Adults' and Children's Services Policy and Scrutiny Committee

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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
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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