

## 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