Appendix 2

NW London Summary OOH Recovery Plan: concepts, principles and high-level plans - final draft

As we implement this plan in practice we will be guided consistently by a set of five principles

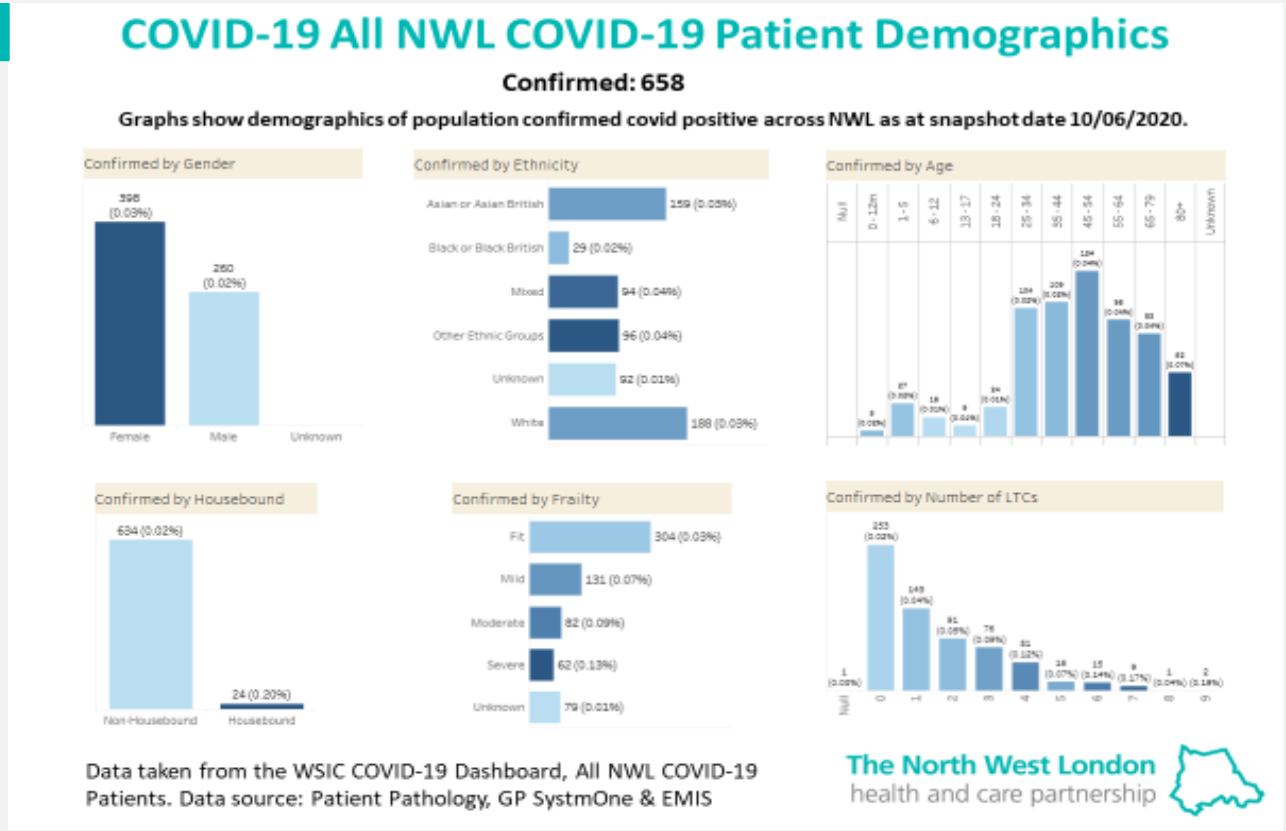
Within the detail of our work, key themes have emerged that we will focus on as we prepare for a second wave of Covid-19.

- Patient, resident and staff safety is the driver of our OOH plan and commitments. With >140 care homes for older people, resilient and safe care homes are a priority - learning from how we have responded to date, and developing systematic NHS support for the long term. We will deliver an ICS staff & resident testing regime, and develop clear pathways of care. We must give confidence to those afraid to bring health concerns to our attention, that we are here for them.
- Our actions focus on responding to the inequalities' that Covid19 has exacerbated; recognising the impact that this disease has had for individuals, families who are grieving, and particularly our BAME communities across NWL. Covid19 has also had a particular impact on our older population, resulting in this plan committing to greater partnership work across health and care as we seek to support those who are isolated, shielding, and in need of residential support.
- We will build on and strengthen the resilience developed within local communities, and we will work in partnership with them to improve wellbeing, to enable whole person care, and to foster continued partnership with the NHS and local authorities.
- We will use population health intelligence systems (WSIC) and signposting to wider services , to ensure we are diagnosing long term conditions In a timely way and supporting people to manage them well, with a particular focus on a small number of agreed conditions that have the greatest impact on health outcomes (e.g. diabetes). We must build and invest in the digital response to Covid-19, and over time, step back up services in line with 'Talk before you Walk'. User engagement and consultations may be needed to support this, as some services may change. We will enable rapid access to Primary Care through digital triage.
- Further work is needed to focus on the specific needs of Children and Young People, which will follow this draft submission.
- We hold to our strategic plan for integrating care around a patient, building strong community teams around PCN's. Whilst this is a NWL Plan, our ambitions will be locally delivered through user engagement and borough focused plans. A one page summary from each Borough demonstrates how the plan will be delivered.

Inequalities has always been an important issue, but amplified through the COVID-19 infection **it is an urgent issue** and we will act to improve health outcomes for those with greatest need

Diversity and inequalities in NWL

- NW London is home to one of the most ethnically and economically diverse populations in the country, with 2 of our boroughs having more than 12 years difference in life expectancy across their communities.
- In half of our boroughs unemployment rates are higher than the national average and in all but 2 average weekly earnings are lower than national average.
- All of these significant, existing inequalities have been exaggerated through the impact of COVID-19 and without coordinated focus could further be exemplified in the coming months.
- The expected reduction in economic output for NW London in 2020/21 - 2022 is18%. We know that for every 1% decrease in employment there is a 3% increase in mental health issues, as well as impact on long term conditions and an individual's ability to proactively manage their health.
- Domestic violence has also increased dramatically eg Hounslow has witnessed an 83% increase in reported cases.
- Our out of hospital recovery will therefore be rigorously focussed on enabling access, targeting health and care provision to our residents with long-term conditions, our BAME community and others within these disadvantaged groups and where the impact of COVID-19 has been disproportionate.
- Local authorities, health and the voluntary sector will work together on the wider determinants of health, wealth & wellbeing thus enabling people to live healthier lives
- Some Children and young people will need system support



Inequality is an issue of distribution – of both resources and health burdens. To tackle inequality is to say that **we will allocate resources in ways that are not uniform**: more resource will be channelled to areas of greatest need. This unavoidably prioritises some activities and de-prioritises others.

Source: Data from WSIC, NWL Five Year Strategic Plan, and LA sources

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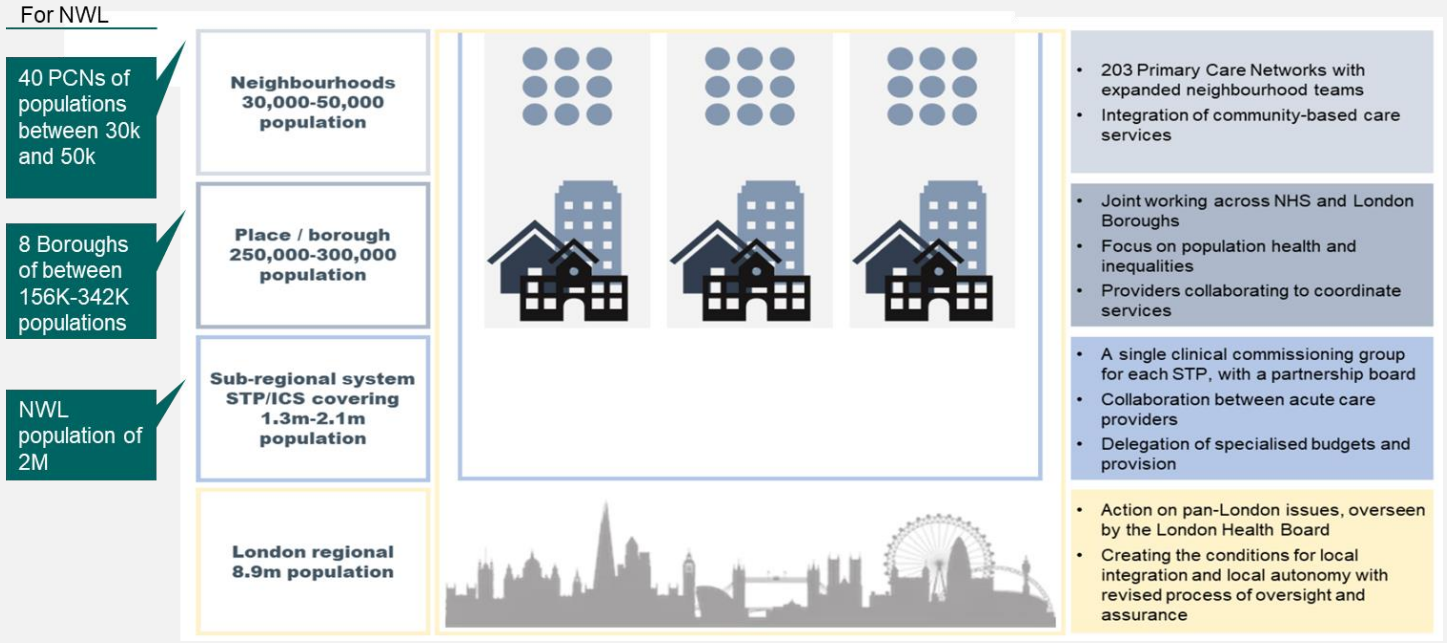
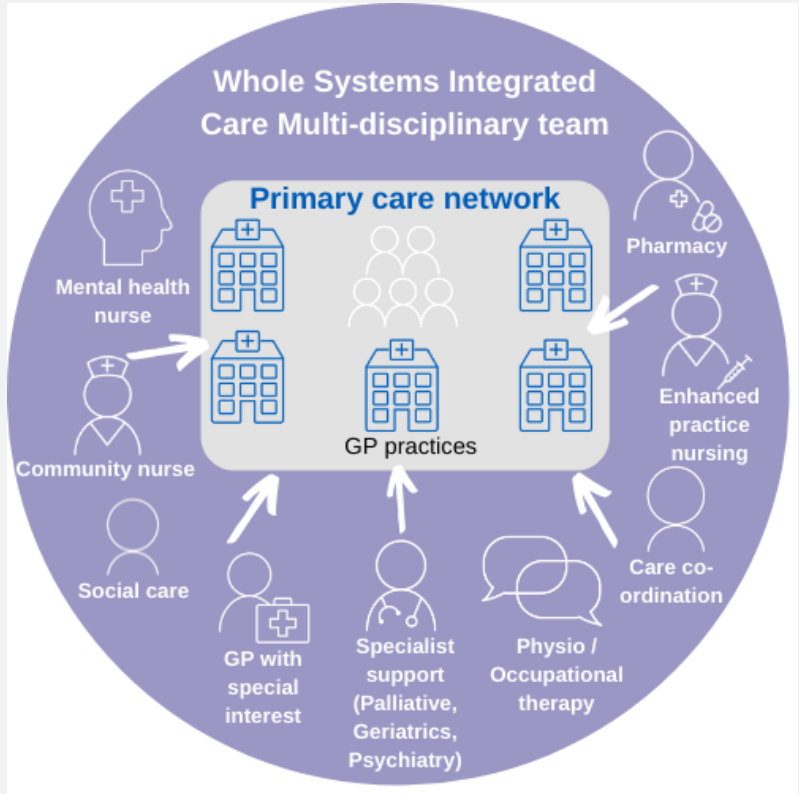
To deal with COVID-19, and tackle the health consequences of structural inequalities, we will adopt an integrated approach to deliver OOH services





- Through the COVID-19 crisis NWL boroughs have consistently demonstrated the benefit of working in partnership focussed around the common issue of best supporting residents through the crisis. There is now real commitment to build on this joint approach – bringing our skills and expertise together with, and for, our patients and residents.
- This plans marks a start of that process, we lay out our plans for the immediate period to ensure preparation for a 2nd wave and to restore focus and our committed to working together to develop a joint approach to the more strategic development of out of hospital services.

Our plan focuses on Rebalancing and Restoring services, as we prepare for future waves of COVID-19 and future work will be required to consider wider Renewal of health and care in NWL

This OOH Plan is produced jointly by the eight NWL local authorities and NHS partners, in response to Covid-19; and it complements the NWL ICS Draft Plan, and NWL MHLDA Plan. These are all consistent with the sector's long term plan; but we recognise step-changes in the speed of delivery in some areas, as we respond to and learn from pandemic, and prepare for a second wave of infection.

What we will focus on

- **Reactive care: discrete / episodic**
- **Proactive care: proactive, preventative and integrated population health management**
- **Caring about the whole Person: 'more than medicine'**

How we will work

'One Team' through service integration at a local level

When we will do things

Focus of this document

- **Respond** to the first wave of the crisis: *Feb 2020 – July 2020*
- **Rebalance** to restart wider services and prepare for a potential second wave: *August 2020 – April 2021*
- **Renew** - Developing Plans in Health which take us to renew services from April 21,

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Priorities for the OOH Recovery Plan, delivered through an ICS framework and a focus on Integrated care

A: Reactive care: discrete / episodic

First contact referring into urgent & emergency services

- Accessed through 111 (talk before you walk) with onward referral into either A&E, a hot-hub, or into a PCN / GP practice for triage and call-back.
- Consistent Rapid Response specification, and direct access to 111/LAS
- Maintain appropriate same day primary care access

Responsive pathways of care

- Accessed following a GP consultation, and involving further scheduled interaction(s) with diagnostics (pathology or imaging) and specialist advice.
- Talk before you Walk across community clinics.
- Advice and Guidance as standard for non-urgent Outpatient referrals

B: Proactive care: proactive, preventative and integrated population health management , delivered through integrated services

Public health actions planned for population

- Public health interventions as planned episodes, covering health checks. Focus on Children's Imm & vaccs, and flu.
- Review approach to minimise harm from people not seeking medical care through Covid.
- Understanding impact of Covid on CYP, to develop support

Community Services (Discharge, re-ablement and rehabilitation)

- Discharge Hubs - support people to leave hospital quickly and safely.
- Community rehabilitation pathways – COVID-19 Protect & COVID-19 Risk Managed. Consistent service specifications.
- Continued assessment of community bed capacity.
- Post Covid-rehabilitation, continue monitoring within LTC management

People with long term conditions*

Long Term Conditions through Integration

- Integrated MDT approach to LTCs and older people/frailty.
- Consistent minimum service specifications
- WSIC/PHM to prioritise patients and inform care.
- Strategic development of PC at scale through PCNs, integrated with community & MH teams.

Last phase of life

- Having an agreed health and care plan
- Support to people and their families when they approach the end of life
- Resilient hospice sector

People who live in care homes

- Getting the right NHS support to residents
- Consistent services
- Stability for the care home market
- Consideration of NHS input to supported living

C: Caring about the whole person

- Taking a holistic approach to a person's needs,
- Supporting self-care
- Connecting wellbeing, mental and physical health.
- Taking an assets-based approach and helping people to engage their time and talents in their communities.

Safety first

Working with and through communities

One team approach

Digital and data driven

Tackling inequalities

** Note: 'People with LTCs' refers to managed care to cohorts of people with ongoing health needs, including frailty and dementia*

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Our current focus is rebalancing and restoring services as we prepare for future waves of COVID-19; and future work will be required to consider wider renewal of health and care in NWL

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

- Primary care established a total triage approach with online and telephone-based management as default and Escalated Care Clinics for face to face management of Covid suspected and positive patients
- Used ITU and G&A demand data to inform tactical decisions about community service provision.
- Added 31 surge community beds to a core stock of 155
- Implemented a daily community health sit rep
- Redeployed community health, CHC, and social care staff to implement Discharge to Assess at all acutes
- CYP teams deployed across prioritised service areas, eg community beds
- Agreed a standard Domiciliary Care SOP for IPC and use of PPE in the community by social care and health staff.
- Agreed common principles for the restoration of community health to underpin a ICS-wide approach including clinically-led decisions with the safety of patients and staff paramount; within the financial envelope.

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

- Embed Talk before you Walk as philosophy
- We will create a single view of demand and capacity for health and social care, including capacity to cohort patients in line with IPC guidance, and for transitional beds to reduce infection risk to care homes.
- We will use the demand and capacity model and community sitrep to prepare for future COVID-19 wave/s delivering an alert for the potential for increased demand, triggering surge and super surge capacity.
- We will make primary care premises IPC safe, including providing diagnostics in hubs, and establishing recall systems for immunisations and vaccinations.
- Community providers will flexibly balance managing the restoration of services informed by national guidance, alongside maintaining COVID-19 related services including discharge hubs and increased support to care homes.
- Restore relevant community services to new models increasing the use of virtual models and maximising capacity by reducing non-clinical contact time.
- Specific children's rebalance decisions with PH/LA's.

Renew: What we need to think about for the future

- We will ensure that care homes and domiciliary care provision are represented in system-wide modelling.
- We will work together across social care, community health, and primary care to expedite the development of community MDTs so that resources are targeted at people in most need, and that people at risk are managed proactively.
- We will use the community sitrep sector to enable capacity management at a system level, supporting the further integration of services.
- We will review and seek to maintain those new models which deliver improved access and equity of care. Review of community clinic model of care is central to this
- We will develop a plan to deliver new services and alongside existing ones based on sustainable staffing and funding solutions.
- Consider longer term reshaping of some emergency care responses in the community,

APPENDIX

local plans for NWL

Hillingdon Health & Care Partners (HHCP)

Local Plans

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

- **COVID-19 co-ordination hub** – system wide function co-ordinated daily operational issues/surge throughout the crisis and ensured a collective system response
- **Virtual by default approach ensured** a reduction in the number of face to face patient contacts as well as enabled staff to work remotely.
- Undertook a systematic **review of all Out of Hospital Services** to prioritise and redeploy resources to support essential services.
- Rapidly mobilised **Total Triage way of working**, with all urgent and Routine Primary Care Appts triaged either through e-consult or via telephone triage as appropriate.
- **Zoned COVID-19 Risk Managed (Hot) and COVID-19 Protected (Cold) facilities** for managing patients face to face, supported by our HHCP Co-ordination hub.
- Developed integrated Shielded & Vulnerable Person management function with all partners – so that patients have **one personalised care plan and one key worke**r across health, social care and volunteers.
- Established **discharge hubs to help with improved patient flow** from acute trusts - further integration of our community and discharge teams.
- **Integrated management of care homes** – including system response to quality assurance and support input for individual homes – day-to-day basis.
- Supported families and carers to cope with an **increasing numbers of deaths in the community**, key learning is EoL now seen systemwide rather than a stand alone specialist area.
- Development of a **Mental Health Emergency Crisis Hub** to help support both adult and children's not having to attend A&E.
- Provided additional support to **Care Homes** joining up NHS and LA management of care homes – including system response to quality assurance and support input for individual homes – day-to-day basis, Expanding Acute GP visiting service to a 7 day service

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

- **Total Triage:** Access to General Practice will be triaged either through e-consult or via telephone triage as appropriate
- **Virtual by Default:** Following triage, Primary Care appointments will be either by an e-consult response; video appts, telephone appointment or F2F (non-COVID+ only) .
- **Zoned COVID-19 Risk Managed (Hot)** primary care referrals will continue to be made to the Integrated Urgent Response Hot Hub.
- A **digital front-door for primary and urgent care** (working with PCNs, UTC and A&E Front-Door to stream same-day demand will be implemented and provide for a 'hard stop' to ED at the front door of the UTC).
- **PCN (Neighbourhood) teams deliver proactive personalised care** and support offer, utilising a single Shielded Patients list integrated with the LBH to support Primary Care to proactively monitor the holistic needs of individuals.
- **Test, Track, Trace & Monitor** - Joined up Public Health, Social Care and NHS approach locally – to ensure all health and care staff have access to nationally available or local testing.
- We will provide a fully **integrated Urgent Response Hub** to respond within 2 hours to step up care and enable patients to remain within a community setting (home or bed based).
- **Reinstate elective care services** on a phased basis for Pre-COVID and urgent referrals addressing current backlog – and implementing Advice & Guidance and **integrated MDT triage** for all major specialty
- We will embed integrated way of working to proactively **support care homes** and ensure extension of this model to all care homes for adults in line with PCN DES requirements for enhanced support to care homes.
- We will develop a system wide **End of Life training programme** to support all care delivery settings.
- We will sustain **7 day Mental Health community services**

Renew: What we need to think about for the future

- Formalise integrated governance ICS/ICP
- Contracts/pooled resources between partners – moving towards dynamic allocation across organisations
- Resources and activity shifts with greater **Out of Hospital capac**ity (e.g. integrated nursing and therapies across primary, community and acute)
- Develop **integrated community workforce**, with roles that cross organisational boundaries, job rotation, flexible roles.
- Developed **Pathway based clinical leadership** that operates across organisational boundaries
- **System QI approach:** In order to support the HHCP workforce we will develop a system wide approach to improving quality
- **Population Health & tackling Inequalities** – tackling vulnerable groups (through personalised care and support planning, self management) and unwarranted variation
- **Digital** – further developing digital front-door and triage for primary and urgent care (e.g. triage and eConsult), digital personalised care and support planning, integrated elective pathways between primary and secondary care (e.g. Vantage), addressing digital access for population who need additional support (e.g. Older People, MH, LD & Autism, Lower Income Families)
- **Review estates** – to deliver segregated care and virtual MDT working.

…safety first	All care will be virtual by default unless there are good reasons, and where we must see patients face to face we will maintain high standards of Infection Prevention and Control throughout all delivery models.
…with and through communities	We will develop new community-based approaches to managing long term conditions which incorporates shielded citizens, and which has a strong emphasis on prevention, self-management and choice.
…one team approach	Through HHCP we have system wide integrated models of care in place for Urgent and Emergency Care, Proactive Care and an emerging model for Elective Care. In these 3 areas, cross organisational teams are working in a flexible and integrated way through common pathways.
…Digital and data driven	Using Whole Systems Integrated Care (WSIC) data to optimise service delivery in order to reduce inequalities, unwanted variation and deliver improved outcomes for the our residents.
…tackling inequalities	We will deliver high quality population health driven by the data with a needs-led approach that balances personalisation with delivery of population health outcomes