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

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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

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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
- **SPA 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

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

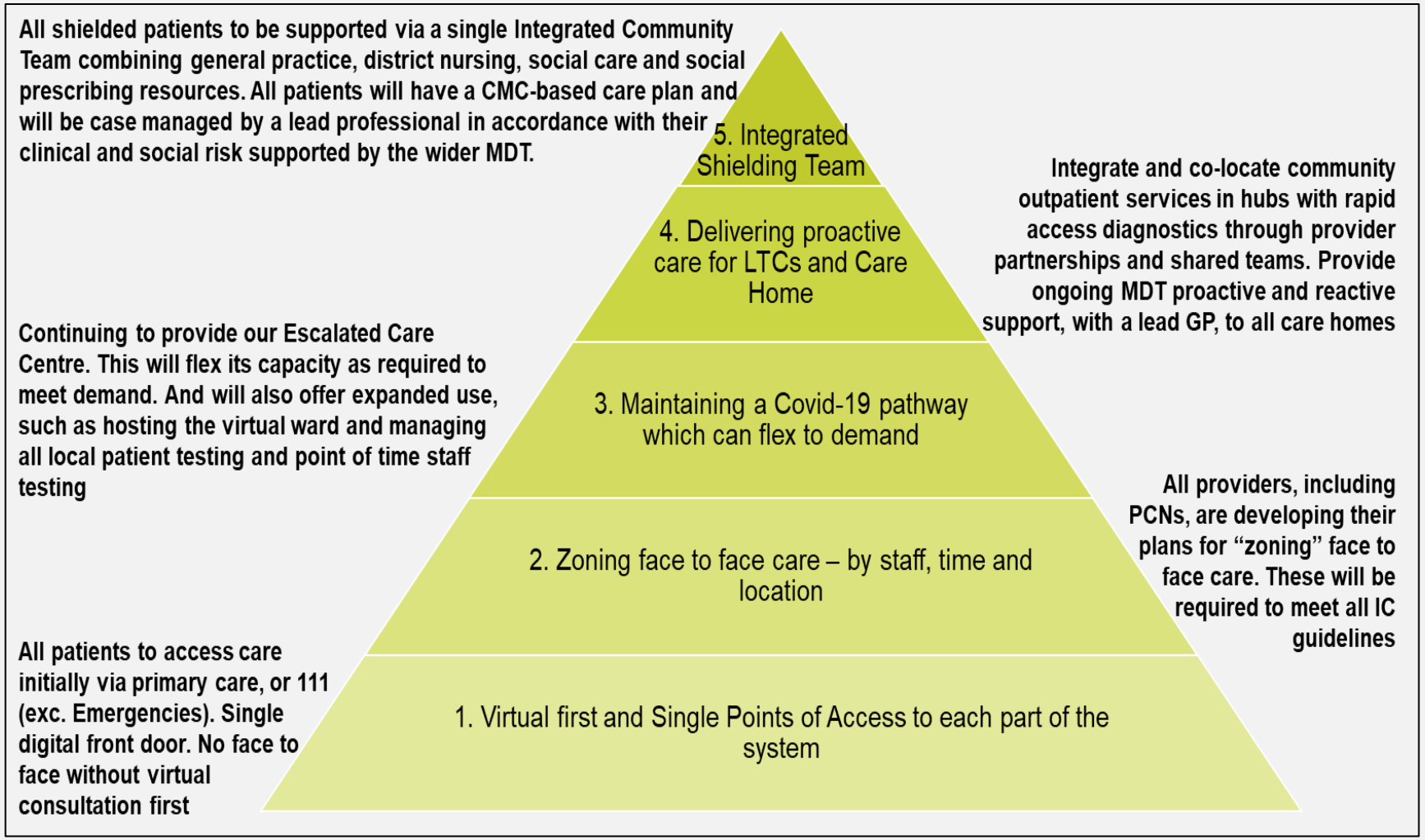
- **Regular phone support** from primary care, community, mental health, social care and voluntary services to all vulnerable and shielding patients
- Feedback from patients on the shielding offer highlighted a that many patients were receiving a **large volume of contact** from different organisations 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.



The North West London health and care partnership

Planning for Recovery and 2nd Wave - Delivering segregated care

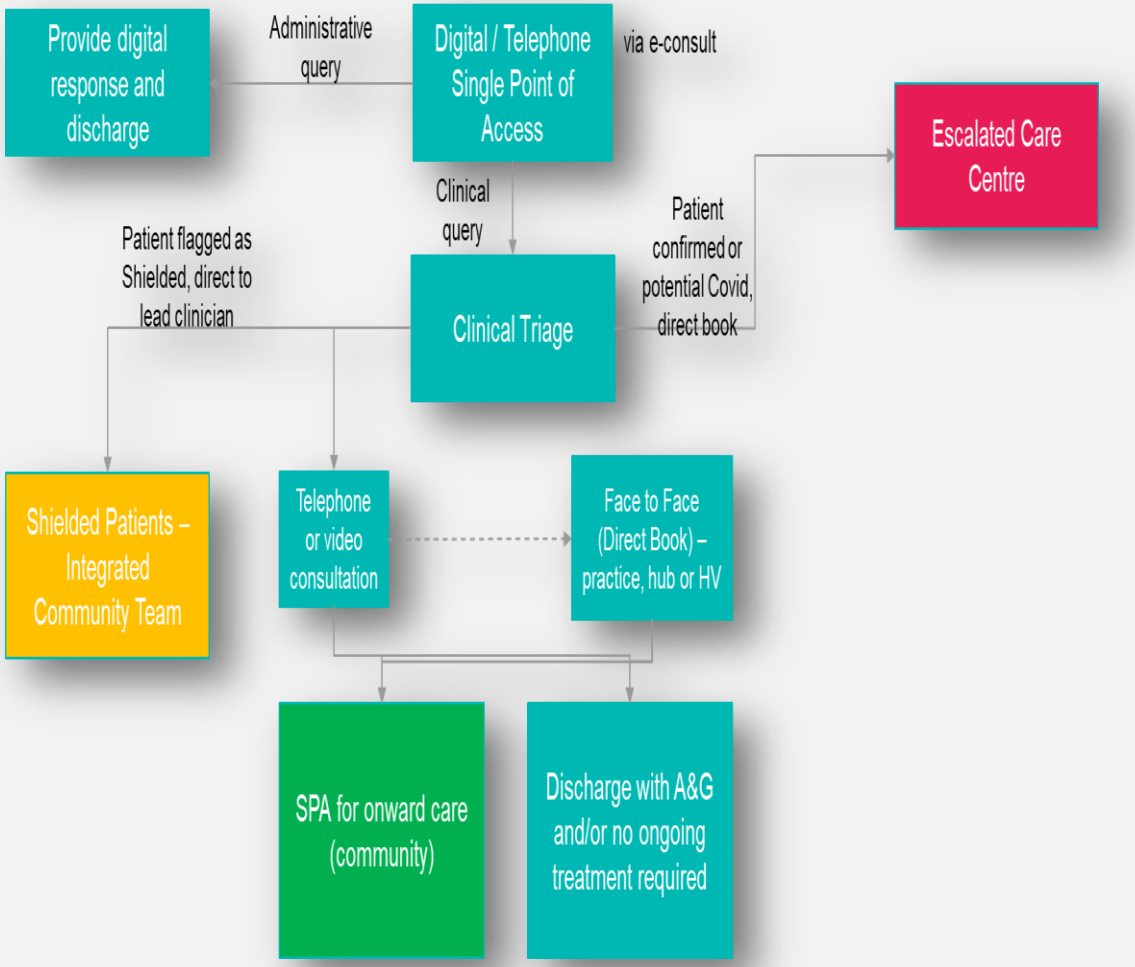
Step One: Virtual first through a single point of access

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

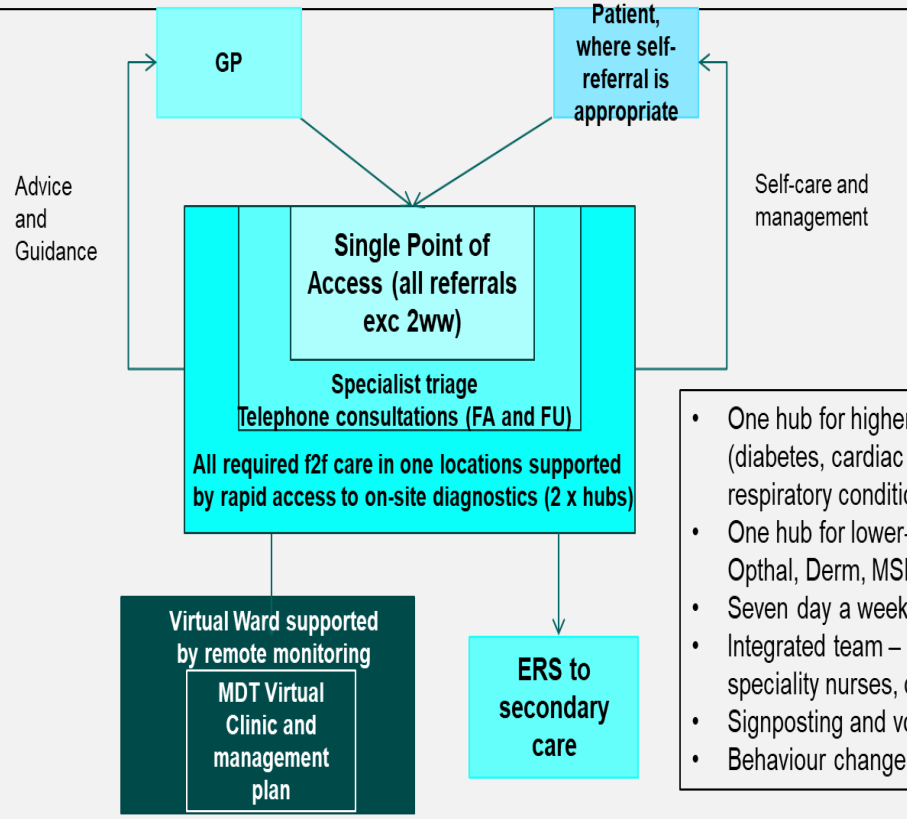
Local “hot” pathway is valuable in managing patients with confirmed Covid-19 or potential Covid-19 in a way which protects both staff and patients and which provides assessment, monitored symptom control as well as rapid access to care in a safe and effective way. However, there are challenges with this 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

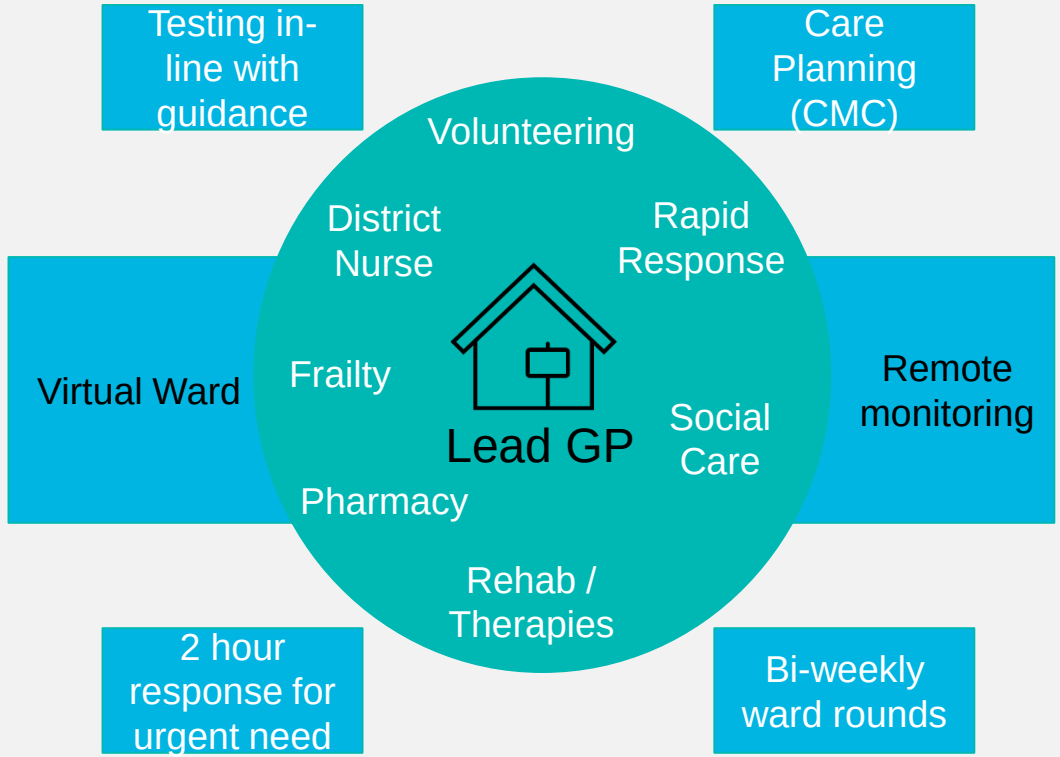
Step 4:Proactive care for long term conditions and care homes

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

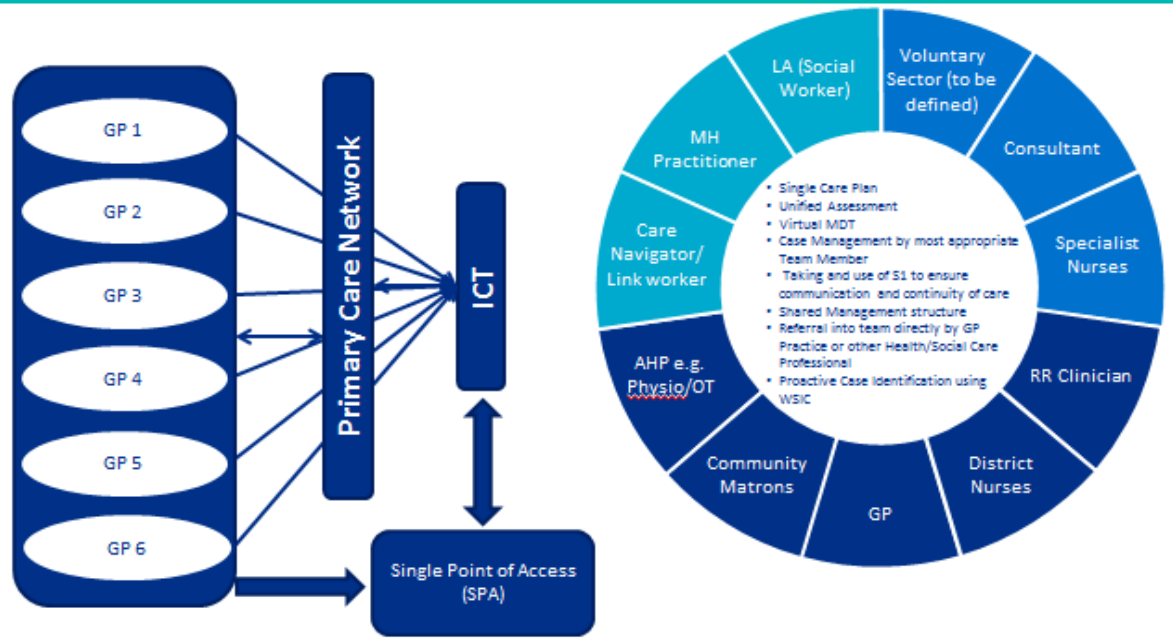


The North West London health and care partnership

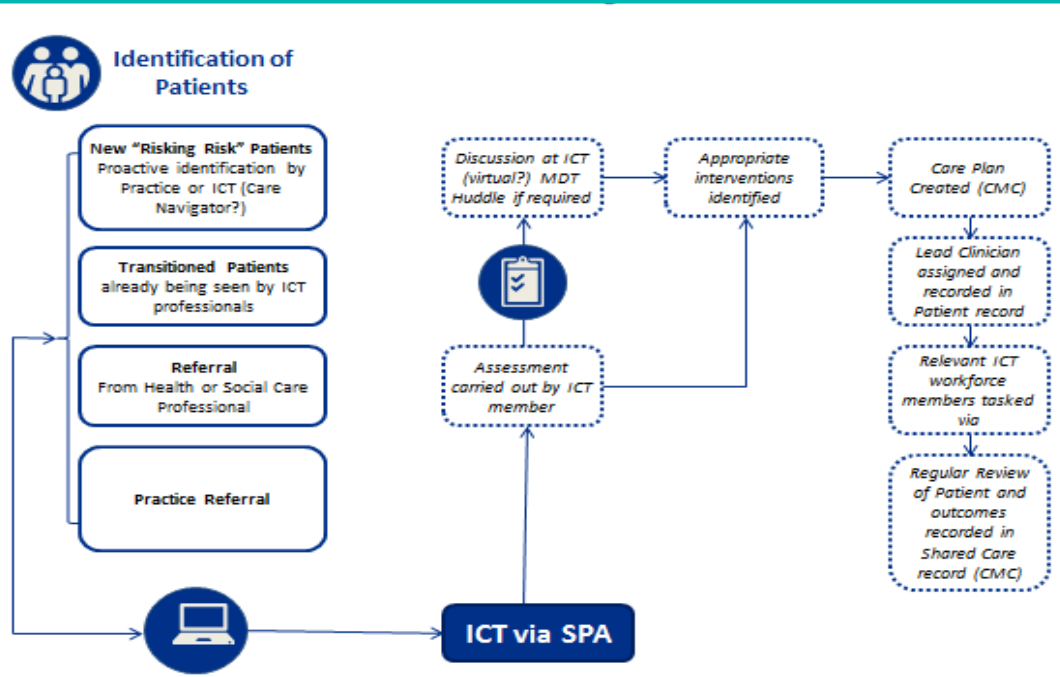
Step 5: An integrated community team for shielded patients

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

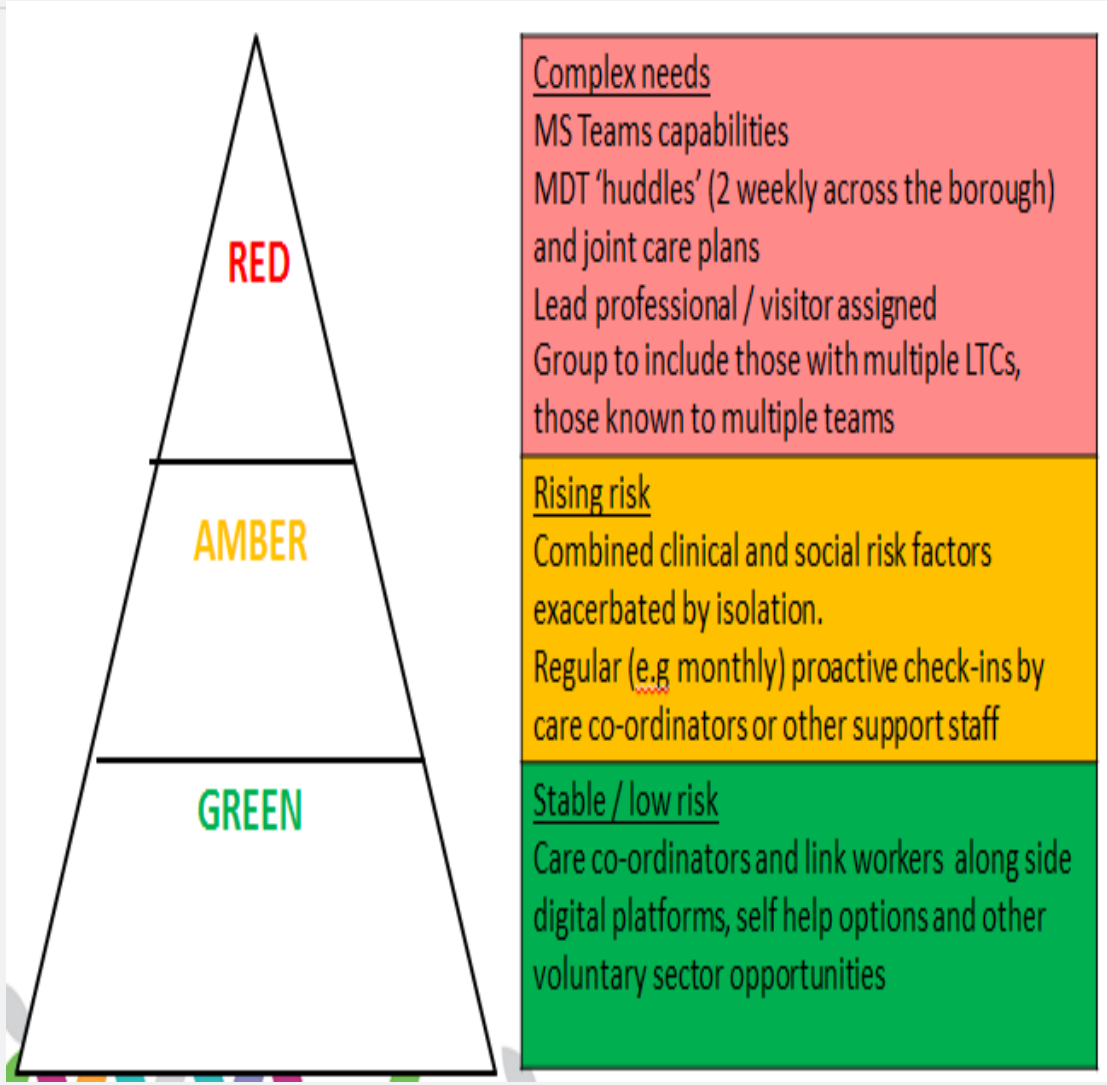


Planning for Recovery and Wave 2 - Support to shielded patients

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)

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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.**

The North West London health and care partnership

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

The North West London health and care partnership

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

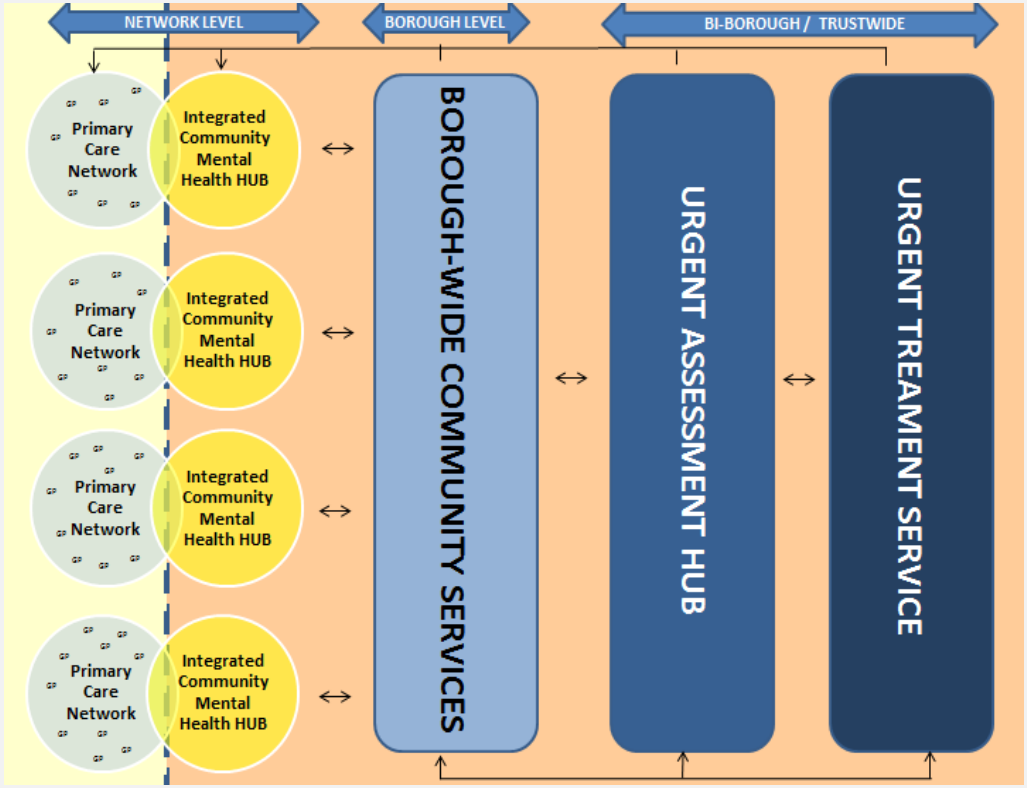
Proactive planned care (2/3)

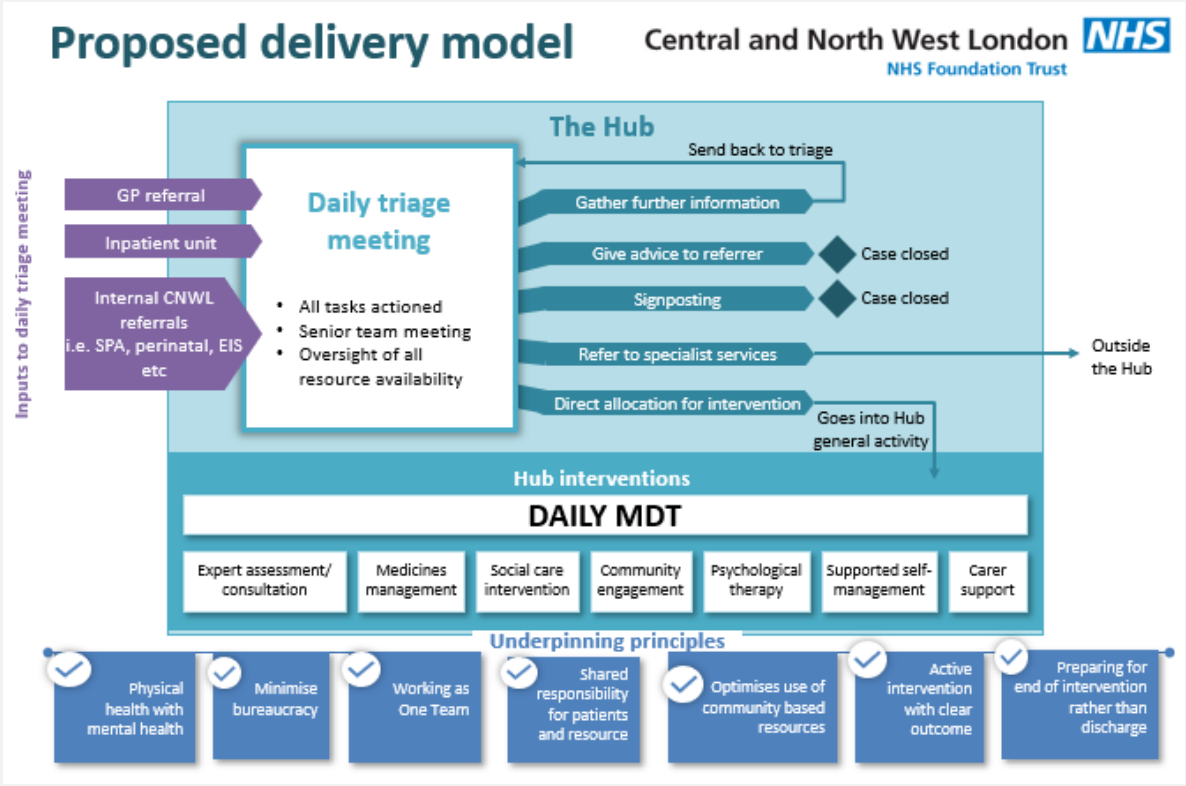
Area	Approach
Cancer and Palliative care	We will roll-out “C the signs” in all practices to improve identification and screening of potential cancer patients. Access to community-based support from cancer specialists and palliative care specialists has been identified as an area of learning. As a result, 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*



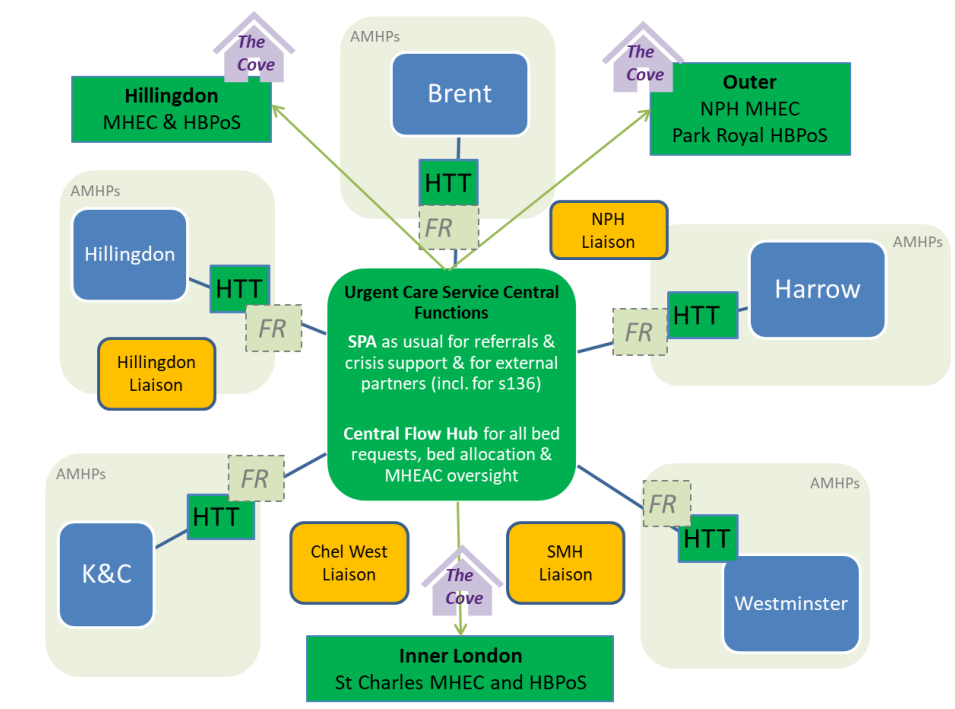


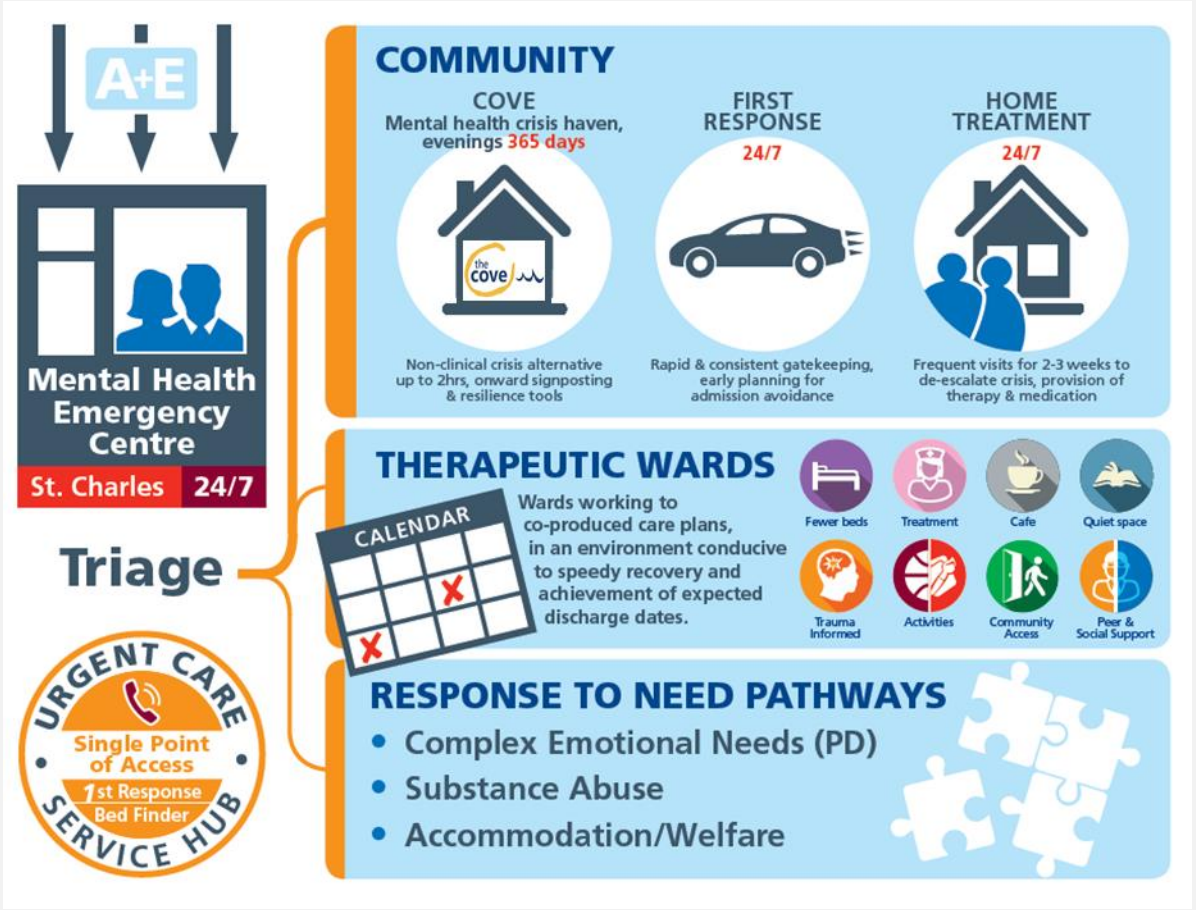
Integrated community-based urgent care (1/2)

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





The North West London health and care partnership

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.	**Practices identify PCN partners** and develop shared plan for realisation	PCNs have **defined future business model** and have early components in place.	**PCN business model** fully operational.
Integrated Working	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Analysis on variation** in outcomes and resource use between practices is readily available and acted upon.	Functioning **interoperability within networks**, including read/write access to records, sharing of some staff and estate.	**Fully interoperable IT, workforce and estates** across networks, with sharing between networks as needed.
Targeting Care	**Time:** Primary care, in particularly general practice, has the headroom to make change	**Basic population segmentation** is in place, with understanding of the needs of key groups and their resource use.	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.	**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.
Managing Resources	**Transformation resource:** there are people available with the right skills to make change happen, and a clear financial commitment to primary care transformation	**Integrated teams**, which may not yet include social care and voluntary sector, are working in parts of 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.	**New models of care** in place for all population segments, across system. Evaluation of impact of early implementers used to guide roll-out.
Empowered Primary Care		Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them.	**Networks have sight of resource use and impact on system performance**, and can pilot new incentive schemes.	PCNs **take collective responsibility for available funding**. Data being used in clinical interactions to make best use of resources.
		Steps taken to ensure **operational efficiency** of primary care delivery and support struggling practices	Primary care plays an **active role in system tactical and operational decision-making**, for example on UEC.	**Primary care providers** full decision-making member of ICS leadership, working in tandem with other partners to allocate resources and delivery care.
		Primary care has **a seat at the table** for system strategic decision-making		

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.