Westminster

Response: what we did for the first wave and what we learnt	Rebalance: what we need to sustain and/or do differently for second wave and other services	Renew: What we need to think about for the future
• **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	• 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	• 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