners transformation restarting, incorporating learning from Covid-19 and building on some gains made re caseload review during emergency response. This delivery will incorporate development of what a virtual/digital offer might look like taking learning and feedback from staff and patients during C19 crisis and ensuring accessibility to those who are shielding/C19+ patients going forward.*

- *K&C system partner meeting asap for next steps on integrated model across Community Living Well, CMHT, wider third sector and LA*
- *Westminster implementation Group regrouped on the 6th of May to discuss what work could be relaunched and milestones*



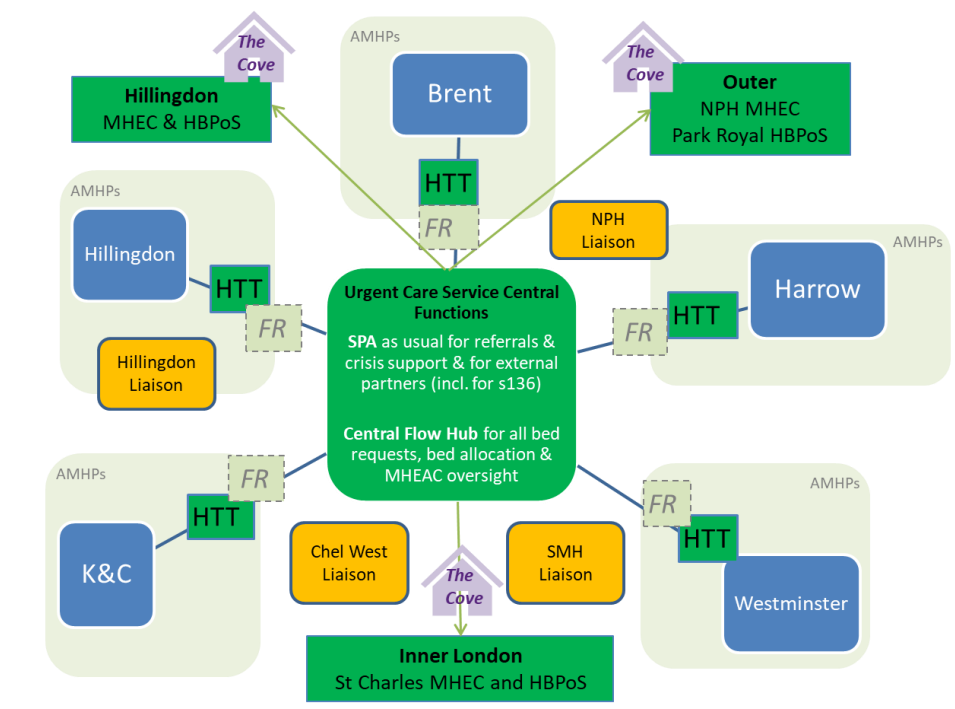


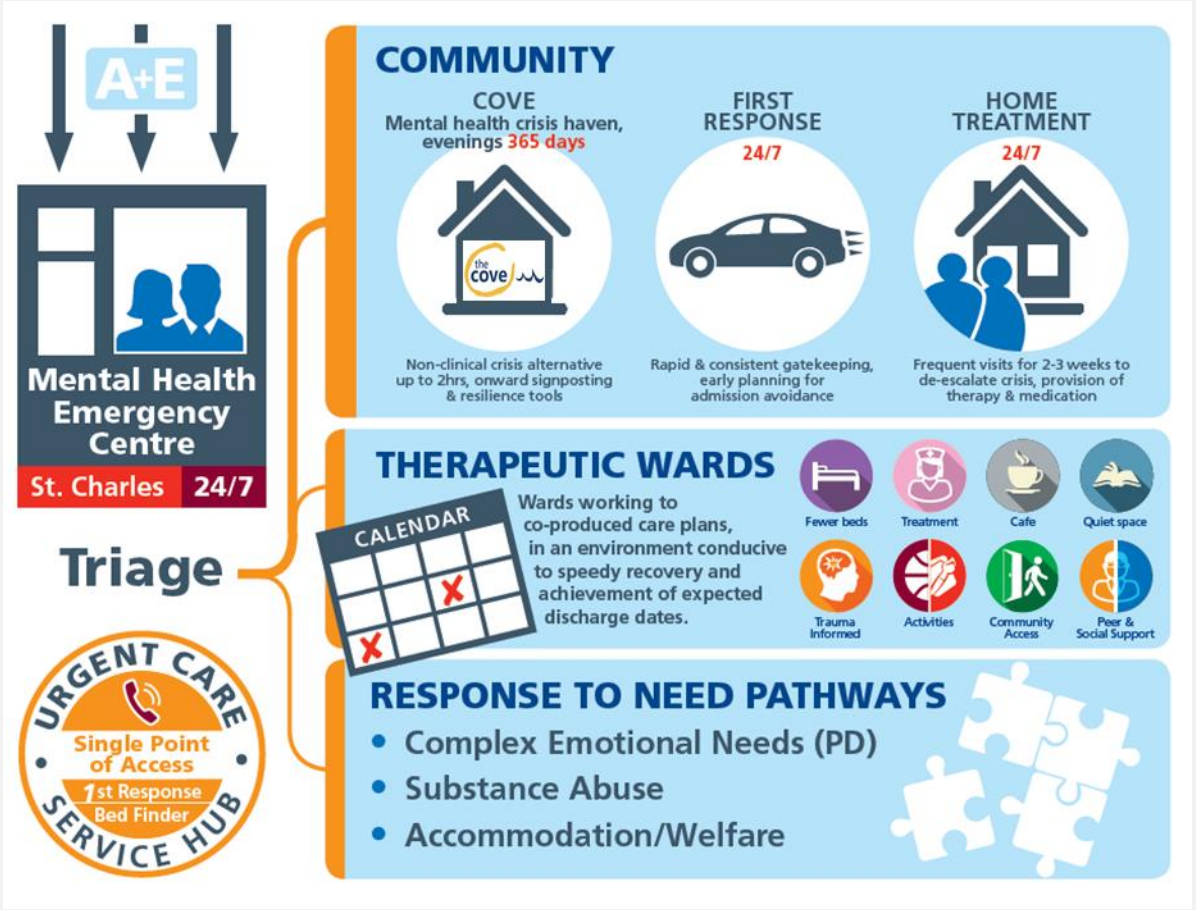
Integrated community-based urgent care (1/2)

Area	Approach
Demand Suppression	The proactive planned care model described in the preceding slides is expected to help supress demand for urgent care through improved risk stratification, proactive management of “rising risk” patients and integrated delivery models. We intend to integrated existing extended access primary care services into our planned care hubs so that the hubs can also respond to urgent, same day demand care, supported by rapid access to diagnostic support within those hubs. Our integrated proactive planned care model and shielded patients models will ensure include single points of clinical escalation for complex patients – e.g. lead clinician. We will look to improve the handover from these integrated models into out of hours services so that rising risk patients are known to out of hours services in advance.
Talk before you walk	All services are implementing a “talk before you walk” with an unprecedented shift of activity to virtual consultations. This frees up capacity to undertake urgent face to face consultations on the same day where this is clinically required. In line with the NWL plan, NHS 111 will be the single Point of Access (SPA) for all urgent referrals to ED and UTCs. All patients will be directly booked into ED/ UTC unless blue lighted. NHS 111already has the ability to direct book into extended access primary care services, core primary care and our escalated care centre.
Clinically driven triage	Working with EDs, UTCs and our integrated community models, we will look to ensure that pathways into same day emergency care services within the hospitals are clearly articulated and that there is a greater degree of clinical / professional triage to direct people into the correct care pathways. We will also work with EDs and UTCs to ensure that redirection pathways back to general practice are clearly articulated and followed.
Rapid Response	Build on changes made to rapid response services as part of the Covid-19 response and adopt these into business as usual. Continued focus on prevention of admission and supporting people into appropriate end of life care pathways or admission to hospital as clinically appropriate. Identify how remote monitoring capability can best be utilised as part of the rapid response service to support case management. Work across the primary and community system to make access rapid response services as easy as possible, including ensuring that rapid response nursing teams are included in all integrated community models.
Children’s Mental Health	Review the CAMHS Emergency Assessment Service introduced as part of the 24/7 emergency offer during Covid-19 to scope long term provision options. A surge in A&E presentations by Children and Young People with mental health needs is anticipated as lockdown measures lift. We will continually review staffing to ensure that we can adapt as required to changing demand, we will also consider how the available volunteering offers can be used to support this cohort. CAMHS will work with key partners including Social Care and Education to support children as they return to schools, reviewing known cases and providing pathways for escalation for all children whose condition may have changed or be showing signs of entering a crisis.

Integrated community-based urgent care (2/2) - Mental Health

Continuation of delivery of Urgent Care Service redesign to support principles, respond to local complexities and pressure points and enhance the community based crisis offer (incl. alternatives to A&E and admissions) in line with Covid-19 learning and NWL principles of recovery, and delivery of the Long Term Plan – overarching NWL model below, then detailed KCW in the diagram on the right describing functions meeting recovery plan principles





How we will support Implementation - PCN development and expectations

Development of PCN capability and capacity required in order to deliver the plan include:

Use of Population Health Data
Basic population segmentation is in place, with an understanding of key groups, their needs and their resource use and each PCN priority population cohorts identified. Covid-19 has enabled sharing of records and functioning interoperability within networks which must not be lost where permitted by IG requirements. PCNs will now use the data to design proactive care models to reduce health inequalities, unwarranted variation and support development of the "new normal" model.

Clinical Leadership across and within the PCNs
PCNs have an established approach to strategic and operational decision making across and within PCNs which has been further enhanced as a result of operating in a command and control structure as part of Covid-19 response. Focus now needs to be around PCNs leading decision making at ICS and place level, working with partner health and care organisations to allocate resources and deliver care.

Quality Improvement
PCNs monitor the quality of enhanced services through the PCN board meetings including agreement about actions to improve areas of variation. They will need to build on this model to encompass the new ways of working including the increased use of hub-based services and virtual first models. There is an additional level of Safety and Quality assurance built in at Federation level to which the CDs contribute their expertise.

Team Development
As part of the new normal, PCNs will need to develop and implement plans for sharing of resources to establish centralised practice teams that work across the PCN and Borough footprint in order to increase capacity, capability and resilience. This includes an eHub to enable the virtual first model and a single point of access to triage all calls into primary care.

Flexible Working and New Roles
Social prescribing link workers, as the newest role to be introduced, must now be fully embedded within PCNs playing a pivotal role in supporting shielding and vulnerable patients as well ensuring links to the wider community, supporting long term condition management and enabling quality proactive care planning.

Working across the borough, where appropriate
The 4 PCNs CDs and Chairs have developed strong working relationships based on regular contact, improved joint decision-making and the sharing of best practice and expertise. The four PCNs are also supported via the resources of the local Federation, which they intend to use as an umbrella organisation to allow for reduction in duplication of effort, skills and expertise sharing, and efficiencies from the pooling of resources

How we will support Implementation - PCN development and expectations

Primary Care Network Maturity Matrix

Foundations are in place and Step 1 completed in all PCNs

Step 2 is in progress.

The steps outlined in this recovery plan will move PCNs further towards completion of Steps 2 and 3

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right Scale	**Plan:** Plan in place articulating clear vision and steps to getting there, including actions at network, place and system level. **Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there. **Time:** Primary care, in particularly general practice, has the headroom to make change **Transformation resource:** there are people available with the right skills to make change happen, and a clear financial commitment to primary care transformation	**Practices identify PCN partners** and develop shared plan for realisation **Analysis on variation** in outcomes and resource use between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of the needs of key groups and their resource use. **Integrated teams**, which may not yet include social care and voluntary sector, are working in parts of the system. Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them. Steps taken to ensure **operational efficiency** of primary care delivery and support struggling practices Primary care has **a seat at the table** for system strategic decision-making	PCNs have **defined future business model** and have early components in place. Functioning **interoperability within networks**, including read/write access to records, sharing of some staff and estate. All primary care clinicians can access **information to guide decision making**, including risk stratification to identify patients for proactive interventions, IT enabled access to shared protocols, and real-time information on patient interactions with the system. Early elements of **new models of care** in place for most population segments, with integrated teams throughout system, including social care, the voluntary sector and easy access to secondary care expertise. Routine peer review. **Networks have sight of resource use and impact on system performance**, and can pilot new incentive schemes. Primary care plays an **active role in system tactical and operational decision-making**, for example on UEC.	**PCN business model** fully operational. **Fully interoperable IT, workforce and estates** across networks, with sharing between networks as needed. **Systematic population health analysis** allowing PCNs to understand in depth their populations' needs and design interventions to meet them, acting as early as possible to keep people well. **New models of care** in place for all population segments, across system. Evaluation of impact of early implementers used to guide roll-out. PCNs **take collective responsibility for available funding**. Data being used in clinical interactions to make best use of resources. **Primary care providers** full decision-making member of ICS leadership, working in tandem with other partners to allocate resources and delivery care.
Integrated Working				
Targeting Care				
Managing Resources				
Empowered Primary Care				

How we will support implementation - Integrating our services

As borough partners, we have been developing our approach for how we will integrate our services for some time. Our approach is based on four key components of change :
1.) Flexible use of teams and resources
2.) Joining up support and corporate functions across all partners
3.) Integrated clinical leadership at borough level
4.) Integrated governance

There are lessons to learn from our recent experience of working together during the Covid-19 pandemic. Partners across our borough have pointed to the benefits of reduced bureaucracy, virtual meetings, taking practical and solutions focussed approaches to work and increasing trust in our relationships as the key reasons we have been able to undertake so much transformation in such a short space of time.

We recognise the need to refresh our approach to borough partnership working over the longer term to reflect this learning and ensure that we can build on the strong foundations that we have now set.

1.) Flexible use of teams and resources to meet the needs of the population.
Our vision for the future workforce flexibility is of joined up teams wrapped around primary care networks. These teams will act as one integrated team providing seamless care that is more proactive. There will be integration between parts of the health and social care system that are currently not working together optimally. There will also be coherence between the development of a single CCG for NWL, the development of an STP level ICS, and greater provider collaboration. Integration plans will take a team development approach to the workforce that is focussed on removing boundaries between teams, sectors and services and that builds resilience. We will also build operational and clinical teams around PCNs with more role substitution in the integrated teams with improved understanding of each other's roles. Our integration plans will include patients, service users and carers as equal partners in design and implementation of new models of care.

How we will support implementation - Integrating our services

1.) Flexible use of teams and resources to meet the needs of the population (cont)
During Covid-19, we have operated a mutual-aid approach which has led to both the redeployment of both commissioner and provider staff and resources from across the borough to support the system. We have also seen cross-organisational teams coming together to work as one, taking on new functions and roles to deliver essential care and improve outcomes for those most affected during this time. Our vision for the future workforce is to continue these ways of working and increasingly join up our teams wrapped around primary care networks. These teams will act as “one team” providing seamless care that is more proactive. Our borough plan highlights our immediate priority areas to integrate teams are shielded patients, long term condition management and care home support. There will also be a focus on integration between parts of the health and social care system that have previously not working together optimally as well as working across the Inner North West London cluster to harmonise models of care where this makes sense for our population and for our system partners.

2.) Joining up support/corporate functions across partners
We have an ambition to support partners to come together and operate in a seamless and integrated way. we do not think that this should be done through mandating formal structural changes but through identifying the functions that need to be joined together to deliver better care and less fragmentation. Key support functions that need to operate as one include: IT, workforce development, Estates management, data/BI, finance and contracting. The sudden transformation of services experienced over the last few months now needs to mainstreamed and made into business as usual, this will require enabling functions such as IT, organisations development and estates transformation to work at pace to unlock barriers to these approaches. Joining up our corporate and support teams to work in a matrix management approach collectively against projects and workstreams will enable us to drive delivery quicker than returning to our silos. With settings of care shifting dramatically across acute, community and primary care settings and the roles and functions of team being transformed alongside this, we will also need to consider our approach to collectively pooling budgets and resources so that all partners in the system are supported to cover the costs they are incurring.

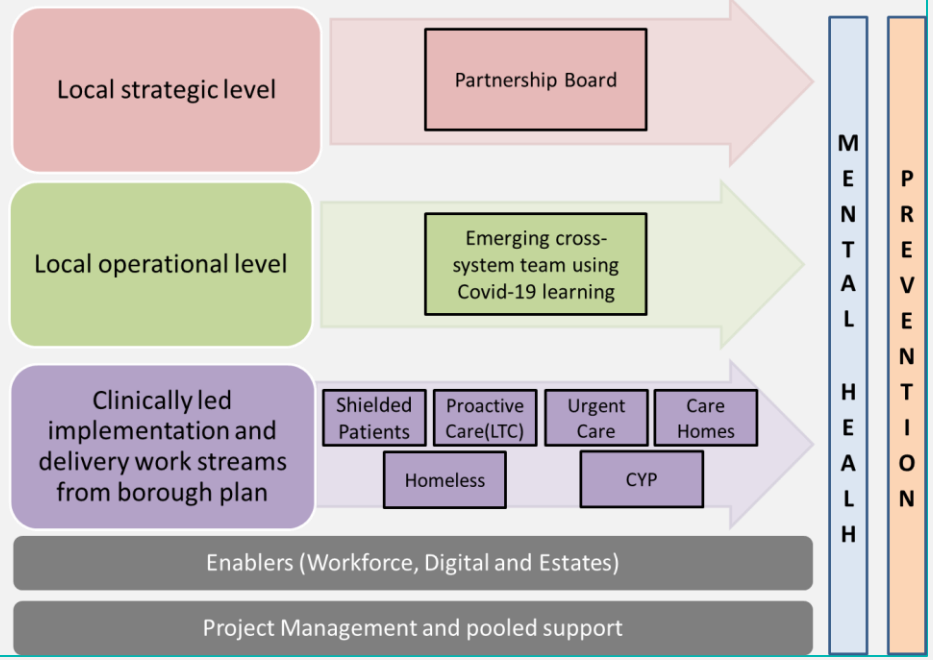
How we will support implementation - Integrating our services

3.) Integrated clinical leadership at a borough level

An incidental development as a result of our ways of working through the Covid-19 pandemic has been the redesign of care to meet the needs of specific populations groups – we have seen significant successes in delivering holistic, whole system care to our homeless populations, our care homes and increasingly for our shielded patients. We need to continue this approach, identifying the specific populations where silo'd working and fragmented services are causing concern and working on redesigning our services one by one. There is strong appetite for joint clinical leadership to lead this change, with the buddying of clinical directors from community and mental health services and providers with PCN clinical directors and other primary care leaders against each programme of work.

4.) Integrated governance

The Westminster Partnership Board has been functioning as the key governance body for Integrated working in Westminster for some years. The Partnership Board undertook a governance review in 2019. Implementation of the recommendations from that review were being progressed in early 2020 but were suspended during Covid-19. Following learning during the Covid-19 response and our planning for recovery, we have agreed to simplify our governance structures as a system to enable swifter decision-making and groups being able to deliver within their own remits and respond in an agile way. We have also recognised that previous structures, had the unintended consequence of separating mental health from physical health pathway development. We are committed to no physical health without mental health and will integrated mental health into all workstreams. The diagram opposition demonstrates this.



This page is intentionally left blank

City of Westminster

Adults' and Children's Services Policy & Scrutiny Committee

Date:	20 October 2020
Classification:	General Release
Title:	**2020/21 Work Programme and Action Tracker**
Report of:	Richard Cressey, Head of Cabinet and Committee Services
Cabinet Member Portfolio	Cabinet Member for Adult Social Care and Public Health and Cabinet Member for Children's Services
Wards Involved:	All
Policy Context:	All
Report Author and Contact Details:	**Lizzie Barrett** **ebarrett@westminster.gov.uk**

1. Executive Summary

1. This report asks the committee to agree topics for the 2020/21 work programme and note the committee's action tracker.

2. Key Matters for the Committee's Consideration

2.1 The Committee is asked to:

- Review and approve the draft list of suggested items (appendix 1) and prioritise where required.
- Note the action tracker (appendix 2).

3. Work programme

3.1 The proposed list of topics (appendix 1) takes in to account comments by the committee at its previous meeting.

If you have any queries about this report or wish to inspect any of the background papers, please contact Lizzie Barrett.

ebarrett@westminster.gov.uk

APPENDICES:

Appendix 1 – Master Work Programme 2020/21
Appendix 2 - Action Tracker

WORK PROGRAMME 2020/2021
Adults' and Children's Services Policy and Scrutiny Committee

ROUND THREE 20 October 2020		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To update the committee on key areas of work within its remit and the Cabinet Member's priorities	Councillor Tim Barnes, Cabinet Member for Children Services
Update on the Gordon Hospital	To receive an update on the closure of the Gordon Hospital and the broader implication for mental health provision in Westminster.	Central and North West London NHS Foundation Trust
Westminster Out of Hospital Recovery Plan	To review CL CCG's plan for 'out-of-hospital' services in light of the COVID-19 pandemic.	Central London CCG

ROUND FOUR 2 December 2020		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To update the committee on key areas of work within its remit and the Cabinet Member's priorities	Councillor Tim Barnes, Cabinet Member for Children Services
Obesity in Westminster	To receive an update obesity rates in Westminster for both adults and children and consider the broader impact this has for health outcomes as well as reviewing current strategies for reducing obesity rates.	
Children's oral health	To receive an update on children's oral health in Westminster and examine the council's approach to achieving better oral health outcomes for children.	

ROUND FOUR 17 February 2021		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To update the committee on key areas of work within its remit and the Cabinet Member's priorities.	Councillor Tim Mitchell, Cabinet Member for Adult Social Care and Public Health
Carer Strategy	To receive an update and review Westminster's Carer Strategy.	
Safeguarding Adults Executive Board Annual Report	Review annual report	
Public Health Annual Report	Review annual report	

ROUND SIX 28 April 2020		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To update the committee on key areas of work within its remit and the Cabinet Member's priorities.	Councillor Tim Mitchell, Cabinet Member for Adult Social Care and Public Health
Young people and mental health	To receive an update on mental health and young people in Westminster. Particularly, on whether any lessons were learnt through the lockdown where changes had to be made to the way services were provided.	
SEND (special educational needs and disabilities) transition	To examine how the council supports SEND children when they are transiting from either primary to secondary school or when they are leaving secondary school.	

Unallocated/additional work-programme items		
Agenda Item	**Reasons & objective for item**	**Represented by**
COVID-19 impact on BAME communities		

School exclusions		
Screening rates in Westminster and Immunisations		
Autism Strategy		
Loneliness		
ANNUAL REPORTS		
Looked after Children and Unaccompanied Asylum-Seeking Children Annual Report		
School Organisational Strategy Annual Report		
Local Safeguarding Children Partnership Annual Report		

This page is intentionally left blank

Adults' and Children's Policy and Scrutiny Committee Action Tracker

ROUND ONE 15 JUNE 2020		
Agenda Item	Action	Update
Item 4: Cabinet Member Update	Requested more detail regarding the statistics for care home deaths in Westminster.	Completed
Item 5: Cabinet Member Update	Requested information on what the council's plans were for children if the Free School Meals Programme was not going to be extended over the summer holidays.[1]	Completed

ROUND TWO 8 SEPTEMBER 2020		
Agenda Item	Action	Update
Item 4: Cabinet Member Update	Requested information on how many fines have the Police issued to members of the public not wearing face masks on public transport?	In progress
Item 4: Cabinet Member Update	Requested that a further update be provided by CNWL providing a full background on why the closure had taken place. A breakdown was also requested detailing which facilities Westminster patients were now having to be admitted to, including if any of these were located in outer London.	Completed
Item 4: Cabinet Member Update	Requested information on whether the Police had been consulted on the closure of the Gordon hospital.	In Progress
Item 7: COVID-19 Support to Adult Social Care Providers	Requested an update be provided on staffing at care homes, specifically were they able to cover any staff isolating and what levels of additional recruitment were required?	Completed

[1] Government announced Free School Meals Programme was extended after meeting.

Item 8: Matching process for adolescents in care	Requested information on support available to foster carers through council tax relief.	Completed