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# Health and Wellbeing Board

## Tuesday 23 July 2024 at 6.00 pm

Conference Hall - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Please note this will be held as an in person meeting which all Board members will be required to attend in person.

**The meeting will be open for the press and public to attend. Alternatively the meeting can be followed via the live webcast HERE.**

## Membership:

| | |
|---|---|
| Councillor Nerva (Chair) | Brent Council |
| Dr Mohammad Haidar (Vice-Chair) | Brent Integrated Care Partnership Executive |
| Councillor M Patel | Brent Council |
| Councillor Donnelly-Jackson | Brent Council |
| Councillor Grahl | Brent Council |
| Councillor Kansagra | Brent Council |
| Robyn Doran | Brent Integrated Care Partnership Executive |
| Simon Crawford | Brent Integrated Care Partnership Executive |
| Jackie Allain | Brent Integrated Care Partnership Executive |
| Cleo Chalk | Healthwatch |
| Sarah Law | Residential and Nursing Care Sector |
| Rachel Crossley | Brent Council - Non-Voting |
| Kim Wright | Brent Council - Non-Voting |
| Nigel Chapman | Brent Council - Non-Voting |
| Dr Melanie Smith | Brent Council - Non-Voting |
| Claudia Brown | Brent Council - Non-Voting |

**Substitute Members (Brent Councillors)**
Councillors: M Butt, Farah, Knight and Krupa Sheth
Councillors: Hirani and Mistry

**For further information contact:** Hannah O'Brien, Senior Governance Officer
Tel: 020 8937 1339; Email:hannah.o'brien@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit: **www.brent.gov.uk/democracy**

**Notes for Members - Declarations of Interest:**

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also significant enough to affect your judgement of a public interest and either it affects a financial position or relates to a regulatory matter then after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.

(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.

(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.

(d) **Land -** Any beneficial interest in land which is within the council's area.

(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.

(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.

(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:

- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:

- You yourself;
- a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest.
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# Agenda

Introductions, if appropriate.

| Item | | Page |
|---|---|---|
| **1** | **Apologies for absence and clarification of alternate members**<br><br>For Members of the Board to note any apologies for absence. | |
| **2** | **Declarations of Interest**<br><br>Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate. | |
| **3** | **Minutes of the previous meeting**<br><br>To approve as a correct record, the attached minutes of the previous meeting held on 15 April 2024. | 1 - 10 |
| **4** | **Matters arising (if any)**<br><br>To consider any matters arising from the minutes of the previous meeting. | |
| **5** | **North West London Mental Health Strategy**<br><br>To outline the development of the mental health strategy for adult residents of North West London (NWL). | 11 - 106 |
| **6** | **Joint Health and Wellbeing Strategy Refresh**<br><br>To present new proposed commitments for the Joint Health and Wellbeing Strategy for approval by the Health and Wellbeing Board. | 107 - 150 |
| **7** | **Brent Carers Strategy**<br><br>To set out the Council's responsibilities to carers, demographic information on carers in Brent, and information on the engagement work that has taken place to inform and develop the Carers' strategy for unpaid carers. | 151 - 230 |

**8 Brent Health Matters Annual Report 2023-24** 231 - 254

To present the first Brent Health Matters (BHM) Annual Report which summarises the BHM programme approach, achievements between April 2023 and March 2024, and priorities for 2024-25.

**9 NWL ICB Joint Forward Plan** 255 - 374

To present the NWL ICB Joint Forward Plan to Brent Health and Wellbeing Board.

**10 Better Care Fund** 375 - 384

To present and seek formal ratification for the end of year report for the Better Care Fund (BCF) 2023-24, and seek formal ratification from the Health and Wellbeing Board for the Better Care Fund Plan for 2024-25.

**11 Health and Wellbeing Board Membership Refresh**

To consider refreshing the membership of the Health and Wellbeing Board. Members' attention is drawn to the government guidance regarding Health and Wellbeing Boards - Health and wellbeing boards – guidance - GOV.UK (www.gov.uk).

**12 Health and Wellbeing Board Forward Look**

To discuss and agree any future agenda items for the Health and Wellbeing Board.

**13 Any other urgent business**

Notice of items to be raised under this heading must be given in writing to the Deputy Director – Democratic Services or their representative before the meeting in accordance with Standing Order 60.

**Date of the next meeting: Monday 28 October 2024**

Please remember to turn your mobile phone to silent during the meeting.

- The meeting room is accessible by lift and seats are provided for members of the public on a first come first served basis. Alternatively, members of the public can follow the meeting live via the webcast HERE.

Brent

NHS
Brent Clinical Commissioning Group

**MINUTES OF THE HEALTH AND WELLBEING BOARD**
**Held as a hybrid meeting on Monday 15 April 2024 at 6.00 pm**

**Members in attendance:** Councillor Nerva (Chair), Dr Mohammad Haidar (Vice-Chair), Councillor Mili Patel (Brent Council), Councillor Harbi Farah (Brent Council, on behalf of Councillor Grahl), Councillor Donnelly-Jackson (Brent Council), Simon Crawford (Deputy Chief Executive, LNWUHT - online), Cleo Chalk (Healthwatch Service Manager), Robyn Doran (Director of Transformation, CNWL, and Brent ICP Director), Nigel Chapman (Corporate Director Children and Young People, Brent Council – non-voting), Dr Melanie Smith (Director of Public Health, Brent Council – non-voting), Claudia Brown (Director of Adult Social Care)

**In attendance:** Tom Shakespeare (Integrated Care Partnership Director), Wendy Marchese (Strategic Partnerships Manager, Brent Council), Hannah O'Brien (Senior Governance Officer, Brent Council), Sarah Nyandoro (Head of Mental Health, Learning Disabilities and Autism – All Age – NHS NWL)

## 1. Apologies for absence and clarification of alternate members

Apologies for absence were received from the following:

- Kim Wright (Chief Executive, Brent Council)
- Councillor Grahl (substituted by Councillor Farah)
- Rachel Crossley (Brent Council)
- Basu Lamichane (Nursing and Residential Care)
- Simon Crawford – joined online (LNWH)

## 2. Declarations of Interest

None declared.

## 3. Minutes of the previous meeting

RESOLVED: That the minutes of the meeting, held on 22 January 2024, be approved as an accurate record of the meeting.

## 4. Matters arising (if any)

None.

## 5. Healthwatch - Achievements in 2023-24 and Work Programme for 2024-25

Cleo Chalk (Healthwatch Service Manager) introduced the paper which provided an update on the progress of Healthwatch Brent over 2023-24 and an outline of the planned work programme for 2024-25, which aimed to ensure that all residents in the borough could influence the delivery of health and social care in Brent. In introducing the report, she highlighted the following key points:

- Healthwatch had a statutory responsibility to engage residents and patients as active planners in Healthwatch projects, which was done partly through the Advisory Board, made up of 11 local experts including representatives from community organisations and patients with lived experience, and partly through The Volunteers Programme. Healthwatch had a pool of 25 active volunteers who undertook activities on behalf of Healthwatch and that pool was made up of many different parts of Brent's communities, including young volunteers. The majority of volunteers also spoke additional languages, allowing them to reach a wider range of residents, which was fundamental for Healthwatch.
- Crucial to the work of Healthwatch was its work with grassroots community partners, and Healthwatch had 38 community partners who received updates on their work and had the opportunity to collaborate. A recent survey had recently gone out to community partners to better understand what those partners would like from Healthwatch.
- During 2023-24, Healthwatch had undertaken a project looking at maternity services, comparing the standards of care across North West London (NWL). Cleo Chalk felt that this was a good example of how Healthwatch could work more collaboratively across NWL. The project had looked at in depth testimonials from women who had recently given birth across NWL. Healthwatch had heard from 207 women, 50 of which were from Brent, and the majority of those women, including the women from Brent, had shared positive feedback both about the experience of giving birth and their postnatal care. Healthwatch identified some key areas of improvement, such as a better listening culture, improving the quality of information shared and better support for breast feeding. Healthwatch had been able to present those findings and areas of learning at an Integrated Care System (ICS) collaborative maternity meeting, and the ICS agreed to respond by outlining the actions they would take to move those recommendations further. Healthwatch was also due to meet with the Northwick Park Hospital Maternity Services team to consider the recommendations with into Brent maternity services specifically.
- Healthwatch's Advice and Signposting Hub was highlighted, which provided a set of online resources with information about the topics residents most commonly asked about. Healthwatch recognised that online resources were not suitable for everyone but had found them to be a useful tool for those who could access online resources. This also freed up capacity to be directed into helping those without online access through other channels. Cleo Chalk encouraged partners to come forward with any additional areas that they would like to see explored on the online resource hub. The hub had been accessed by 783 residents the previous year, and Healthwatch had the ability to see which topics were of most interest to website users. In the previous year, the highest topic of interest was around how to access Adult Social Care (ASC), which was why there would be a major focus on ASC going forward into 2024-25.
- Cleo Chalk thanked Claudia Brown (Director of Adult Social Care, Brent Council) and the Adult Social Care team for their support in shaping and developing the ASC priority and for being responsive and receptive to what Healthwatch could offer. Working with ASC, Healthwatch had developed a Community Engagement Programme which involved connecting with different community groups and conducting mystery shopping exercises through volunteers, which would be complimented by a series of 'enter and view' visits into care homes. The focus on ASC was partly because far more residents were coming to Healthwatch with issues relating to ASC than Healthwatch had seen before, and because it had been recognised that there was a gap in Healthwatch's data. As part of this workstream, Healthwatch intended to engage with different groups including people with dementia, autism, ADHD and young carers.
- There were a range of other areas Healthwatch were looking to focus on, including the Pharmacy First Scheme, as residents were curious how that scheme would work in practice and whether pharmacies would have the capacity to deliver what had been

promised. The Same Day Access Model was another area of focus with many residents in contact with Healthwatch in relation to that.

- Cleo Chalk concluded her presentation by highlighting Healthwatch's way of working, which prioritised ensuring as many different resident groups as possible were involved, specifically from those diverse communities. Healthwatch would be continuing its outreach work with Somalian, Romanian and Brazilian communities and would be undertaking targeted work in particular wards such as Harlesden, Stonebridge and Kilburn.

The Chair then invited contributions from those present. The following points were made:

- The Board was encouraged to see the new ways of working outlined in the report.
- The Board asked for further information about how Healthwatch had targeted work towards supporting online access of services to make it easier for those without digital access, and how Healthwatch planned to address those challenges in 2024-25, particularly around primary care where patients were being encouraged to use online services. They felt that Healthwatch had a unique position to feed in their learning about groups of people who may be digitally excluded. Members were advised that digital access was an area of work that had been done successfully in other Healthwatch boroughs. For example, Westminster and Kensington and Chelsea had done some productive work on digital exclusion and primary care. Healthwatch Brent was having conversations about how to learn from that work and take it forward in Brent, with good ideas on what that could look like.
- Continuing to discuss access, the Board felt it was positive to see references to projects in relation to access, such as work with people with learning disabilities and work with Romanian communities. They queried how much of the experience of residents with learning disabilities rested on them being able to access health information in an easy read format. In addition, for those residents who had a language barrier and also poor literacy skills, the Board queried how health services were ensuring resources were produced in easy read in different languages. Cleo Chalk agreed that Healthwatch recognised there were members of the community who did not speak English and did not have high literacy levels in their native language, and this had come up in a number of different areas of work. Healthwatch were seeing a good push across health services to have more information available in multiple languages and easy read resources could be requested if they were not immediately available, but she highlighted there was a gap for those needing other ways to access information, such as easy read material in a language other than English. There was some best practice that Healthwatch could highlight where services had produced particularly accessible resources which could be shared with health services.
- The Board endorsed an approach whereby statutory partners explored a tech partnership to support the development of resources in accessible formats, such as through AI.
- The Board asked for further information on the maternity project Healthwatch had undertaken. They raised concerns around the maternity risks for Black and Asian women and asked whether Healthwatch was speaking with those women to understand their experience of maternity services in Brent. Cleo Chalk agreed to share the demographic breakdown of the people who Healthwatch had spoken to, as they had targeted people from a range of ethnicities and also patients who did not speak English. It had been hypothesised that people who did not speak English might be receiving a worse standard of care, but that was not evidenced in the findings and Healthwatch found a lot of work had been done to ensure information was being presented in a range of different languages. Only one of the women Healthwatch had spoken to who did not speak English had a negative experience of care relating to her interpretation

needs. Healthwatch had not found that inequalities in standards of care were not driven by a person's borough, the hospital they used or their demographic information, and instead were driven by the busy-ness of the ward, understaffing and complexity of need. Healthwatch were keen to do further research with people who did not speak English to drill down on the findings.

- In relation to antenatal work, Healthwatch had done some work in 2022-23 on antenatal care specifically with Northwick Park Hospital, which had then resulted in the maternity project that had recently concluded. That report had been less focused on language barriers and had found more recommendations for improvement than the more recent maternity project. It was agreed that the antenatal report would be shared with the Board.
- The Board asked whether North Central London ICS had consulted Healthwatch on Start Well and when Healthwatch thought there would be some early feedback of the significant learning about women and families' experiences. Cleo Chalk confirmed that North Central London ICS did engage with Healthwatch and Healthwatch had done some joint consultations with the Start Well teams who had come to the groups at Church End Unity Centre. Healthwatch had not seen the timeline for when those findings would be published.
- The Board asked whether any commissioned or statutory services that Healthwatch had visited had required recommendations for improvement. They were advised that Healthwatch was starting to see some of the changes in response to recommendations made from previous years now come into effect. For example, Healthwatch had visited Park Royal Mental Health Inpatient Wards in 2022-23 and as a result of those visits had now seen some positive changes around how patients received information about advocacy, complaints, and their access to faith leaders through the Multi-Faith Forum. Similarly, Healthwatch had done some work with the London Ambulance Service and made recommendations about how patients were triaged if they had mental health needs and had now seen changes to how triaging worked, particularly with NHS 111 services. Healthwatch had done a series of 'enter and view' visits to GP practices the previous year and made some individual recommendations that were due to be published, the implementation of those would be monitored.
- In terms of priority setting, Cleo Chalk advised the Board that Healthwatch needed to be quite lean with setting priorities as it was a small team and limited in what it could do. As GP access and mental health had been the priority areas for the past 2 years, Healthwatch had wanted to move to a stronger focus on ASC this year. However, Healthwatch did not want to step away entirely from GP access and mental health as these remained important issues within the borough, so there were some plans in place working with the Integrated Care Board (ICB) on a GP access survey looking at resident preferences for accessing primary care. Similarly, in relation to mental health, Healthwatch was looking at doing follow up visits to mental health wards in Park Royal and working with the community teams to see how Healthwatch's recommendations were being made. If anything came up that was felt to be an urgent priority, Healthwatch could be agile and pick that up as an additional priority in the work plan.
- In response to how the GP access survey would work, Cleo Chalk advised the Board that the new Same Day Access model would affect all residents, so Healthwatch were trying to reach out to residents to gather as much feedback as possible, including going out through Patient Participation Groups (PPGs). The survey would also go through Healthwatch's regular engagement activity, taking residents through the survey at different community locations. The survey was also available online and Healthwatch would be promoting that through social media and asking for the information to be shared on patient group social media accounts.

In concluding the discussion, the Chair felt there were areas of information that Healthwatch was working on that could be reported back to the Board before the next annual update, including learning around maternity care and primary care as well as the new work looking at ASC. Cleo Chalk agreed to share Healthwatch's timeline and full work programme for the year, which described what Healthwatch would be focused on month by month and could return to Board in 3-6 months' time to update on these different areas. The Chair invited resident advocates to support the next presentation.

RESOLVED: To formally thank Healthwatch and recognise the progress and outcomes for 2023-24, as well as the work programme for 2024-25.

## 6. Improving Mental Health and Wellbeing Priority - Progress and Plan for 2024-25

Robyn Doran (Director of Transformation, CNWL, and Brent ICP Director) and Sarah Nyandoro (Head of Mental Health, Learning Disabilities and Autism – All Age – NHS NWL) introduced the report, which updated the Health and Wellbeing Board on the Integrated Care Partnership (ICP) priority area for improving mental health and wellbeing. In introducing the report, the following points were highlighted:

- The Board were reminded of the previous discussions in relation to inequalities, levelling up, and the need to have the data to back up the business case for levelling up. In terms of levelling up, Brent had historically been underfunded, and when looking at its data the problem was getting bigger and not smaller. There was disappointment that the case for levelling up had been under discussion for quite some time and despite the inclusion of data to evidence the case, the ICP had still not received an response to the business case that was put forward 6 months previously. The ICP had hoped that Integrated Care System (ICS) partners would be available to answer some of those questions during the meeting but due to the pre-elections period the ICS had not been able to attend. The ICS had committed to attend the next meeting to answer some of those questions.
- There was an ongoing area of concern regarding CAMHS and early intervention and there was now some resource being put in place around neurodiversity which was hoped would see significant progress for children and young people.
- It was highlighted that, when compared with the other 8 NWL boroughs, Brent had the highest number of people registered as having severe mental illness. When looking at those accessing mental health support, such as Talking Therapies, Brent also had the highest number of people accessing services, and the largest numbers being admitted into an inpatient unit. The report aimed to highlight that demand was outstripping capacity.
- The report demonstrated the work done by the priority groups in the Mental Health and Wellbeing ICP Subgroup including employment and housing. Within housing, as well as the support being given to people to access accommodation, there was now the addition of the Rough Sleepers Initiative focused on mental health issues, general health issues, physical health and substance misuse. The ICP were hopefully that this would enable a lot more targeted work with the homeless population. The report also detailed the work being done to improve rehabilitation services.
- Targeted work was taking place in NW2, NW10 and HA9 which the ICP now knew these were the areas with the largest proportion of those experiencing severe mental health issues . Those residents, both children and adults, were accessing services at the point they were experiencing a crisis rather than before they reached

crisis point, the ICP had developed a programme of targeted work in those neighbourhoods which they felt would make an impact to individuals in those areas. One programme was around crisis outreach through Clinical Crisis Workers, who would be reaching into those neighbourhoods with high levels of acute mental illness attendances and working with those neighbourhoods before they reached crisis to prevent escalations. Within that, there would also be Community Connectors appointed, in recognition of the fact that many of Brent's communities knew how to work with individuals but needed additional support to understand someone's mental illness and how to support them. This would mean that communities would be educated and empowered to be best equipped to manage individuals and would form part of the Brent Health Matters' (BHM) inequalities work. The final part of the programme was the person-centred Thrive model, working with children and young people to provide the best help at the right time and under the right circumstances. This model differed from the medical model and focused on encouraging children and young people to ask for help at any time it was needed.

The Chair then invited contributions from those present, with the following points raised:

- It was highlighted that some communities did not recognise mental health in the same way as others and therefore may not come forward to access support. As a result, the Board raised concerns that those communities may not be reflected in the figures for those needing mental health support and therefore may not be receiving information about services. Robyn Doran assured the Board that BHM worked closely with both the Mental Health Trust and Community Services, with a team of 8 Mental Health Specialists working specifically with those communities who traditionally had not recognised mental health and may not have or use words like 'mental health'. This work was connected to the findings in relation to NW10, NW2 and HA9 and the work was being targeted towards those communities. The IAPT team had also done some work the previous year working with communities who had usually not accessed IAPT because the traditional ways in which IAPT services were accessed were not accessible to those communities, and the IAPT team now made far more culturally appropriate interventions that the team were proud of. That work was reported within the health inequalities work and the ICP were confident that the granular information was being collected and was reliable.
- In relation to culturally competent care, it was agreed that the ICP could share some of the work done on mental health wards around the cultural competency of staff.
- Board members pointed out that there would be a migration of disabled residents from Personal Independence Payment (PIP) onto Universal Credit (UC) and asked to what degree the caseload might go up due to mental health illnesses being exacerbated by these changes, while those individuals with a disability were also being encouraged into work. The Board felt it important that partners worked strategically with the Department for Work and Pensions (DWP) to address this. Sarah Nyandoro thanked the Board for flagging that information and confirmed that the ICP did plan ahead, so as well as working with DWP to have early identification of the people impacted by those changes there was also partnership work with Sure Trust to put safety nets around those individuals early.
- The Board were interested to understand to what degree those facing mental health issues were in the private rented sector as opposed to social housing, as Brent had a high proportion of residents living in the private sector and often discharged the homelessness duty into the private sector, which was less regulated. It was felt residents in the private sector would be more likely to experience issues such as disrepair and section 21 no-fault eviction notices, which could further exacerbate

mental health issues. Tom Shakespeare (Director, Integrated Care Partnership) explained that the work the ICP had done around housing had initially focused on social housing and local authority housing to build key lessons, but the intention over time was to work with housing colleagues through the working group to see how those lessons could be disseminated through the private rented sector. The community teams were supporting people in their own homes and did not exclude those with private landlords. In addition, as part of the work the ICP were doing looking at managing the housing market they were reviewing who was receiving support and whether they had social landlords or private landlords. Once that work was done, the ICP could bring further information back to the Board specifically on those in private accommodation receiving mental health support. The ICP acknowledged that the private sector was much more complicated and there was a need to develop this work in partnership.

- Claudia Brown added that ASC was seeing an increase of new diagnoses coming through the Front Door. An area she felt needed to be addressed was supporting individuals in their homes and enabling them to stay in their current accommodation. ASC had now introduced a housing and mental health surgery, giving housing colleagues the opportunity to bring cases to the attention of ASC, and it was being found that often these cases were not known to services at all. She added that every mental health bed was a potential social care client, and if there was no evidence of the borough in which that individual was last resident then they would become a Brent client.
- Councillor Farah, as Cabinet Member for Public Safety and Partnerships, highlighted the need to work in partnership with police and the community safety team, and offered to facilitate those links.
- Simon Crawford (Deputy Chief Executive, LNWH) provided information in relation to mental health and Northwick Park Hospital. He highlighted that early post-covid, there had been an influx of mental health presentations through A & E, many of whom were not formerly known to services. Over the past 18 months, he had seen a step change in the level of support and responsiveness to mental health presentations at the hospital and the support received on a daily basis to find appropriate placements, including for rough sleepers. Robyn Doran confirmed that around 30% of presentations seen were in crisis phase and were coming predominantly through A & E and through Section 41 of the Mental Health Act, with the majority of those not known to services. That trend had continued since covid, and she felt this was due to the complexity of life during and post-covid, such as individuals losing jobs, family members, housing and having long-covid. In addition, the different communities served in Brent may not recognise mental health illness as an issue until it was acute. This was why the ICP were targeting work on the NW2, NW10 and HA9 areas where most of those acute presentations came from, and an extra 12 mental health beds had been opened in Brent as the ICP recognised the demand was so great.
- In noting the higher numbers of crisis presentations and individuals receiving mental health support in Brent, the Board asked if there was any insight into why Brent had almost double or triple the numbers of other areas. Robyn Doran explained that there were a lot less services in Brent compared to other NWL areas such as Westminster and Kensington and Chelsea, so Brent had a reliance on the third sector and community partners to bridge that support gap. As well as this, the complexity of the communities served in Brent, such as the differences in cultural perspective on mental health meaning mental health illness might not be recognised as an issue until at crisis point, meant families then turned up in crisis at emergency departments. She advised the Board that the ICP needed to focus on both ensuring there were enough beds now for the people who needed them while

demand was high and in tandem focus on the levelling up case to get more resources into the borough that would allow services to target earlier interventions and reduce the number of people getting to crisis point and requiring admission to a mental health unit.

- Considering the figures in the report that compared Brent to boroughs in NWL, the Board asked for comparisons figures against more similar boroughs in terms of diversity and levels of deprivation, such as Newham and Tower Hamlets. Brent ICP confirmed this could be done.
- As part of the levelling up discussion, the Board agreed there was a need to deep dive on the data so that it was available per population rather than single figures. For the next report, the Board requested information on the ICPs plans for further work on cultural competence, a focus on those individuals affected by the changes in the benefits system and a deep dive into the data regarding mental health patients from the private rented sector. Following the analysis of that information, the Board felt it may then be appropriate for the Chair and Vice Chair of the Health and Wellbeing Board to write to the ICB to support the case for releasing levelling up resources.

In bringing the discussion to close, the Chair asked the Board to note the report and confirm support for the approach that has been taken.

## 7. Brent Children's Trust Update and Forward Look

Nigel Chapman (Corporate Director Children and Young People, Brent Council) introduced the report, which provided an update of the Brent Children's Trust (BCT) work programme covering the period July 2023 to March 2024 and set out a proposal to redefine the purpose and vision of BCT for 2024-2026. Some of the key points were highlighted as follows:

- The report covered the progress and challenges of BCT as they related to health matters.
- As well as monitoring by the Health and Wellbeing Board, there was other scrutiny that occurred for the three BCT work programmes. The arrangements for Looked After Children and Care Leavers were reviewed at Corporate Parenting Committee, arrangements for children with SEND were considered at the Community and Wellbeing Scrutiny Committee, and Early Help and Intervention was subject to government oversight through the Supporting Families Programme.
- Time had been spent to develop a refreshed approach over the next 2 years, looking at how BCT operated as a Trust and continuing to focus on those three key work programmes; Looked After Children, SEND, and Early Help. The work would also monitor the effectiveness of the ICP priority workstreams as they affected children, such as the mental health and wellbeing workstream and Brent Health Matters (BHM) and their new remit into children's work to reduce health inequalities affecting children and families.
- How the Trust worked was underpinned by 3 pillars – shared accountability, better performance information and improved communications and engagement.
- The Trust felt they were in a good place organisationally in a complex landscape to respond in an agile way to issues that arose, and this was thanks to the good relationships between providers, the local authority and Brent Integrated Care Partnership (ICP).

- Robyn Doran added that the Trust had now agreed that it would benefit from having third sector partners around the table, so would begin work to find a way to represent that voice.

In considering the report, the following points were raised:

- Members felt that the report needed further information on where the challenges were, what the Trust was looking to improve, and what the metrics against those issues were. Nigel Chapman agreed to provide performance information across a range of indicators as they affected Looked After Children, inclusion, and early help for future reports. Those metrics were monitored and reported corporately as part of the Borough Plan Key Performance Indicators and could be drawn into this report. In addition, the Board requested future reports to bring out the voice of the child.
- The Board were informed that there was now a Clinical Lead within BCT, Dr Anne Murphy, who was working hard and collaborating with partners.
- The Board asked about the interface with mental health services for young people and SEND and how mental health and SEND interfaced with the criminal justice system. They were advised that there was a close interface between SEND and mental health and wellbeing. The Children and Young People Department was running a programme called 'Delivering Better Value', funded through the DfE, which helped to early identify where there were SEND needs and any potential interface with mental health and wellbeing, which could be a porous boundary. There was also an intervention first programme aiming to early identify SEND needs and better help professionals working in schools to understand where there may be undiagnosed mental health needs as opposed to SEND needs. The expansion of mental health support teams in schools had helped to support that work. In relation to the criminal justice system, there was a Mental Health Practitioner within the Council's Youth Justice Service. When young people became known to the Youth Justice System, they would undergo an assessment which included an assessment of any undiagnosed mental health needs, and when those assessments went before the courts they could draw upon the input of the Mental Health Practitioner. The Mental Health Practitioner also provided intervention and counselling and navigation into other specialist services where needed. It was highlighted that the caseload was relatively low for the Youth Justice Service and had been dropping over the last 5 years thanks to sentencing practice and diversion. Performance reports for this aspect of children's services were presented to the Safer Brent Partnership.
- Robyn Doran highlighted some of the areas of concern for the Trust. Asthma was a concern in relation to health inequalities and children and young people and was outlined in the JSNA as an area needing focus. School Nurses were also doing a lot of work to support children to manage their asthma as they were seen to be best placed to identify the early need for support. Dentistry was also a challenge for children both nationally and in London to get access to good dental support, so the Trust were looking at how the system could work together to improve that. Dr Melanie Smith highlighted that Brent was seeing a small but real improvement in children's oral health as a result of the Public Health Team getting more fluoride on teeth, but there were still issues in access to NHS dentistry for children, who should be seeing a dentist a minimum of once a year. A report on dentistry, optometry and pharmacy would be brought to a future Board meeting.
- In relation to mental health, the Trust was focused on earlier intervention, where there was currently limited resource. This also formed part of the BHM inequalities work.
- The Board asked what the future plans were for extra support in schools with funding now available for schools. Robyn Doran advised members that recruitment to the BHM team was underway to provide that extra support to schools, targeting those schools

where the Trust knew there were particular issues. There was also a recognition that if schools did not get right the support for children with complex diabetes this caused challenges. The Trust were working on some case studies around this and would bring that back to a future Board meeting.

As no further issues were raised, the Chair drew the discussion to a close, asking the Health and Wellbeing Board to note the strategic oversight activity of the Brent Children's Trust for July 2023 to March 2024. For future reports, the Board requested an expanded document that had asks of partner agencies and further information around the challenges and metrics for BCT.

8. **Any other urgent business**

The Board was advised that this would be Basu Lamichane's final meeting as the Nursing and Residential Care Sector Representative on the Board. Members extended thanks for his input on the Board and noted that the ICP was in the process of recruiting a new representative to fill that post.

The meeting was declared closed at 7:45pm

COUNCILLOR NEIL NERVA
Chair

| | |
|---|---|
| Brent<br>NHS<br>North West London | **Brent Health and Wellbeing Board**<br>23 July 2024 |
| | **Report from the Executive Director of Strategy and Population Health** |
| | **North West London ICB** |

# Mental Health Strategy for adult residents of North West London

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | Appendix 1 - Mental Health Strategy |
| **Background Papers:** | None |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Toby Lambert<br>Executive Director of Strategy and Population Health, North West London ICB |

## 1.0 Executive Summary

1.1 This paper outlines the development of the mental health strategy for adult residents of North West London (the strategy for children and young people will follow).

1.2 The strategy has been developed by a working group drawing representation from local authorities and our providers, chaired by clinicians.

1.3 It sets out ten ambitions (paragraph 0 below), supported by more detailed recommendations in the supporting slide pack.

## 2.0 Recommendation(s)

2.1 That the Health and Wellbeing Board note the content of the report.

## 3.1 Detail

3.1.1 North West London has been developing the mental health strategy for our residents in two stages – first, for adult residents of North West London, then the strategy for children and young people will be developed over the autumn. This paper covers the strategy for adult residents.

3.1.2 The strategy has been developed by a working group comprising representatives from Local Authorities, Borough-Based Partnerships, the VCSE, Service Users, ICS Programmes and ICB Core Teams. The working

group was chaired by the medical director of CNWL's Jameson division and the ICB's GP mental health lead. Together, the working group has:

a. Reviewed and analysed data points from the Mental Health Joint Strategic Needs Assessment toolkit to demonstrate a shared understanding of need;

b. Reviewed the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed for each of our boroughs;

c. Gathered insights from our regular outreach engagement programme, drop-in sessions in each borough and online focus groups. These have encouraged our residents to share their personal experiences and stories as well as their views on further improvements;

d. Collected views on areas of success, biggest challenges and current priorities, to inform the themes of this strategy. As we implement, we will continue to engage to ensure that services continue to support – and better support – all of our residents that use them.

3.1.3 We have conducted extensive engagement with residents in developing this strategy, with eight pivotal sessions across each of the eight boroughs. These sessions held from late August to early October, brought together a diverse range of residents and service users to share their experiences. Two online sessions (lunchtime and evening) open to all residents also took place. The engagement report is available at https://www.nwlondonicb.nhs.uk/get-involved/your-views-mental-health-services-nw-london

A number of key themes were highlighted through engagement which included increasing residents' awareness of services and improving access to them, expanding community mental health offers, reducing waiting times for assessments, ensuring a tailored and inclusive approach to services as well better integration of services to avoid patients passing from one service to another.

3.1.4 The draft strategy has been tested with the mental health, learning disabilities and autism programme board, mental health trust chief executives, and various operational and clinical groups within our mental health trusts.

3.1.5 The strategy makes a number of recommendations which set the following ambitions for our adult mental health services:

a. Raised awareness across North West London so that every resident knows how to access mental health support both in crisis and more widely in the community.

b. Developed an assets-based approach to promoting mental health, wellbeing and independent living, partnering with and investing in local community organisations.

c. Increased equity and equality of service access to reflect different needs of our local and diverse communities, with greater targeted support to those with severe mental illness.

d. A consistent core offer for community and crisis care for adults, with a focus on severe mental illness, that also enables flexibility for local and diverse needs.

e. Reduced variation and increased productivity in caseloads and staffing across community services.

f. Improved staff recruitment and retention.

g. Waiting times measuring in the top quartile in England.

h. Integrated care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness.

i. High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment.

j. Worked together with our Local Authority partners to develop solutions to the housing and employment pathway challenges.

Work continues to develop the work programme and tracking against each of these areas.

3.1.6 We had anticipated bringing the strategy to the April Brent Health and Wellbeing Board, the April board of the Integrated Care Board and the May meeting of the Integrated Care Partnership. However, NHS England guidance makes clear that it is inappropriate for board and public meetings to discuss new strategies in the period leading up to the London Mayoral and Assembly election and the General Election.

**3.2 Contribution to Borough Plan Priorities & Strategic Context**

3.2.1 The Mental Health Strategy for adult residents of North West London builds on the Health and Care Strategy developed by North West London's Integrated Care Partnership, and on the Joint Health and Wellbeing Strategies developed by each North West London's boroughs.

**4.0 Stakeholder and ward member consultation and engagement**

4.1 The Mental Health Strategy for adult residents of North West London builds on the North West London Health and Care Strategy that was developed last year. This strategy was subject to public consultation and the final iteration included feedback from residents and communities.

4.2 Continuing input from the ICB's 'What matters to you' engagement programme has been fed into the development of the JFP.

4.3 We have conducted extensive engagement with residents in developing this strategy, with eight pivotal sessions across each of the eight boroughs. These sessions held from late August to early October, brought together a diverse range of residents and service users to share their experiences. Two online sessions (lunchtime and evening) open to all residents also took place. The engagement report is available at https://www.nwlondonicb.nhs.uk/get-involved/your-views-mental-health-services-nw-london

**5.0 Financial Considerations**

5.1 No direct financial considerations for Brent London Borough Council.

## 6.0 Legal Considerations

6.1 None

## 7.0 Equality, Diversity & Inclusion (EDI) Considerations

7.1 While the initiatives outlined in the Mental Health Strategy will doubtless give rise to EDI implications, North West London addresses these considerations (though, for example, EQIAs) as we prepare for implementation.

## 8.0 Climate Change and Environmental Considerations

8.1 N/A

## 9.0 Human Resources/Property Considerations (if appropriate)

9.1 N/A

## 10.0 Communication Considerations

To outline relevant considerations in relation to any required communication strategy or campaigns.

10.1 N/A

***Report sign off:***

***Toby Lambert***
***Executive Director of Strategy and Population Health***
North West London ICB

North West London Integrated Care System
Working together for better health and care

NHS
North West London



# Strategy for meeting the mental health needs of adults in North West London

FINAL DRAFT July 2024

# Overview and context

This document presents the work that has been undertaken to refresh the strategy for mental health care for adult residents of North West London. The document:

- Takes a **phased approach to refreshing the strategy**, initially focusing on adult community and inpatient mental health services. Children and Young People (CYP) will be covered in the next phase, supported by the annual refresh of the NW London CYP Mental Health Transformation Plan.
- Includes a **summary of current need** and anticipates how this need will change over the next five years.
- Reviews **current capacity** of NHS services and analyses how this could be optimised.

**Engagement** **with local residents** and service users was undertaken from late August to early October to hear personal experiences to understand what was working well and hear ideas on improvements.

The ICB, NHS providers, voluntary providers, local authorities and local residents have developed and discussed **key themes** of this strategy.

**This document does…**

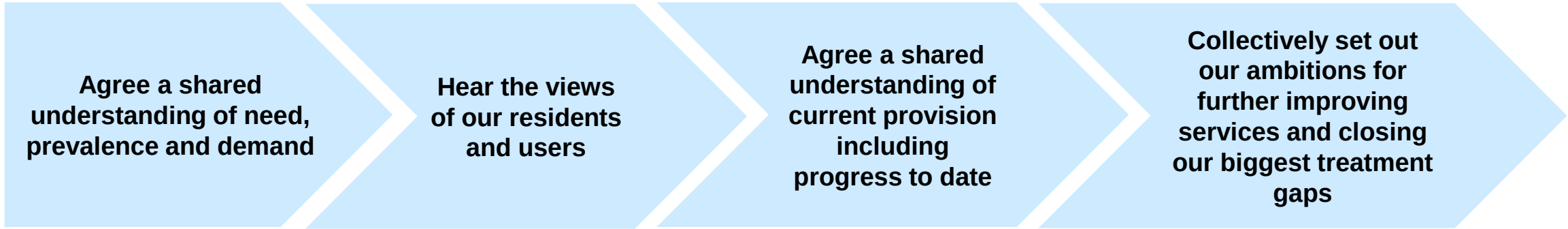
- Build upon the North West London's Integrated Care Strategy that was published in November 2023
- Build upon our boroughs' Joint Strategic Needs Assessments and complements their Joint Health and Wellbeing Strategies
- Recognise the stressors that may drive increase demand in mental health services. Each of our boroughs publishes its own health and wellbeing strategy, and this document is not intended to duplicate these – it acknowledges these existing local strategies/ plans in place for promoting resilience and wellbeing.

**This document does not…**

- Make recommendations as to how to improve overall wellbeing – that is the presence of our boroughs, in their health and welling services
- Recommend optimal inpatient capacity site by site. Instead, it models future demand for key services and highlights opportunities for transformation;
- Analyse workforce and finances in detail;
- Set out a detailed implementation plan: this will be developed following agreement of strategy.

# Executive summary

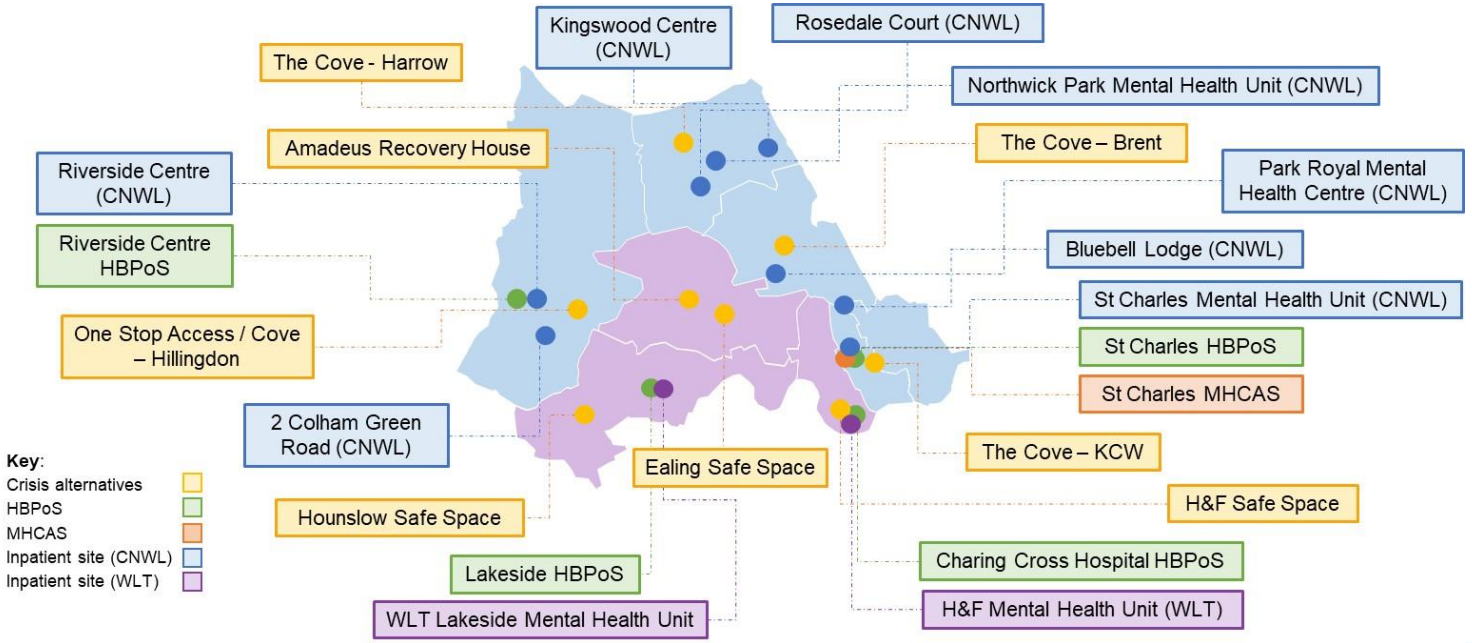
# We have developed this strategy in four stages






- Partners from Local Authorities, Borough-Based Partnerships, the VCSE, Service Users, ICS Programmes and ICB Core Teams have worked collaboratively to develop this strategy.
- Together, we have:
  - Reviewed and analysed data points from the Mental Health Joint Strategic Needs Assessment toolkit to demonstrate a shared understanding of need;
  - Reviewed the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed for each of our boroughs;
  - Gathered insights from our regular outreach engagement programme, drop-in sessions in each borough and online focus groups. These have encouraged our residents to share their personal experiences and stories as well as their views on further improvements;
  - Collected views on areas of success, biggest challenges and current priorities, to inform the themes of this strategy. As we implement, we will continue to engage to ensure that services continue to support – and better support – all of our residents that use them.

# Mental health services in our ICS cover eight places for our 2.1m resident population




## Our residents

- North West London is one of the largest, most diverse, and vibrant integrated care systems in England, with a population of over 2.1m people speaking over 100 languages.
- 19% of adults in North West London have common mental health problems such as anxiety or depression.
- 25,955 people are registered with a severe mental illness.
- The suicide rate in males is three times higher than that for females
- Over 23,000 adults are currently in contact with community mental health services and 50,300 in contact with Talking Therapies services

## Mental health provider landscape

- The total spend by the ICB on mental health services (MHIS target) in 2022/23 was £472m, representing 12% of the ICB's total allocated budget.
  - This does not include time spent by general practice supporting residents with mental health issues
  - The ICB spent £380m on block contract adult mental health in 2022/23 with the main two mental health providers
- The main mental health service providers are:
  - Central and North West London NHS Foundation Trust (CNWL)
  - West London NHS Trust (WLT)

# Adult mental health services in North West London

| | |
|---|---|
| **Talking Therapies** | A range of talking therapies for people who feel anxious and worried, or down and depressed |
| **Community mental health (Mental Health Integrated Network Teams and Community Mental Health Hubs)** | Community based teams made up of different professionals with a wide range of skills. They focus on supporting people's mental health, alongside their physical health and social care needs. Teams work closely with GPs, social services, the voluntary sector and other organisations to offer treatment and care in a more integrated way. |
| **Crisis services** | (i) Home treatment teams providing intensive short-term care to vulnerable patients considered for admission or discharge as an alternative to inpatient care<br>(ii) Community based crisis alternative services are a variety of complementary and alternative crisis services to A&E and admission, offering non-clinical support to individuals experiencing a crisis or mental distress |
| **Liaison psychiatry** | Specialist services providing mental health care in a physical health setting. They specialise in the link between people's physical and mental health, and typically provide support to people who may have co-occurring physical and mental health needs |
| **Acute mental health inpatient** | For adults and older adults in need of inpatient support for severe mental health difficulties or a mental health crisis |

# We face significant unmet need in addressing common mental health disorders, while our residents with severe mental illness continue to be much more likely to die prematurely

**1 Adults in North West London**

- Our residents generally report a **high level of happiness**, with **74%** of our residents reporting a high happiness score, compared to **72% nationally** and **71%** in the **rest of London**
- There are several risk factors for people developing mental health crises - including **poverty**, **unemployment, social isolation**, **homelessness and rough sleeping**, **smoking**, **alcohol and substance misuse** and **poor overall health.** In NWL, we have a particular issue in many of these areas (e.g., unemployment in **NWL** is **4.9%,** compared to **3.5% nationally**) – these will need to be addressed through our broader work on prevention, **working closely with ICS and wider partners.**

**2 Adults with common mental health disorders**

- In NWL, **178,000 adults** are currently registered with **depression** – **7.8%** of our adult GP-registered population. This is in stark contrast to the rest of **London (9.5%)** and the rest of the country **(13.2%).**
- **Depression** is the **4th leading cause** of disability-adjusted life years **(DALYs)** lost in NWL, behind lower back pain, heart disease, and diabetes.
- The prevalence of **depression** (recorded) has **increased at a significant rate** over the **past 10 years** – growing **6.6% year-on-year** – a slower growth rate than the rest of the country (8.5%), but a faster growth rate than many long-term physical conditions.
- This information, when considered alongside analyses of NWL demographics, national surveys, and service usage data, suggests that NWL has a substantial level of **unmet need** for common mental health disorders, with an estimated **under-diagnosis** of c. **30%.**

**3 Adults with severe mental illness (SMI)**

- **1.11%** of our population is registered as having **SMI** – approximately **33,000 people**, with prevalence relatively **constant** at this level over the last five years. Recorded prevalence is highest in **K&C (1.44%)** and **Westminster (1.39%)** – approximately 50% higher than the national level (**0.95%**).
- **Premature mortality** for patients with SMI is high in **H&F** and **Hillingdon,** with a **c. 45%** and **30%** higher rate than the national value.
- There is a strong link between **long term physical health** and **mental health** - particularly apparent in **patients with SMI**.
- Patients with **SMI** are **390%** more likely to **die prematurely** (i.e. under 75) than people without SMI. Whilst this is in line with the rest of London and the rest of the country, this demonstrates the need to develop a more **holistic and proactive** in supporting these patients.

**4 Adults with higher acuity mental health needs**

- The number of patients with mental health diagnoses **attending emergency departments** across North West London has increased by **5%** from pre-COVID pandemic levels – with a significant proportion (~25%) of patients attending still **'unknown'** to NWL mental health services. Waiting times in emergency departments remain high, with patients waiting 8-12 hours on average. In addition, a patient with mental illness will be **twice as likely** to breach the **12 hour mark** in ED than a physical health patient.
- The NWL **suicide rate** has **decreased** steadily over the last decade – now at **7.7 deaths** per 100,000 population. Whilst this is lower than the rest of the country (**10.3 deaths**), **5 out of our 8 boroughs** have a **higher suicide rate** than the rest of London (**6.9 deaths**).
- Whilst overall inpatient **admissions** have decreased **c. 15%** since pre-COVID levels, **CMHH/MINT referrals** have increased **55%** over the same period, reflecting our investment in this area. However, demand for **CMHH/MINT** remains high and further transformation is required.

# Variation in access and outcomes also exists for different population groups across our boroughs

North West London (NWL) is one of the largest and most diverse population of any ICS in England with 2.1m people speaking over 100 languages. Unfortunately, **19% of adults in NWL have common mental health problems such as anxiety or depression, whilst c25,000 people are registered with a severe mental illness.** Similarly to the rest of London and England, mental illness is not evenly distributed throughout the NWL population – differences in prevalence vary by geography, gender, ethnicity and deprivation level.

**Hammersmith & Fulham and Kensington & Chelsea have the highest prevalence of depression and anxiety**, conditions which predominately impact younger women. Brent, Ealing and Kensington & Chelsea have the highest prevalence of severe mental illness which predominately impacts younger men. Both common and severe mental illnesses are more prevalent in ethnic minority and deprived communities. **Ethnic minority and deprived populations have higher rates of admissions, referrals and caseloads compared to the rest of the population** – suggesting a level of proportionality between prevalence and service use. In absolute terms, protected populations in Brent, Ealing and Hounslow utilise more mental health services however, ethnic minorities from inner NWL utilise more mental health services on a per population basis.



**Mixed and black ethnic groups have approximately 3 times per population admissions than other ethnic groups**. Black British males in Kensington and Chelsea, Hammersmith and Fulham have the highest rates of admissions though the largest gross number of admissions is from Brent. **Males have higher rates of admission than females which may reflect the severity of their mental health conditions**. Mixed, black and 'other' ethnicities have the highest per population referrals into MH services. Females have 1.5 times more referrals into mental health services than males. Mixed females in Kensington & Chelsea and Westminster have the highest referral rate per population.

**Mixed and black ethnicity populations have the highest rate of caseload per population**. Hammersmith & Fulham, Westminster and Hounslow have the highest caseloads per population of any borough. The Kensington & Chelsea caseload is relatively low given the prevalence of depression and anxiety in the borough. The rate of mental health caseload in NWL is consistently higher for females than males (61% vs. 39%). **The number of caseloads per admission is lower for males than for females across all ethnicities,** particularly the black population. This may indicate a higher prevalence of serious mental illness that requires admission amongst males, and/or that males in NWL are not accessing community care in accordance with their need.

**The black population has highest ED attendance rates for mental health conditions**, which has increased nationally and in NWL since 2019. Harrow and Kensington & Chelsea have the highest rates of ED attendances for the black population, both of which have been increasing since 2020/21. **Hillingdon has the highest number of ED attendances in NWL**, over double that of Westminster, the borough with the lowest rate of ED attendances (28.3 vs 12.6). The number of ED attendances by 18-25 years old in NWL is below that of the Rest of England average.

# Considering the demographic profile of the local population allows for strategic planning of services tailored to the needs of individual communities

The demographic analysis is useful to show where populations are clustered into geographical areas and are therefore more likely to be impacted by changes in the location of services. Populations will also be impacted by changes in the quality of services, but this impact is not necessarily dependent on the physical location of the service.

**Demographic composition of the catchment population**

*Proportion of the potentially impacted population that are of particular population groups*

| Area | Households deprived in at least one domain* | Poor general health | Ethnic minorities | Disabled population | Economic inactivity | Unpaid carers | Poor English proficiency | Women of child bearing age** | 18-25 year olds | Single person households | Gender |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Brent | 60% | 4% | 50% | 14% | 21% | 7% | 7% | 45% | 12% | 26% | 51% female |
| Ealing | 54% | 4% | 37% | 13% | 20% | 7% | 6% | 44% | 10% | 26% | 51% female |
| Hammersmith & Fulham | 49% | 4% | 33% | 14% | 18% | 6% | 2% | 53% | 14% | 36% | 53% female |
| Harrow | 51% | 4% | 49% | 13% | 17% | 8% | 5% | 41% | 9% | 21% | 51% female |
| Hillingdon | 54% | 4% | 45% | 13% | 18% | 7% | 4% | 42% | 10% | 24% | 50% female |
| Hounslow | 56% | 4% | 40% | 14% | 20% | 7% | 5% | 44% | 9% | 25% | 50% female |
| Kensington & Chelsea | 47% | 4% | 39% | 15% | 20% | 6% | 2% | 46% | 13% | 43% | 53% female |
| Westminster | 50% | 5% | 44% | 14% | 21% | 7% | 3% | 52% | 15% | 42% | 52% female |
| **NWL total** | **53%** | **4%** | **42%** | **14%** | **19%** | **7%** | **5%** | **45%** | **11%** | **29%** | **51% female** |

*See slide X with notes

# Our current services have evolved considerably over the last few years

The NHS Long Term Plan brought an enormous opportunity to build on previous progress, and direct our attention to new areas of improvement and previously under-represented groups.

Implementation of the NHS Long Term Plan in North West London saw additional investment compared to 2018/19 of:

- £39.9m in integrated models of community care for people with severe mental illness;
- £16.9m in CYP mental health care, with a strong focus on community, crisis and eating disorder services;
- £15.1m to support people with common mental health disorders;
- £10.8m in adult crisis care;
- £8.3m in perinatal mental health care; and
- £1.7m to improve the therapeutic environment of inpatient care settings

- A range of service providers, particularly from the voluntary sector, are supporting local communities to **prevent mental health problems** and support wellbeing.
- For those with common mental health problems, such as anxiety and depression, capacity of **talking therapies** has increased**.**
- Community mental health for adults and older adults is increasingly joined up with primary care and community assets and will become part of the services on offer through our **integrated neighbourhood teams** but there continue to be a number of underserved communities.
- **We have expanded mental health crisis care significantly** with 24/7 community teams, a range of crisis alternatives to A&E and inpatient care available across the North West London as well as expanding liaison psychiatry teams to every A&E department.
- Psychosis services are delivered well across North West London, with a positive impact on **early intervention**.
- In line with recommendations from the Royal College of Psychiatrists, best practice and national policy, we have expanded care for people with severe mental health and acute needs in the **least restrictive setting** appropriate, using admission only when there is no better alternative.

# But we still need to do more – continuing the focus on prevention, shifting to community based models of care and investing in alternatives to admission

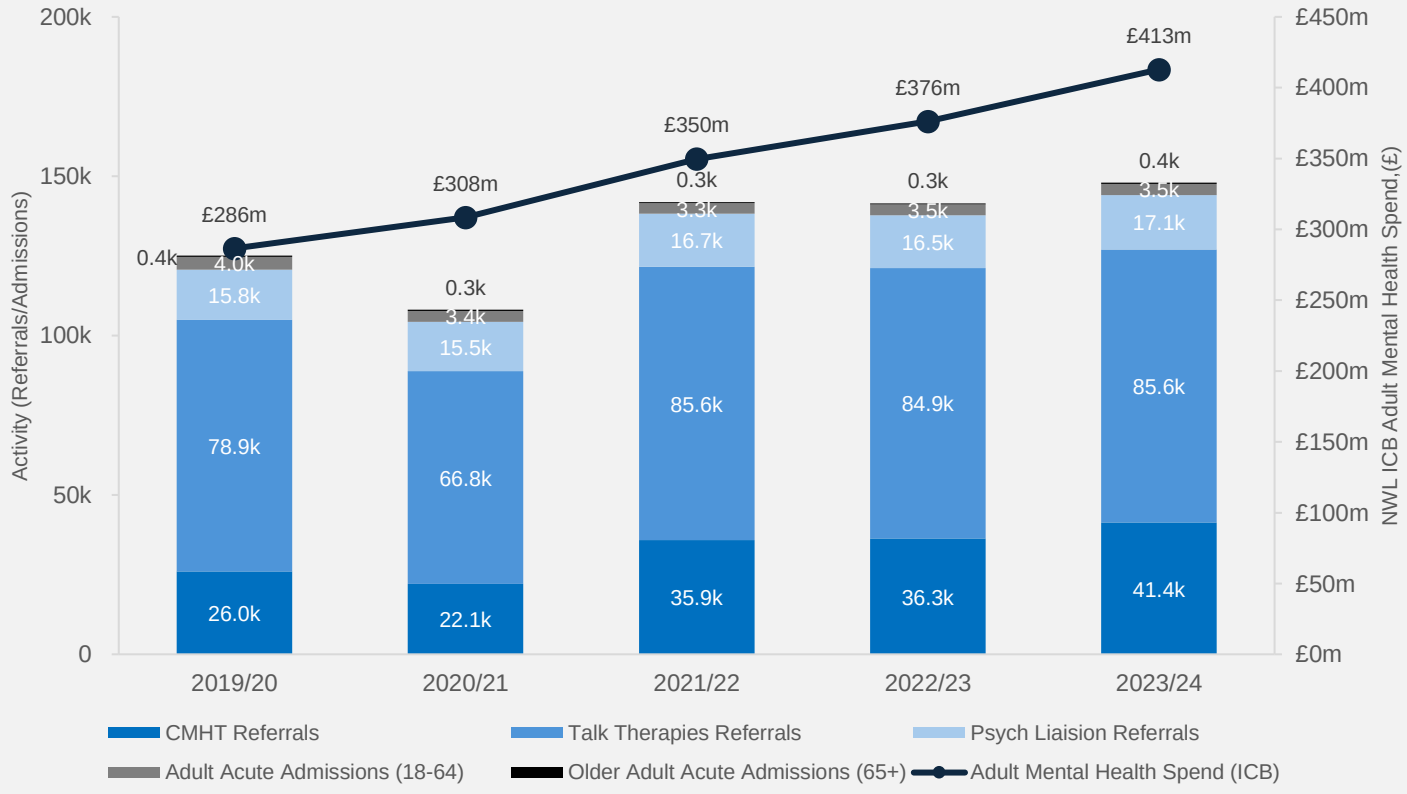
| | |
|---|---|
| 1 **Adults** in North West London | • We must **expand our reach through other organisations, sectors and industries,** to further develop the broader health, social and economic improvements of North West London.<br>• Our local system should continue to recognise and **harness the capacity and skills of the voluntary sector,** working together to enable our residents to take better care of their mental and physical health and build confidence in people to support their mental wellbeing. |
| 2 Adults with **common** mental health disorders | • We must continue to raise awareness of our services so that **every resident knows how to access mental health support** more widely in the community<br>• We must reach more people and address hesitancy to access mental health services by flexing our approach, in particular by **tailoring services to differing local communities**, addressing stigma and building trust by ensuring that our workforce reflects of our residents. |
| 3 Adults with **severe mental illness (SMI)** | • We will ensure that we provide the **highest quality, compassionate, trauma-informed and most appropriate** mental health care for adults and older adults who need it across our boroughs.<br>• We will promote and improve professional and public knowledge of **alternative crisis services** to better direct people to the most appropriate service, preventing the need for A&E attendances and admission.<br>• We are committed to further increasing access and **advancing health equalities for those with SMI**.<br>• We will continue to **tailor our offer for older adults**. |
| 4 Adults with **higher acuity** mental health needs | • We continue to implement the principle that **acute inpatient care should only be used when there is no better alternative**. There will be improved support to reduce risk of re-admission.<br>• When hospital based care is required, it will be delivered in **a timely way, by an expert team, within a therapeutic and compassionate** environment.<br>• We will provide **inpatient facilities** that meet modern standards of acute mental health care, supporting patient dignity and privacy, with ease of access where required. |

# Investment in adult mental health services has increased significantly (9.6% per year on average), however activity has not increased at quite the same rate

- NWL ICB has significantly increased investment in adult mental health services at a rate of c. **9.6% per year** over the period **2019/20 – 2023/24.**
- In 2023/24 we spent **£413m** on adult mental health services (i.e. excluding CHC, prescribing, learning disability & autism and CYP mental health services).
- Over the same period, we have experienced an increase in demand for key community mental health services such as community mental health teams, talking therapies.
- We have also seen an increase in liaison psychiatry referrals and a decrease in demand for inpatient admissions.
- However, activity (in terms of referrals and admissions) on the whole has not increased at quite the same rate as overall investment, suggesting that productivity could be improved.
- However, it should be noted that the chart on the right only looks at the trend in activity for certain key services, and should be used merely as an approximate indicator of productivity.



**NWL adult mental health spend compared to key service referrals / inpatient admissions**




**Sources:** CNWL / WLT activity data [April 2019 – Dec 2023, extrapolated to March 2024]; NWL ICB finance data [2019/20 – 2023/240.



North West London

# Looking at quality, our key mental health services are considered 'good' overall by the CQC, however some services have been rated as 'requires improvement' in the *safe* domain

Both CNWL and WLT have been **rated as 'good' overall** by the CQC in their most recent inspection reports (CNWL report – published **February 2024**; WLT report – published June **2020**). Both providers were deemed to provide similarly high quality services across most of the five CQC domains, with a rating of 'good' against the 'effective', 'responsive' and 'well-led' domains. Both providers were also rated **'outstanding' against the 'caring' domain** – a testament to the staff at those providers. However, both providers were also rated as 'requires improvement' against the 'safe' domain. See below for additional information against each CQC domain.

Mental health services provided in primary care are more difficult to assess, though the most recent GP Patient Survey (2023) suggests that **NWL primary care services are generally good** and perform in line with the national average. For example, **70% of survey respondents** in NWL rated their overall experience of their GP practice as **'very good'** or 'fairly good' – in line with the national average of 71%. In general, patients also find it easier to get through to their GP practice on the phone compared to the national average – 59% of NWL respondents rated this as 'easy', versus 50% nationally.

## Safe

- CNWL and WLT rated as **'requires improvement'** in this domain, with most wards deemed to be safe, clean, and well equipped.
- The CQC found that CNWL had implemented quality improvement methodologies to improve areas such as **falls** and **pressure ulcer care**, and had already resulted in in reductions in violence, aggression and restrictive interventions.
- However waiting times for patients with higher MH needs may affect patient safety. For example, waiting times in A&E remain high (see responsive domain) and waiting times for **CMHT** range from c. 30 days to 40 days and waiting times for crisis resolution teams or home treatment teams can range from less than a day to multiple weeks depending on the month and borough. **Waiting times** for these services may need to be **reduced** to improve the safety of patients referred to these services.

## Effective

- CNWL and WLT rated as **'good'** in this domain, with the CQC finding that staff assessed the physical and mental health of patients on admission and **individual care plans** were developed and reviewed regularly through MDTs.
- The latest GP Patient Survey (2023) concluded that GPs in NWL generally do recognise the mental health needs of the patients they see – **79% of patients** confirmed that their mental health needs were recognised in their last GP appointment. This is broadly in line with **the national average** – **81%.** However, variation is significant across PCNs in NWL – from **65%** to **91%.**
- Recovery rates for talking therapies are just below the **50% target**, with **44-48% of patients** deemed to be **'moving to recovery'** after completing treatment.
- Both CNWL and WLT have a **lower proportion** of **30 day readmissions** for adult acute services than other London providers (5-8%, compared to 9% for London).

## Caring

- CNWL and WLT rated as **'outstanding'** in this domain.
- CQC inspectors highlighted that services were patient-centred and staff wanted patients to experience the best possible outcomes and that there were many examples of staff and leaders going the extra mile.
- However, the friends and family test (FFT) results for CNWL and WLT are slightly below the England average for mental health providers.
- In the latest 12 months of FFT submissions, CNWL had an average positive response rate of **86%**, and an average negative response rate of **5%**. WLT had an average positive response rate of **82%** and an average negative response rate of **11%.** This means that generally **82-86%** of respondents would recommend these services to friends and family.
- However, the FFT response rate for both providers is relatively low – approximately **1%** in February 2024.

## Responsive

- CNWL and WLT rated as **'good'** in this domain.
- The CQC did highlight major pressures on the mental health urgent care pathway, with people waiting excessive periods of time in A&E and crisis assessment services. Across NWL, approx. **30%** of MH patients wait over 12 hours to be admitted, transferred or discharged from arrival – this is twice as high as patients attending for physical health reasons.
- Waiting times for most community mental health services are quite good or in line with national targets. For example, **99%** of patients had their first **talking therapies** appointment within **6 weeks** of referral, according to most recent data (December 2023). However, waiting times between appointments can be quite high and variable – anything from **29 days** on average to **67 days** on average.

## Well-led

- CNWL and WLT rated as **'good'** in this domain.
- CNWL was committed to supporting staff to 'speak up' and also had a strong reporting culture for incidents, with 98% of all incidents were reported as resulting in no or low harm, and reports were completed to a high standard.
- However, the CQC did highlight that the **escalation and oversight** of operational risk at CNWL needed to be strengthened – though work is already underway.
- WLT received similarly good feedback from the CQC, stating that leaders had the **skills, knowledge and experience** to perform their roles and that **governance processes** operated effectively and per**formance and risk** were managed well.
- Staff at WLT also engaged actively in **quality improvement** activities.
- However, it should be noted that WLT's last CQC inspection took place almost four years ago.

**Sources:** CQC reports for CNWL/WLT; GP Patient Survey 2023 (sample size = c. 17,000); CNWL/WLT/NWL ICB Monthly Information Returns; NHS England FFT submission Mar 2023 – Feb 2024..

# Enhancing our mental health services with new digital technologies will help improve outcomes and the patient experience, whilst also improving productivity

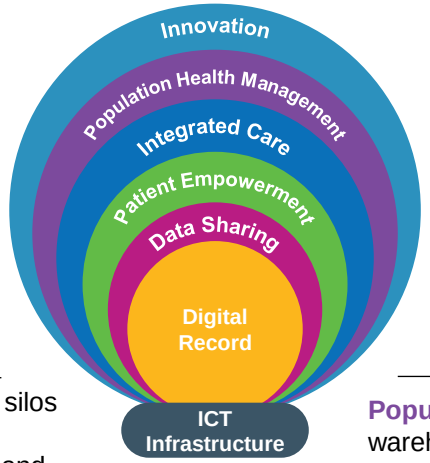
**The NW London ICS Digital and Data Strategy sets out the digital and data technologies and actions that are required to enhance our mental health services. It will continue to be developed in the coming year to reflect this MH strategy and better support the recommendations that are being made.**

**ICT Infrastructure:** Our providers have a mostly mature ICT infrastructure, with clinical systems hosted in the cloud and reasonable investment in resilience and cyber security.

Further planned work includes enhancing access in locations outside our main MH estates, better access management, and greater use of portable devices in the community.

**Digital Record:** Our key mental health providers have already deployed Electronic Patient Record (EPR) systems which have largely replaced paper-held records, but in many areas more work is required to optimise these systems and achieve the Digital Capabilities Framework defined by NHS England.

**Data Sharing:** We will continue to move beyond individual provider silos and ensure data is shared (as appropriate) between providers and between sectors – using systems such as the London Care Record and the Universal Care Plan. This will enable more effective care planning and improve handovers of care, but will require further investment.




**Patient Empowerment:** We will deliver a care model centred on the citizen/patient and prioritising the user experience – with patient facing systems that share care history and enable self-management of appointments. However, MH EPR systems require significant investment to deliver this functionality. We will also provide a greater range of smartphone and web-based apps to help people manage their own health and well-being.

**Integrated Care:** We know there is much more we can do to integrate MH services across care sectors. For example, we will continue to improve our integrated demand and capacity planning at system level – building on work completed as part of this MH strategy and including other sectors. We will also exploit shared records to better manage care that spans different settings – so that we understand people's issues as they move from primary care through to community, acute and specialist mental health services.

**Population Health Management (PHM):** Our MH providers are investing in internal data warehouses and BI tools to help track the outcomes and the quality and efficiency of the care they are delivering – supporting our ambitions to improve care quality, reduce inequalities and increase efficiency. Thinking about care in population health terms will help us target under-represented cohorts with specific interventions to improve outcomes for those groups. This will require a cross-sector, integrated approach to managing the mental health of our residents – as described above.

**Innovation:** We will develop capabilities for people who increasingly wish to interact with our mental health services using digital tools (bearing in mind the risk of digital exclusion) – both digital models of care and digital tools to navigate the mental health system. Whilst we have already implemented patient-facing tools in our CYP services such as Kooth (with some success), we will also look to implement other tools and continue to explore the wider digital mental health market and assess the suitability of new tools as appropriate, building them into our pathways.

As described in this strategy, we also know that there are productivity gains that could be made to increase the value for money of our mental health services – particularly in community services. Innovative digital tools such as e-rostering platforms and AI-assisted note taking and planning tools will help unlock these gains – reducing the administrative burden on 'caseload-carrying' staff and freeing up more time for patient care. This will require careful planning and close-working with patient-facing staff in a supportive manner.

# The ICS workforce priorities and programmes support the ambitions of the Mental Health Strategy

## Our ICS Workforce Strategy

ICS Workforce priorities are grouped together into two strategic intentions:

**A great place to work** by bringing together our ICS wide collective **recruitment** and **retention** initiatives to ensure availability of the workforce capacity required, minimise attrition and maximise the capability of the registered and non-registered workforce.

**Transform for the future** in order to respond to the NHS Long Term Workforce Plan by conducting strategic workforce planning within 'collaboratives' and 'place', informed by modelling and forecasting to support **new ways of working,** improved workforce planning, efficiency and **tracking productivity across mental health services**, in particular community teams, as well maximising the opportunities afforded by **digital and technological innovations.**

## Mental Health Strategy Workforce priorities

1

**Recruitment and retention:**
- Reducing vacancy rates to improve quality of care
- Increasing workforce capacity through improved retention

2

**Equality and diversity:**
- Diversifying senior leadership and improving experience of black and minority ethnic staff;
- Diversifying the allied health and psychological professions

3

**Education and joint training:**
- Investment in apprenticeships
- Investment in new roles
- Increasing clinical placement capacity to capitalise on investment outlined in the NHS Long term Workforce Plan

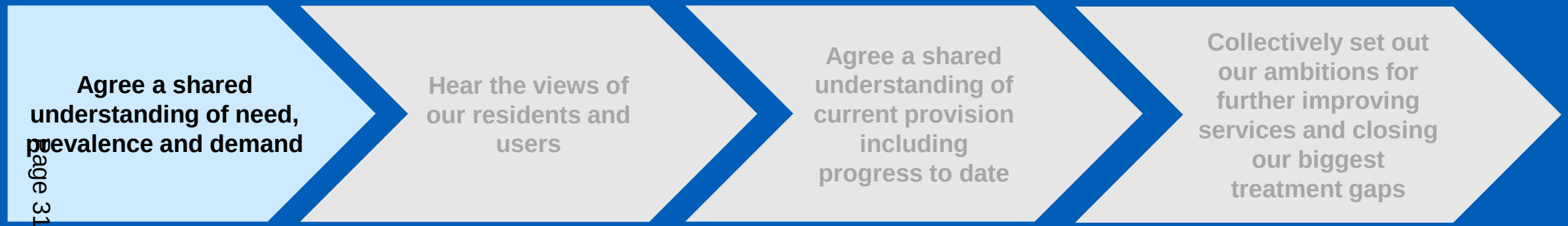
4

**Workforce transformation and productivity:**
- Development of new models of care and the integration of new roles (Mental Health Crisis Assessment Service and HBOS)
- Reducing reliance on the use of temporary (agency) staff

# Our shared aims and ambitions for adult mental health services for the future

**By 2028/29 we will have:**

| Ambitions | Outcomes |
|---|---|
| **RAISED AWARENESS AND PROMOTING WELLBEING**<br>• Raised awareness across North West London so that every resident knows how to access mental health support both in crisis and more widely in the community.<br>• Developed an assets-based approach to promoting mental health, wellbeing and independent living, partnering with and investing in local community organisations. | • Services responsive to population health needs and flexibly delivering changes with no unwarranted variation in outcomes.<br>• Locally tailored and visible, community support services; built capacity in providers to plan and develop their services for patients.<br>• Patients and staff reporting better experiences.<br>• Optimal community and inpatient capacity to respond to growth in need whilst delivering our transformation goals and increasing care in a community setting.<br>• All people known to mental health services with a crisis management plan that supports them to use crisis alternatives to A&E for de-escalating their needs, where there is no physical health need.<br>• No person staying longer in a mental health bed than they need to.<br>• Integrated solutions to housing pathways.<br>• More people gaining and staying in meaningful employment.<br>• Zero adult inappropriate acute inpatient stays outside of North West London. |
| **INCREASED EQUITY AND EQUALITY OF ACCESS**<br>• Increased equity and equality of service access to reflect different needs of our local and diverse communities, with greater targeted support to those with severe mental illness.<br>• A consistent core offer for community and crisis care for adults, with a focus on severe mental illness, that also enables flexibility for local and diverse needs.<br>• Reduced variation and increased productivity in caseloads and staffing across community services.<br>• Improved staff recruitment and retention.<br>• Waiting times measuring in the top quartile in England. | |
| **CARE IN THE RIGHT PLACE**<br>• Integrated care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness.<br>• High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment.<br>• Worked together with our Local Authority partners to develop solutions to the housing and employment pathway challenges. | Enabled by:<br>• Increased funding into mental health, benchmarked with other areas nationally, in line with the medium-term financial plan, alongside increased productivity of services<br>• Allocated resource based on need.<br>• Consistent suite of outcome measures to demonstrate the value delivered |






North West London Integrated Care System

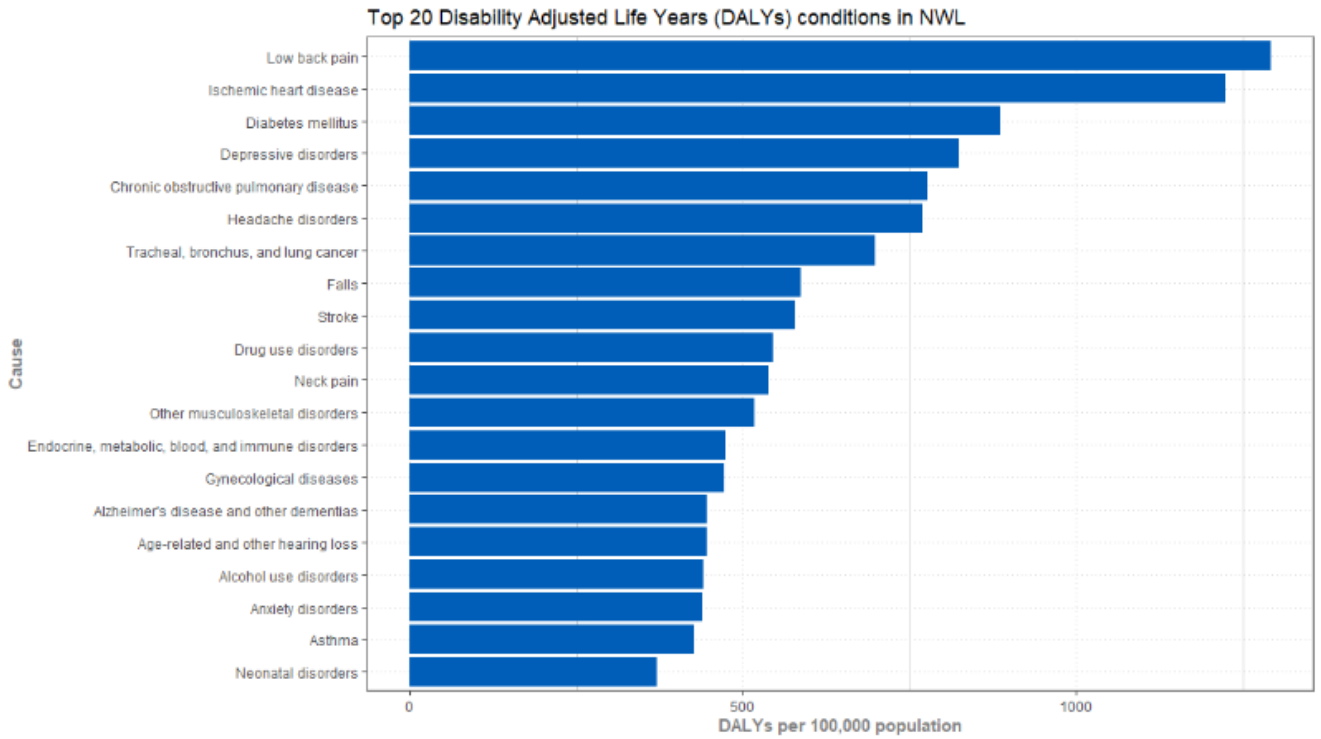
NHS North West London

# Depression is the 4th largest contributor to the burden of disease experienced by residents of North West London, behind lower back pain, heart disease, and diabetes

- **Depression** is the 4th leading cause of disability adjusted life years (DALYs) lost in NWL, behind lower back pain, heart disease, and diabetes.
- In NWL, depression accounts for the loss of c. **800 DALYs** per **100,000** population.
- Anxiety is responsible for the loss of a further c. **450 DALYs** per **100,000** population.
- Under-diagnosis and under recording of anxiety and depression may mean that the burden of anxiety and depression may be even higher.
- Timely, high quality and sustainable mental health services are one of the most effective interventions we can undertake to reduce the burden of disease for our residents.



**Top 20 health conditions, ranked by disability adjusted life years (DALYs) lost**
North West London, 2019



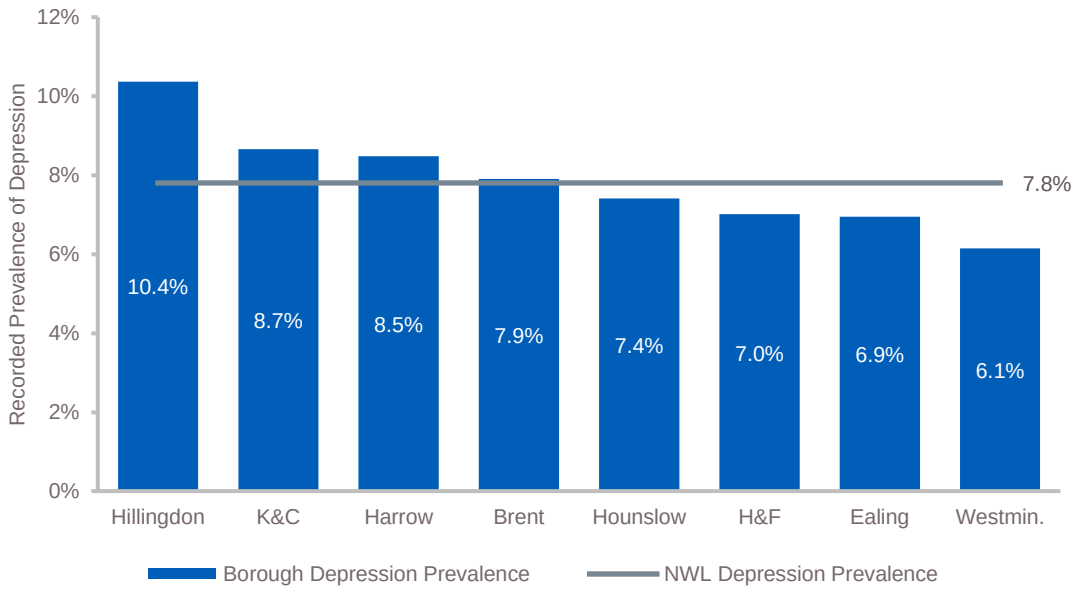

**Sources:** Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease, 2019



NHS North West London

# Recorded prevalence of depression has increased significantly across North West London, though still well below national levels, suggesting potential under-diagnosis

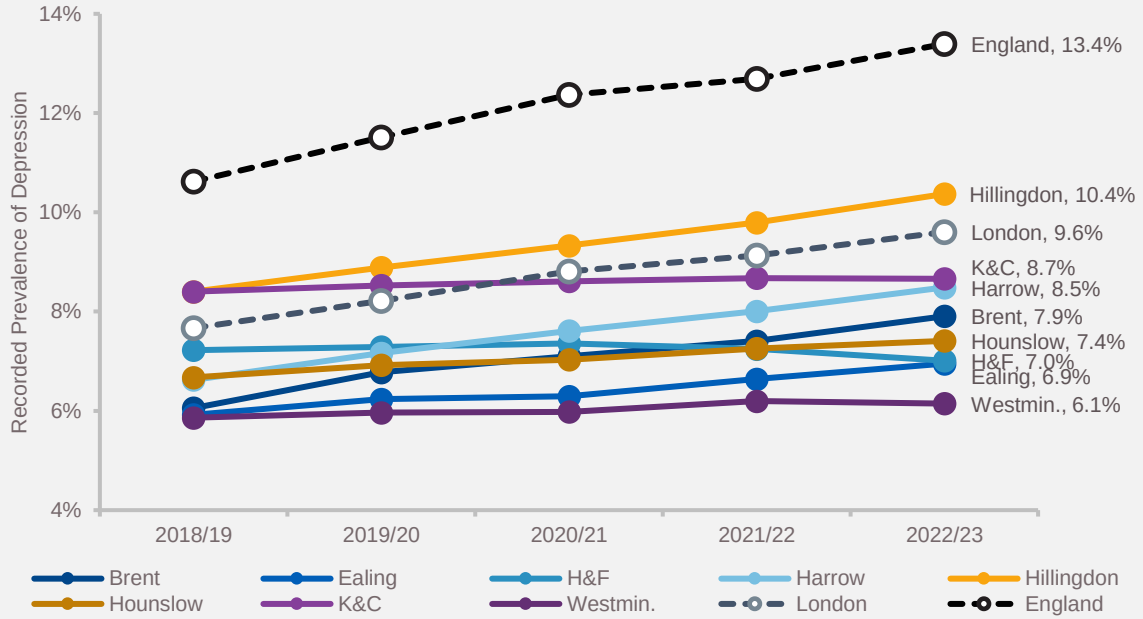
**Depression: Recorded Prevalence**
As a proportion of registered population, 18+ [FY23]




- **Though Hammersmith & Fulham and Westminster both have lower prevalence than the rest of North West London, they also have the two highest suicide rates** – adding weight to the hypothesis that there may be unmet need in the system that needs to be addressed (see analysis on suicide rates at the end of this section).
- Of our 8 boroughs, Hillingdon has the highest recorded prevalence for depression.

**Sources:** NHS Digital, Quality and Outcomes Framework (QOF) – 2022/23 – recorded depression prevalence.

**Depression: Recorded Prevalence**
As a proportion of registered population, 18+: Trend over time

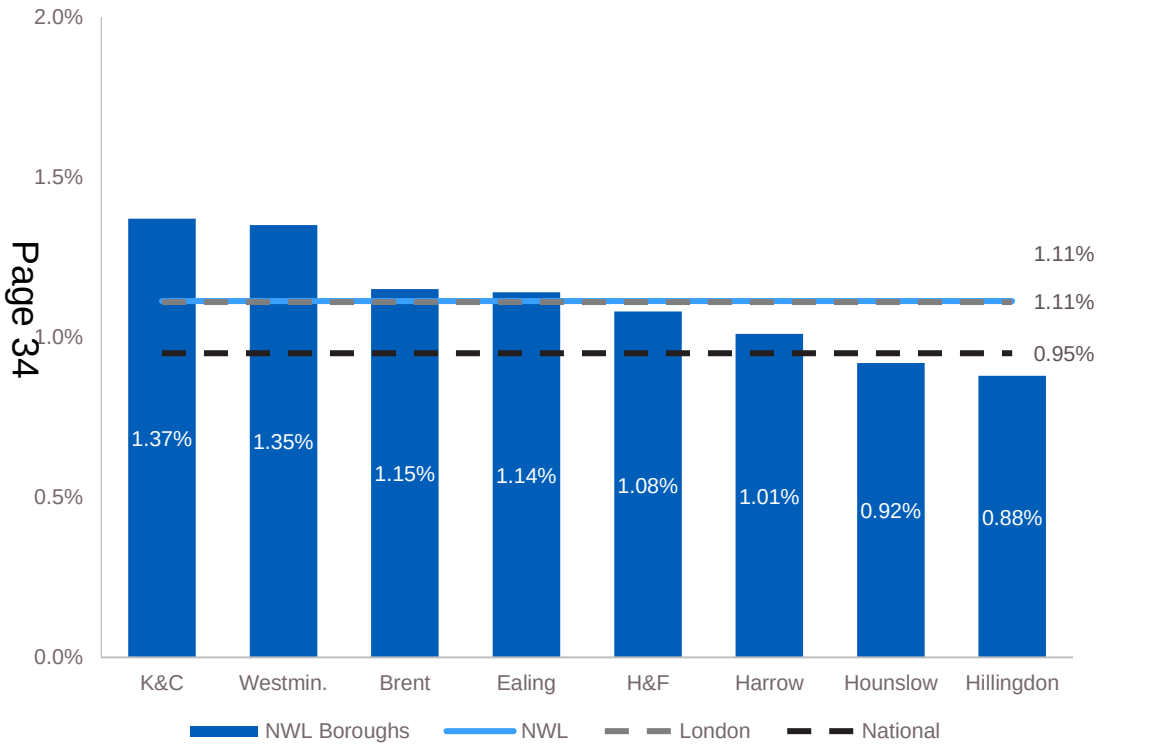



- Recorded depression prevalence in Hammersmith and Fulham has reduced over the period
- K&C and Westminster's recorded depression prevalence has remained flat over the period.
- Most other boroughs have experienced an increase in recorded prevalence in line with the rest of London and the country.
- NWL's (and London)'s recorded prevalence is far below the England average, suggesting either lower actual prevalence or significant under diagnosis. This in turn may reflect hesitancy amongst our residents to seek help, and/ or less effective support for our communities.

# Kensington and Chelsea and Westminster see higher recorded prevalence of severe mental illness; everywhere residents with severe mental illness are much more likely to die prematurely

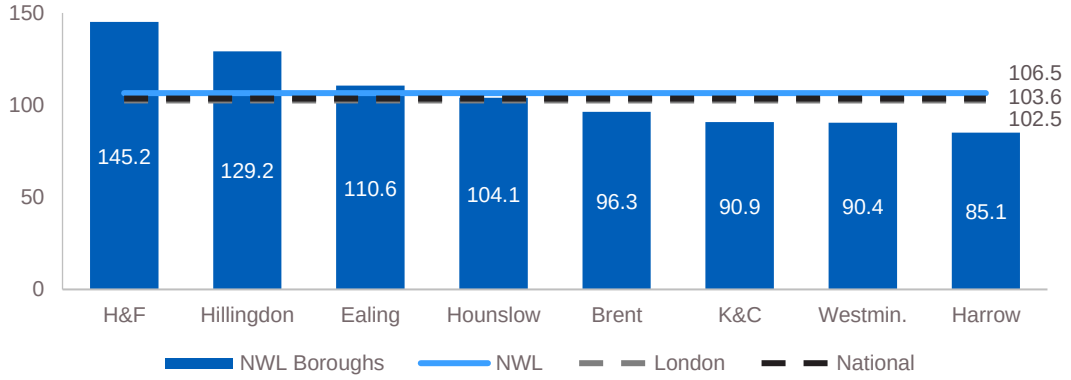
**Recorded prevalence of severe mental illness**
Percentage of registered population aged 18 and over [2021/22]

**Source:** Quality and Outcomes Framework, NHS England, 2021/22



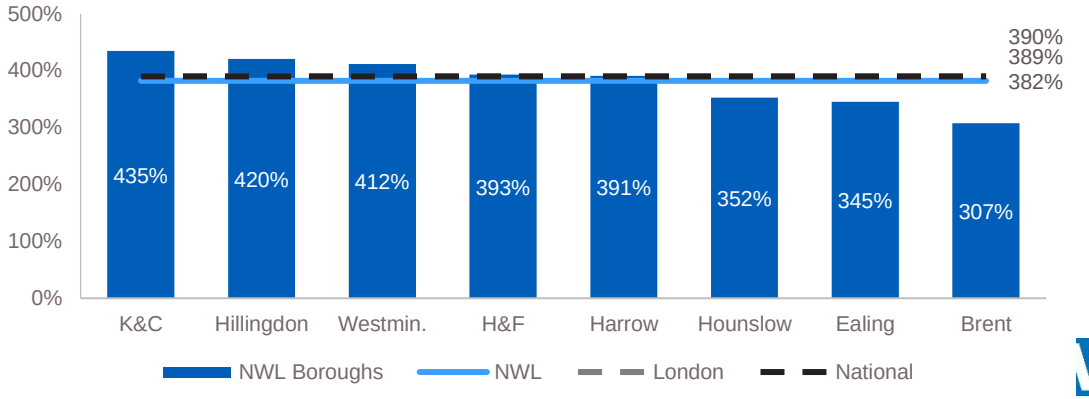

**Premature mortality (before age of 75) in adults with SMI***
Directly standardised rate, per 100,000 population [2018-20]

**Source:** PHE, NHS MHSDS, ONS, 2018-2020




**Excess mortality in under 75s with SMI***
Excess risk – i.e. x% higher/lower risk of premature death (before age 75) than adults without SMI* (%) [2018-20]

**Source:** PHE, NHS MHSDS, ONS, 2018-2020

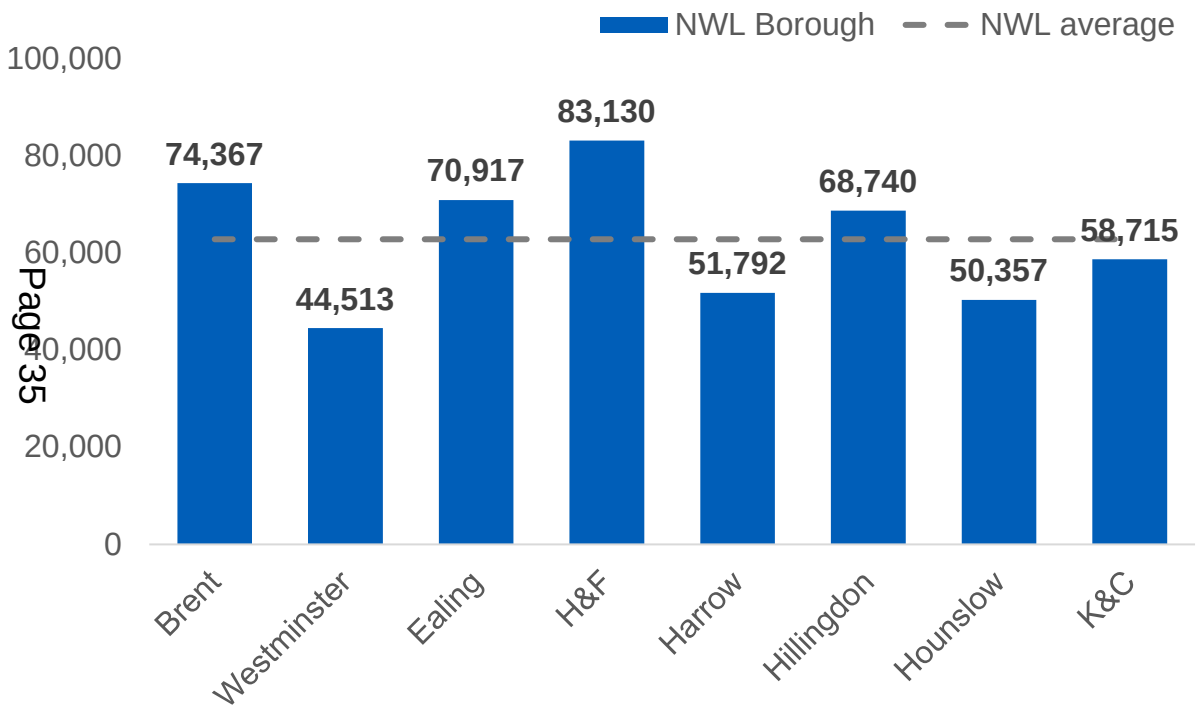



***Note:** SMI for these particular indicators have been defined by Public Health England as having a referral to secondary mental health services in the five years preceding death. It is not directly comparable to the definition of SMI under the NHS QOF.

# Hammersmith and Fulham has the highest prevalence of anxiety and depression in 18-65 year olds throughout NWL

**Prevalence of anxiety and depression by borough in NWL**

*Total number of 18+ years old with anxiety and/or depression by borough*




| Gender | # of people with anxiety | # of people depression |
|---|---|---|
| Female | 166,138 | 146,070 |
| Male | 97,067 | 93,256 |

| Age | # of people with anxiety | # of people depression |
|---|---|---|
| 18-64 | 223,498 | 206,146 |
| 65+ | 36,491 | 33,180 |

| Ethnicity | # of people with anxiety | # of people depression |
|---|---|---|
| Asian / Asian British | 52,477 | 48,110 |
| Black / Black British | 21,379 | 21,903 |
| Mixed | 10,185 | 9,925 |
| Other ethnic groups | 30,119 | 29,876 |
| Unknown | 2,873 | 2,496 |
| White | 146,172 | 127,016 |

| Deprivation Quintile | # of people with anxiety | # of people depression |
|---|---|---|
| 1 (Most deprived) | 39,045 | 39,866 |
| 2 | 85,347 | 81,694 |
| 3 | 71,267 | 63,243 |
| 4 | 46,053 | 38,043 |
| 5 (Least Deprived) | 21,004 | 16,031 |



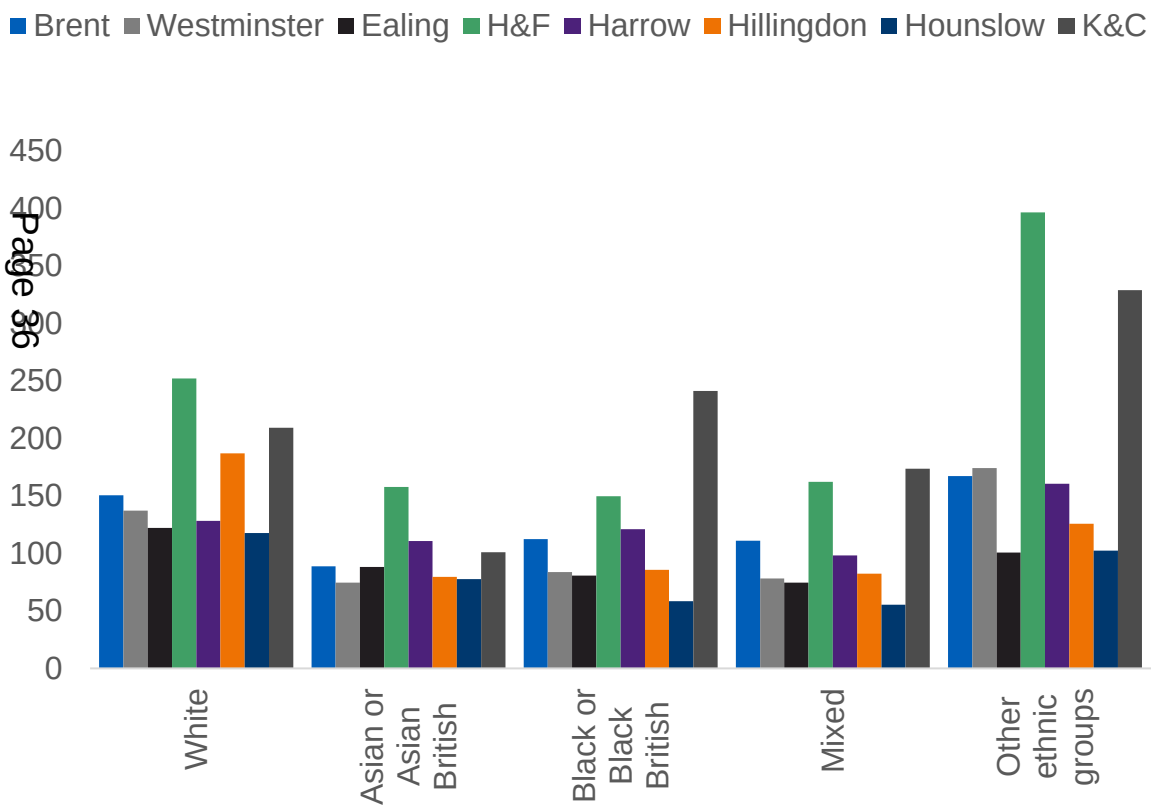


Source: Quality Outcomes Framework 2022/23, CF analysis

# The highest prevalence of anxiety and depression is seen in the other ethnic groups living in Hammersmith & Fulham, and Kensington & Chelsea

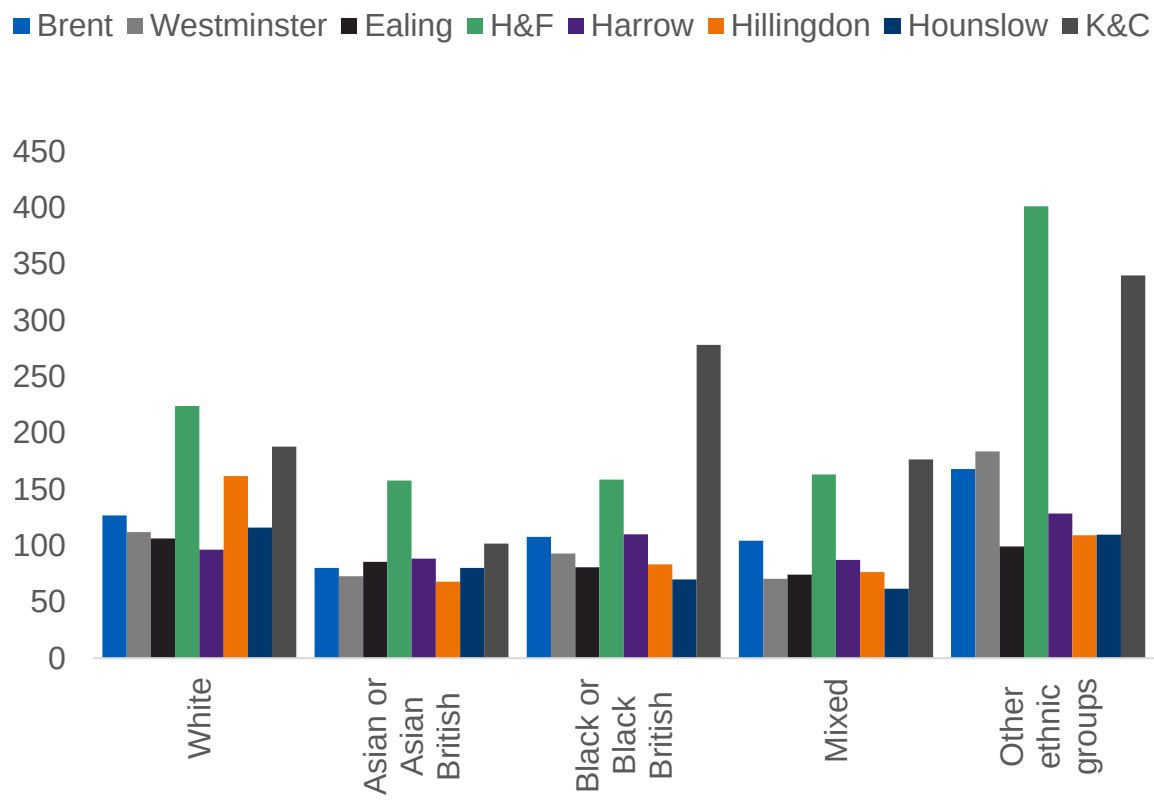
**Prevalence of anxiety by ethnicity in NWL**

*Prevalence of anxiety in the catchment population by ethnicity per 1,000*




**Prevalence of depression by ethnicity in NWL**

*Prevalence of depression in the catchment population by ethnicity per 1,000*



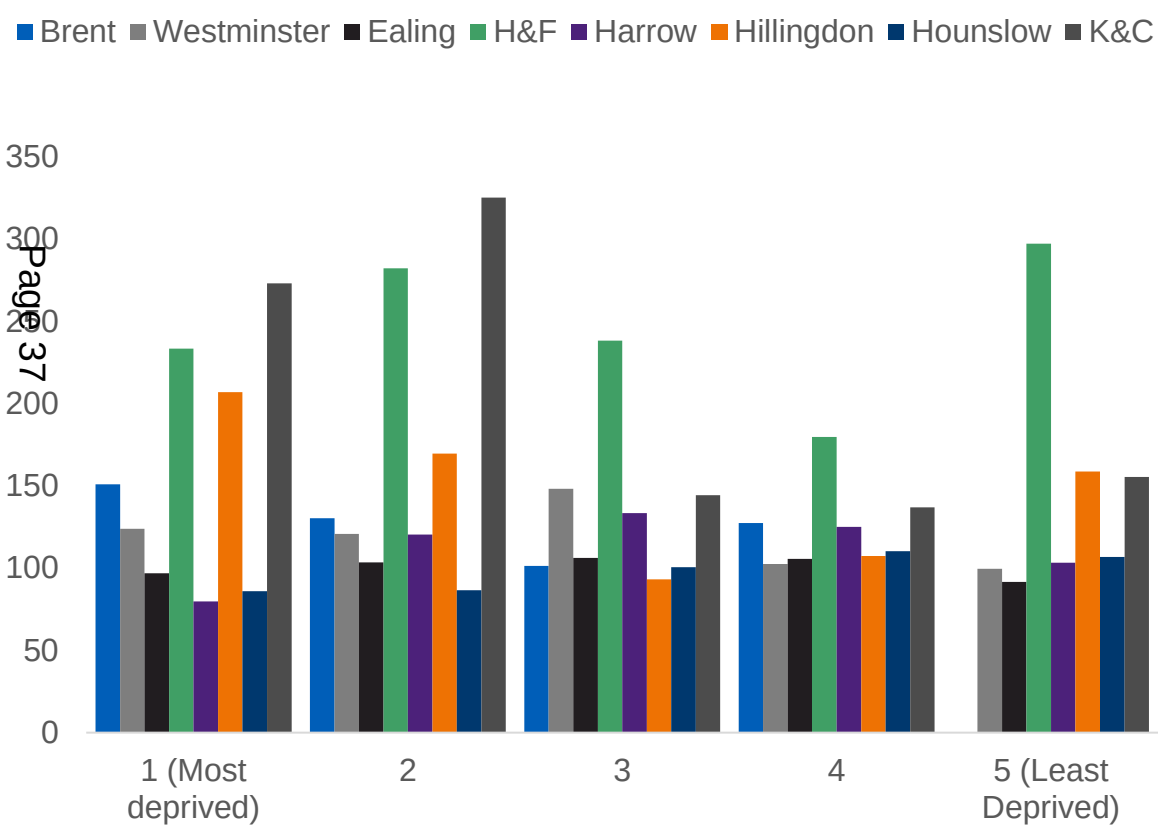



Source: Quality Outcomes Framework 2022/23, CF analysis

# People living in the first and second most deprived quintile in Kensington & Chelsea have the highest rate of anxiety and depression

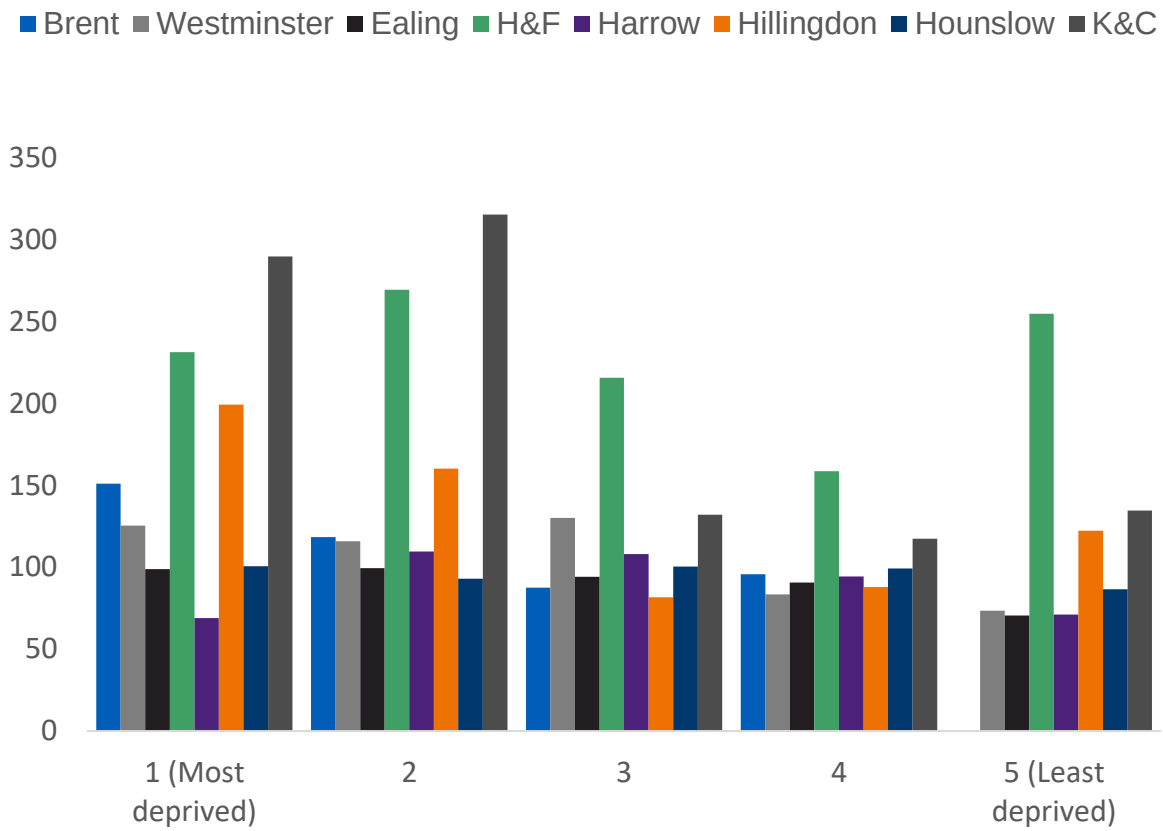
**Prevalence of anxiety by deprivation in NWL**

*Prevalence of anxiety in the catchment population by IMD quintile per 1,000*




**Prevalence of depression by deprivation in NWL**

*Prevalence of depression in the catchment population by IMD quintile per 1,000*





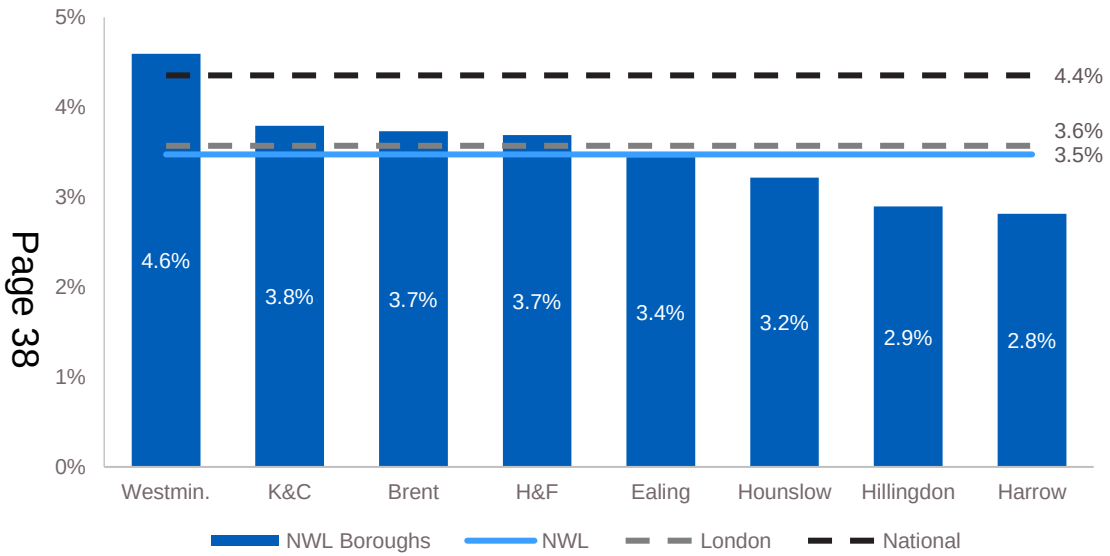



Source: Quality Outcomes Framework 2022/23, CF analysis

# Approximately 60,000 NWL residents are economically inactive due to long-term illness – with c.17,000-33,000 inactive due to mental illness

**Economically inactive due to being long-term sick or disabled (NWL)**
No. of inactive residents (16+) as a proportion of total resident population (16+)

**Source:** ONS Census Data, 2021

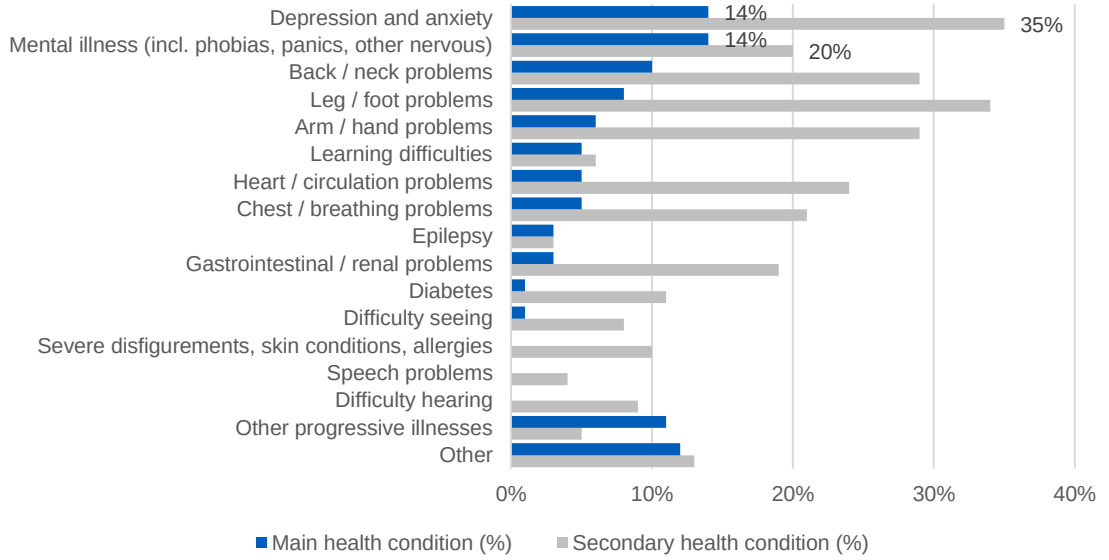





- There are **60,000** people in NWL who are economically inactive due to being long-term sick or disabled – this equates to **3.5%** of our resident population.
- This accounts for approximately **10%** of our **total** economically inactive population – **610,000.**
- Most people are economically inactive for **other reasons**, e.g., retirement, students, or needing to look after the home or family (in that order).
- Our rate of economic activity due to health reasons is **lower than the London** rate of inactivity (**3.6%)** and the **national** rate (**4.4%**).
- However, **variation between boroughs** suggests room for improvement in Westminster, Kensington & Chelsea, Brent, and Hammersmith and Fulham.

**Reason for sickness or disability-related economic inactivity (UK)**
Percentage of respondents identifying their main or secondary health condition(s)

**Source:** ONS Labour force survey dataset, 2019




- Of the long-term sickness or disability related economically inactive people surveyed by the ONS nationally, **14% were inactive** due to depression and anxiety as their main reason, and another **14% were inactive** due to other mental illnesses, such as SMI, phobias, and other nervous disorders.
- Respondents were also asked to list any secondary health conditions that were driving their inactivity, and a total of **55% of respondents** listed depression, anxiety or other mental illnesses as the cause.
- If we apply these **proportions to NWL**, we can infer that **17,000** to **33,000** residents are inactive due to mental illness as the primary or secondary reason respectively.

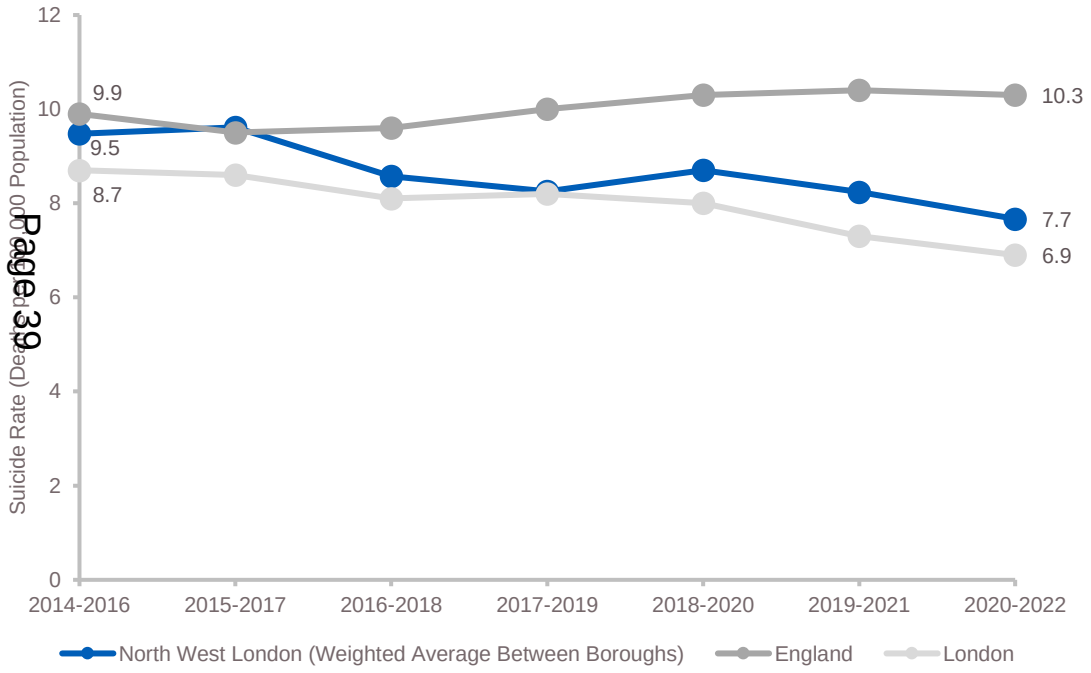
**Note:** This analysis has limitations related to variation in prevalence across the UK and further work is required to derive a more robust estimate, given NWL has a lower prevalence of common mental illness.



NHS North West London

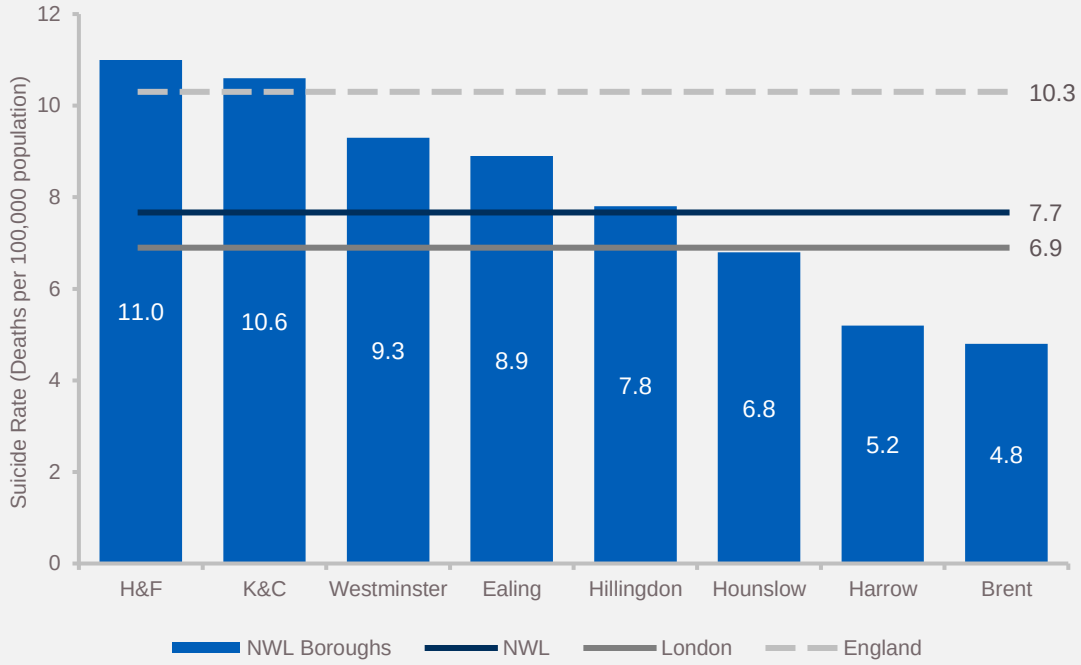
# While North West London's (and London's) suicide rates appear to be falling and are lower than England's, there is still significant variation within North West London

**NWL Suicide Rates** vs **London** and **England** [2014-2022]




- Suicide rates in NWL and the rest of London have gone down over the last 10 years, in contrast to the slight increase in suicide rates across England.
- However, throughout this period, suicide rates in NWL have remained higher than the rest of London, implying a level of unmet need in MH services that should be investigated further.

**NWL Suicide Rates by Borough** [2020-2022]




**Sources:** ONS, 2020-22.

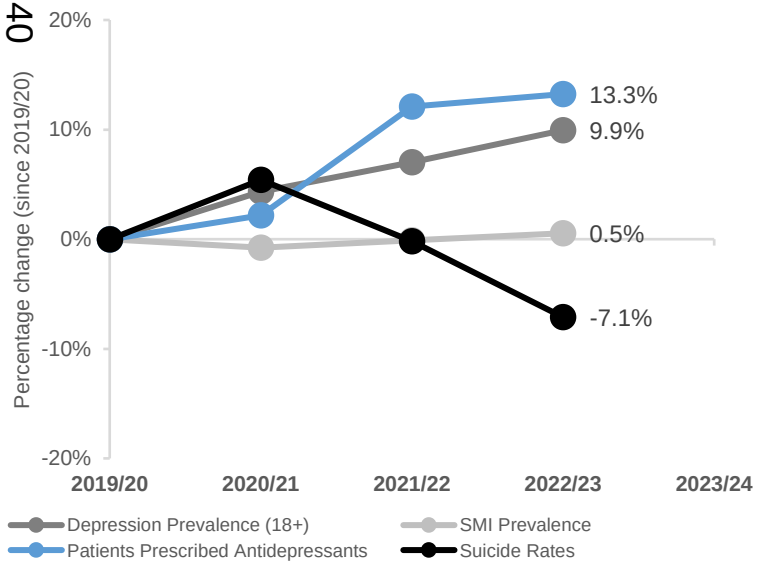
**Note:** Registering a death as a suicide can take a long time, often taking multiple years. This means that there is a significant delay between the actual suicide rate and what is reported by the ONS (and shown here). And reported figures may not yet reflect the full effect of the COVID-19 pandemic on suicides.

The ONS publishes suicide statistics on a rolling 3-year basis for this reason.

# North West London has experienced a significant increase in recorded prevalence and demand for community services, and a decrease in inpatient admissions

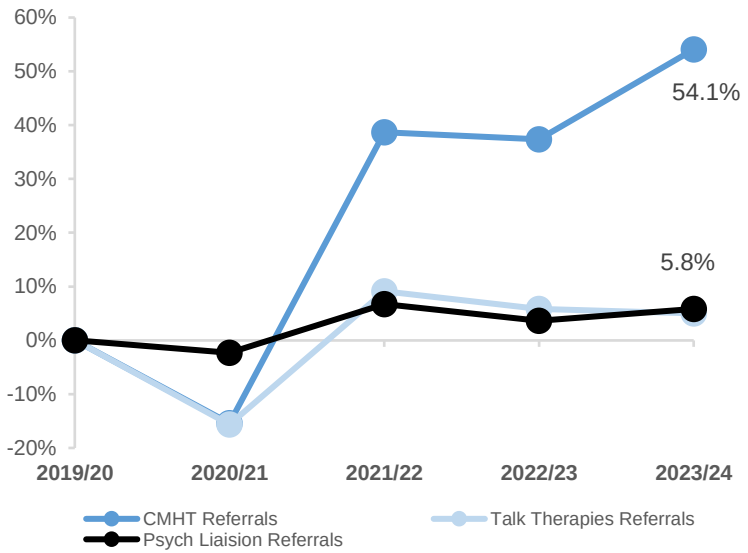
## **Need:** key trends

- The recorded **prevalence of depression** has increased **9.9%** over the past 4 years – roughly in line with our rate of antidepressant prescribing. This may reflect improved case finding, rising actual prevalence, or both
- The recorded prevalence of **severe mental illness** has remained approximately flat over the period.
- Whilst our **suicide rate** has decreased by **7%**, our suicide rate remains higher than the rest of London (see Appendix 1).



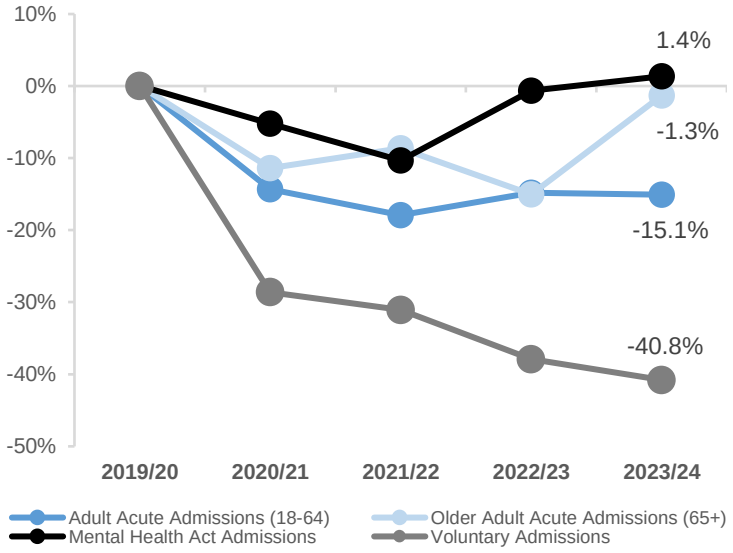

## **Community service demand:** key trends

- **CMHH / MINT** referrals have **significantly increased - 54%** over the period, supported by increased investment in MH community services.
- **Talking Therapy** referrals have increased by **6%** over the same period, though **true caseloads** have increased at a greater rate.
- **Psychiatry Liaison** referrals in our hospitals have also increased. This may reflect increased provision of liaison psychiatry, or unmet need to be addressed (i.e. through providing appropriate care to patients before they need to attend ED / hospital for a MH crisis).




## **Inpatient service demand:** key trends

- Reflecting our focus on improving access to community mental health services and providing care in the least restrictive setting appropriate, **voluntary admissions** have decreased significantly by **40%.**
- Admissions made under the **MH Act** have increased slightly over the past 2 years
- Overall acute admissions for **working age adults** have **reduced by 15%** over the past 4 years.
- Admissions for **older adults** have also decreased, though at a lower rate.




**Sources:** NHS Digital, QOF Data; ONS; NHS BSA, Medicines Used in Mental Health; CNWL and WLT EPRs.



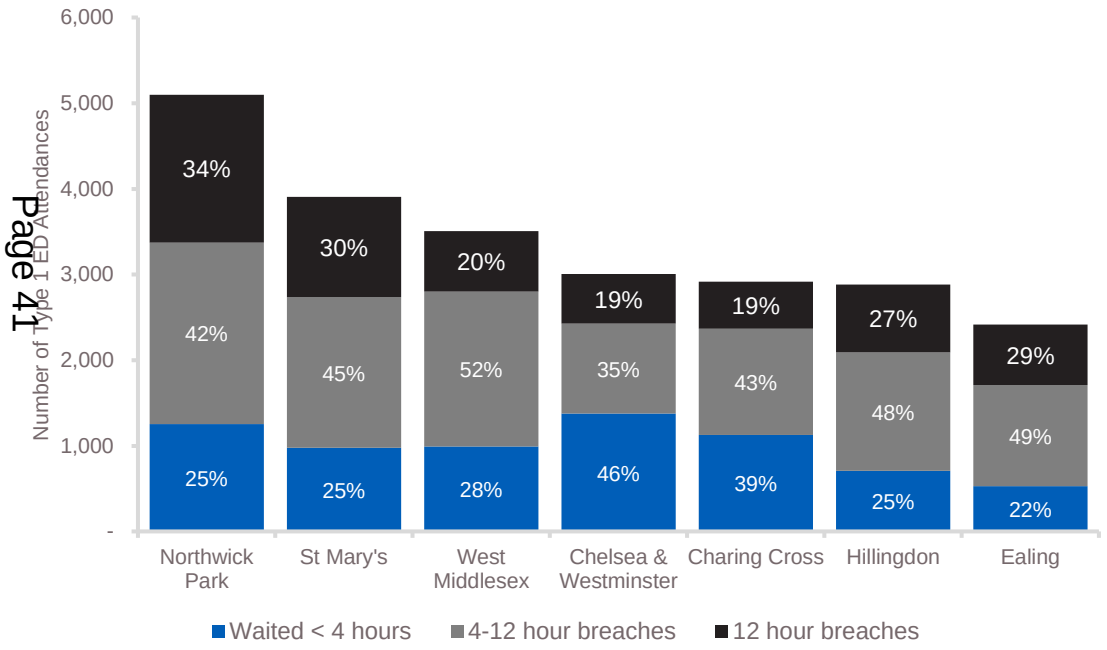


NHS North West London

# Residents attending A&E departments with a mental health diagnosis are twice as likely to wait more than 12 hours compared to those without such a diagnosis

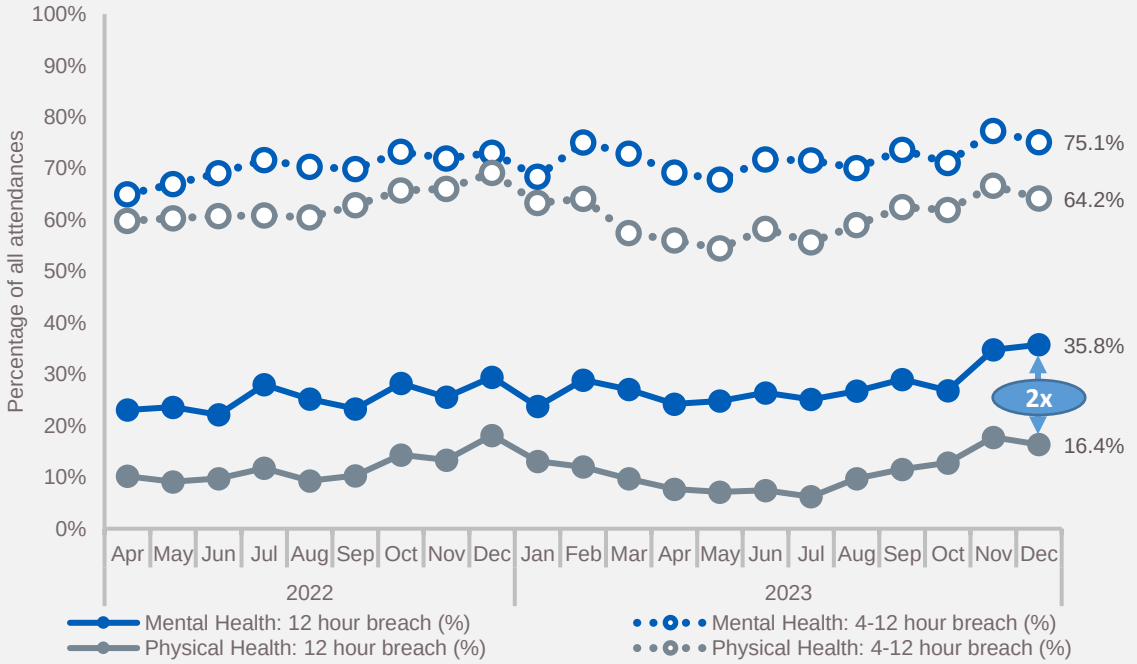
**Patients attending ED with a MH diagnosis**

Split by waiting time bracket [Jan – Dec 2023]




**Mental Health breaches compared to Physical Health breaches**

Split by 4-12 hour breaches and 12 hour breaches [Jan – Dec 2023]

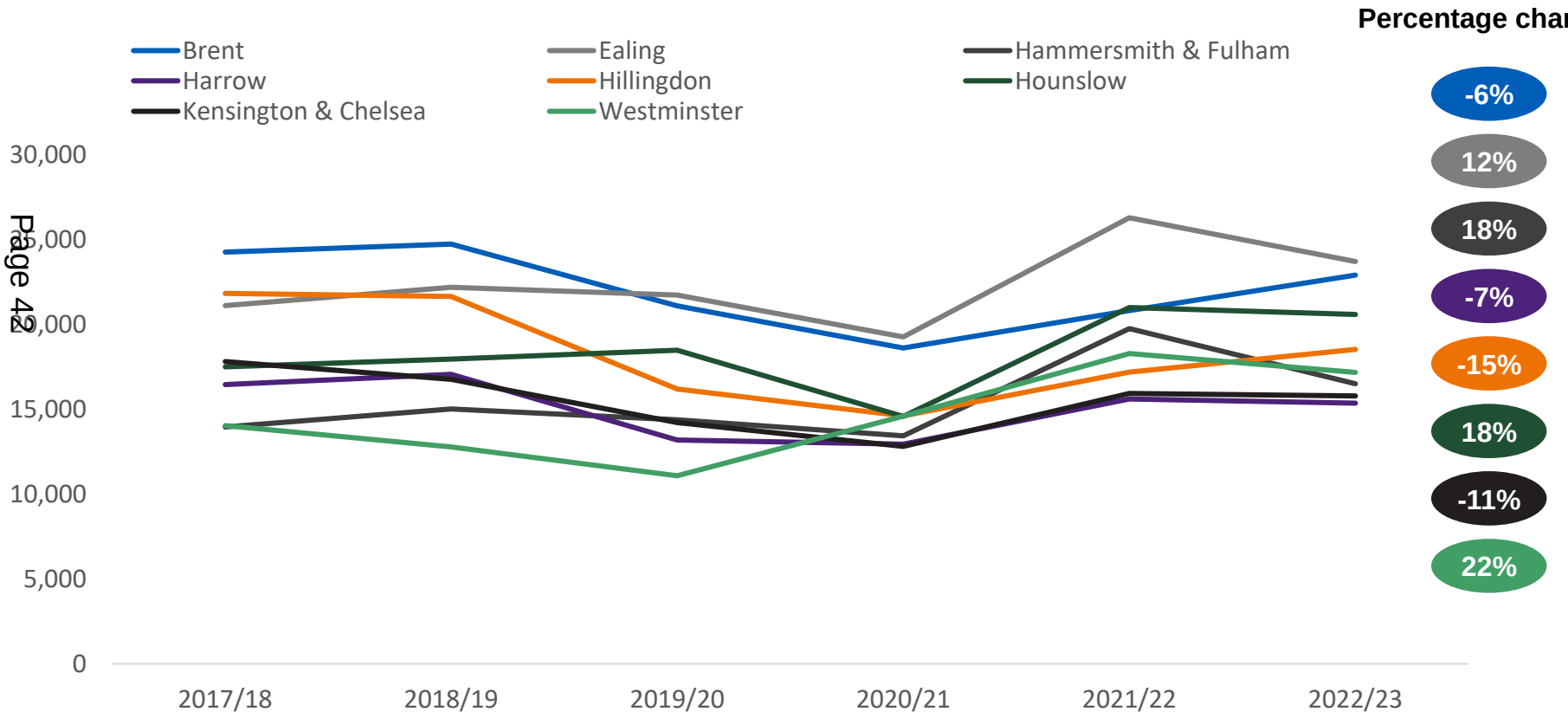



**Source:** NWL ECDS Data [Jan 2023 – Dec 31st 2023] used to quantify daily MH ED attendances using custom NWL logic (through use of primary and secondary diagnoses and other logic.
**Note:** ECDS data is currently part of a thorough data quality improvement programme.

# Total mental health referrals have increased by 2% across NWL between 2017/18 and 2022/23

**Mental Health referrals in NWL**

*MH referrals, 2017/18-2022/23*




- Whilst mental health admissions have decreased compared to pre-pandemic levels, the total referrals across NWL have increased by 2%.
- Referrals have increased by 22% in Westminster and 18% in Hammersmith & Fulham but have decreased by 15% in Hillingdon and 11 % in Kensington & Chelsea
- This increase in referrals is likely to be an impact of the pandemic
- However, the differing trend to total admissions suggests more service users are being cared for in the community





Source: CNWL activity data (provided by Real World Health), CF analysis

# Mixed, black and other ethnic populations have the highest rate of referrals in the catchment area per 1000 population, with females typically having higher rates

**Mental health referrals by ethnic groups by gender by borough per 1,000 population**

*MH referrals, 2022/23*

| | Brent | | Ealing | | Hammersmith and Fulham | | Harrow | | Hillingdon | | Hounslow | | Kensington and Chelsea | | Westminster | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| **Asian or Asian British** | 24 | 27 | 31 | 37 | 38 | 41 | 19 | 26 | 16 | 24 | 35 | 49 | 27 | 42 | 37 | 50 |
| **Black or Black British** | 45 | 62 | 41 | 46 | 62 | 71 | 47 | 74 | 41 | 58 | 45 | 57 | 85 | 123 | 72 | 83 |
| **Mixed** | 58 | 69 | 62 | 78 | 75 | 105 | 59 | 109 | 32 | 77 | 65 | 87 | 141 | 187 | 119 | 164 |
| **Other Ethnic Groups** | 73 | 121 | 43 | 73 | 48 | 85 | 56 | 101 | 49 | 89 | 43 | 82 | 61 | 114 | 50 | 89 |
| **White** | 51 | 58 | 54 | 60 | 84 | 103 | 44 | 60 | 33 | 52 | 68 | 81 | 90 | 97 | 68 | 66 |
| **Total** | 34 | 42 | 37 | 46 | 43 | 52 | 27 | 37 | 26 | 44 | 43 | 58 | 45 | 62 | 48 | 58 |



- The mixed ethnicity population in Kensington and Chelsea and Westminster have the highest rate of mental health referrals in NWL, with females having higher rates than males
- The Asian population has the lowest mental health referral rates across all ethnicities in NWL

Note this analysis excludes patients where ethnicity is not stated

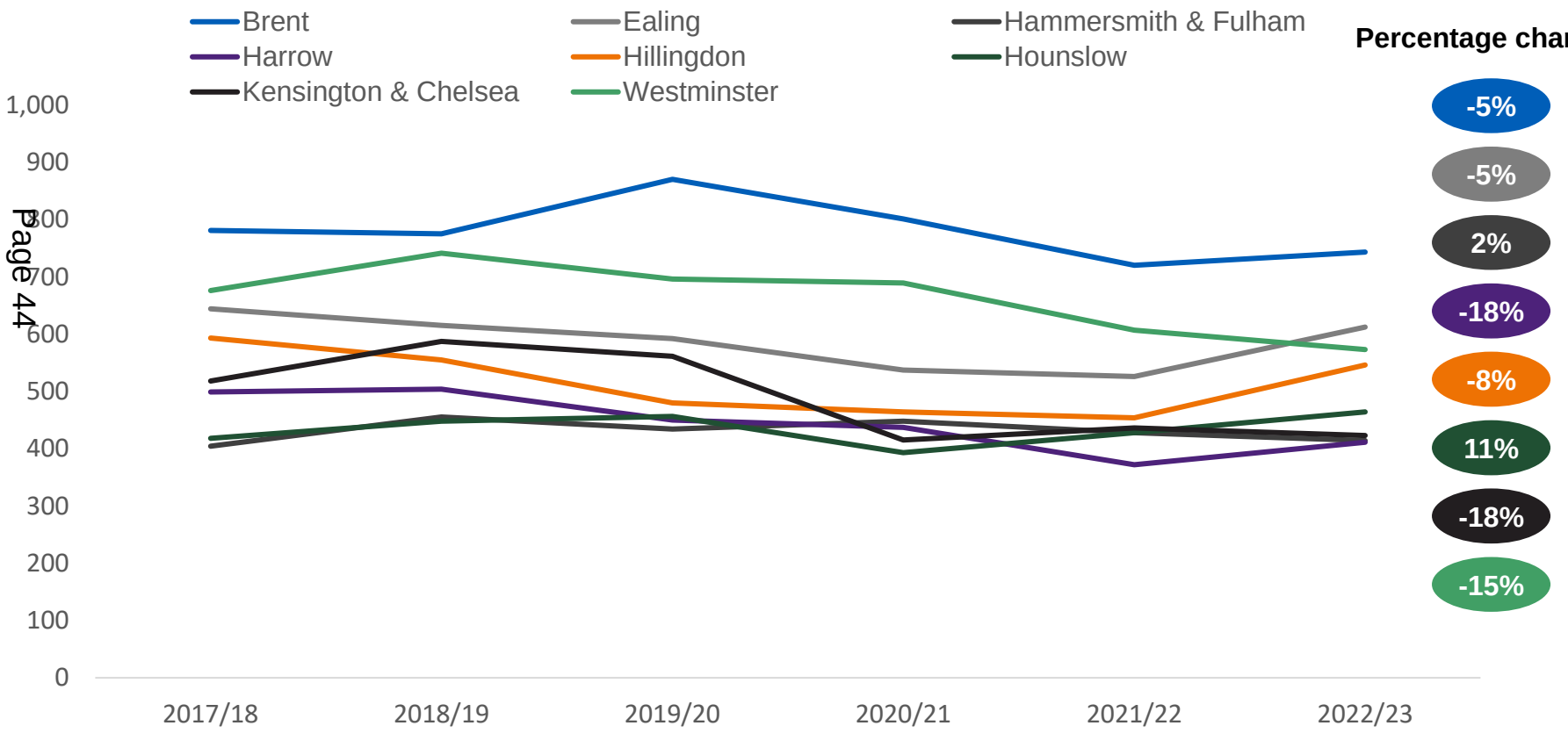


Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

# Total mental health admissions have declined by 7% compared to 2017/18 levels across the catchment population

**Mental Health admissions in NWL**

*MH admissions, all ages and ward types, 2017/18-2022/23*




**Percentage change**

-5%
-5%
2%
-18%
-8%
11%
-18%
-15%

- The mental health admissions for the general NWL population has declined by 7% since pre-pandemic levels
- The decline is most pronounced in Harrow and Kensington & Chelsea (-18%) in 2022/23 compared to 2017/2018
- Hounslow has seen the greatest increase in mental health admissions (11%)



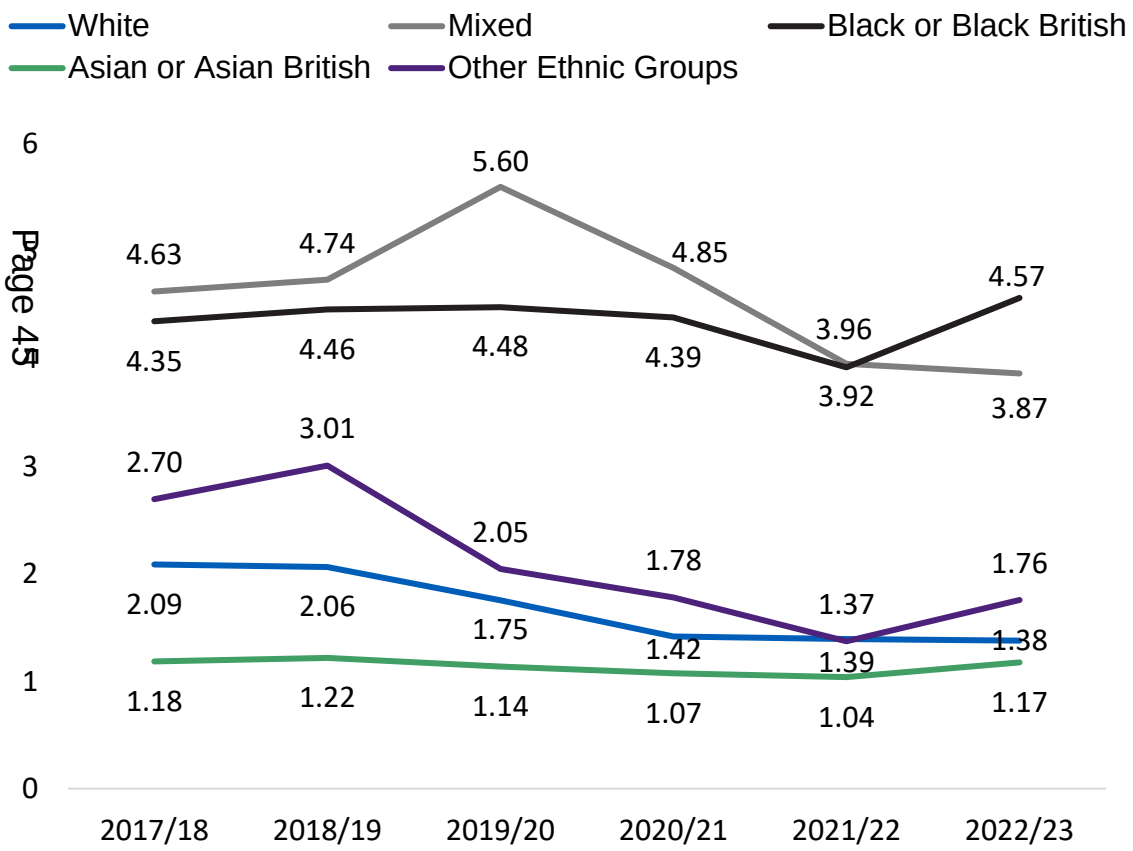


Source: CNWL activity data (provided by Real World Health), CF analysis

# The mixed and black ethnic groups have the highest proportion of admissions per 1,000 population; the white population had the proportion of highest total admissions

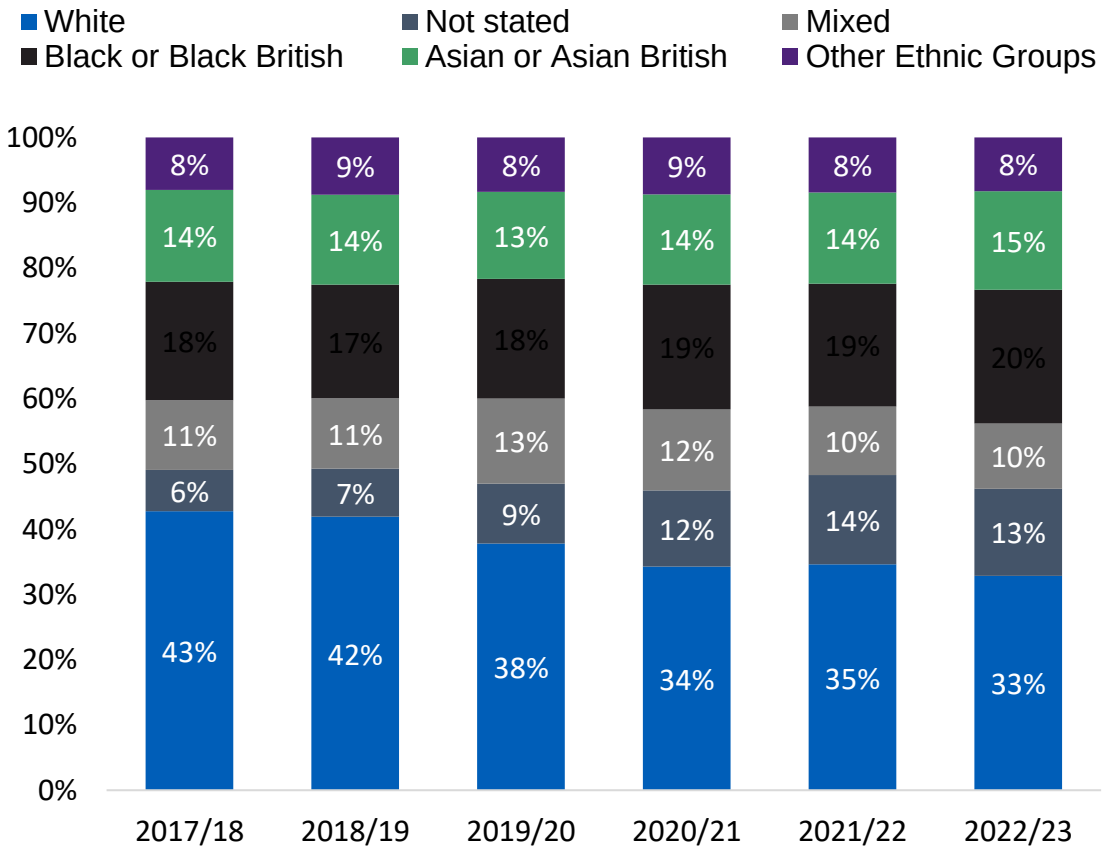
**Mental health admissions by ethnic groups per 1,000 population**

*MH admissions in NWL by ethnic group, 2017/18-2022/23*




**Proportion of mental health admissions by ethnic groups**

*Proportion of MH admissions by ethnic group, 2017/18-2022/23*






Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

# Mixed and black ethnicity populations have the highest rate of admission in NWL per 1000 population, with males typically having higher rates than females

**Mental health admissions by ethnic groups by gender by borough per 1,000 population**

*MH admissions, 2022/23*

| | Brent | | Ealing | | Hammersmith and Fulham | | Harrow | | Hillingdon | | Hounslow | | Kensington and Chelsea | | Westminster | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| Asian or Asian British | 1.4 | 0.5 | 1.5 | 1.2 | 1.7 | 1.6 | 0.8 | 0.8 | 1.3 | 0.7 | 1.7 | 1.2 | 1.5 | 0.9 | 1.9 | 1.9 |
| Black or Black British | 5.3 | 3.6 | 2.8 | 3.0 | 8.2 | 4.0 | 6.5 | 4.1 | 5.4 | 3.8 | 4.5 | 2.8 | 10.5 | 2.5 | 7.0 | 5.9 |
| Mixed | 4.6 | 1.7 | 3.6 | 1.9 | 4.0 | 4.3 | 3.1 | 4.4 | 1.7 | 3.3 | 1.5 | 1.5 | 6.6 | 8.2 | 6.8 | 7.2 |
| Other Ethnic Groups | 1.4 | 1.3 | 1.2 | 1.3 | 1.5 | 1.1 | 1.3 | 1.0 | 1.6 | 1.5 | 1.4 | 1.3 | 1.4 | 1.5 | 1.0 | 0.7 |
| White | 2.6 | 2.4 | 1.3 | 1.1 | 2.5 | 1.3 | 1.7 | 2.0 | 1.9 | 1.8 | 2.6 | 1.9 | 4.4 | 2.6 | 3.0 | 2.0 |
| Total | 2.3 | 1.6 | 1.6 | 1.5 | 2.5 | 1.7 | 1.5 | 1.3 | 1.8 | 1.4 | 1.8 | 1.4 | 2.8 | 2.0 | 2.8 | 2.3 |

- The black male population living in Kensington and Chelsea have the highest rate of mental health admission in NWL, with 10.5 admissions per 1,000 population
- This rate is significantly higher than that of the black female population living in the same area (2.5 admissions per 1,000 population)

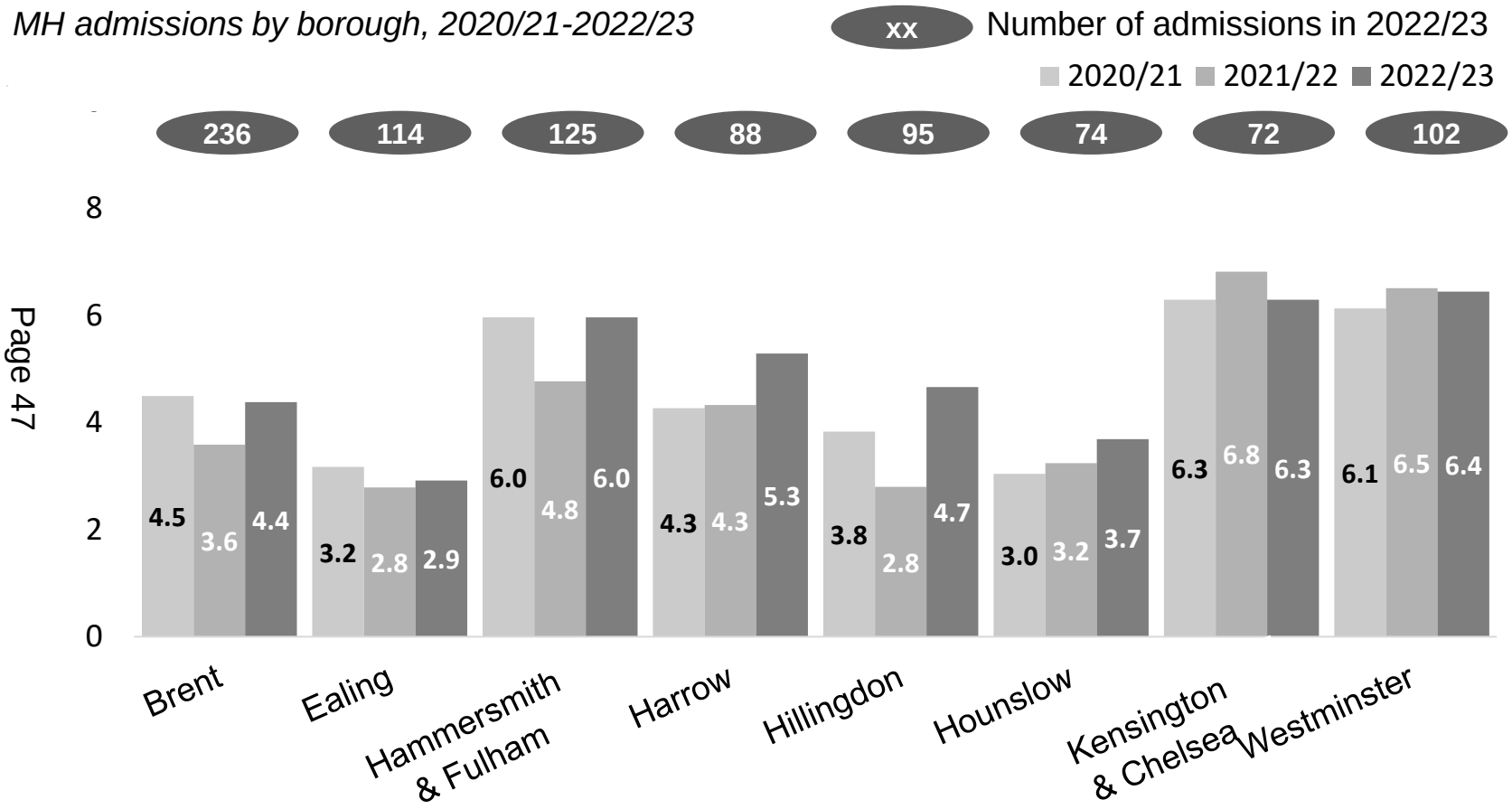
Note this analysis excludes patients where ethnicity is not stated



Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

# The mental health admission rate within the Black population in Westminster was 2.2 times higher than that of Ealing in 2022/23

**Mental health admissions per 1,000 population with Black ethnicity**

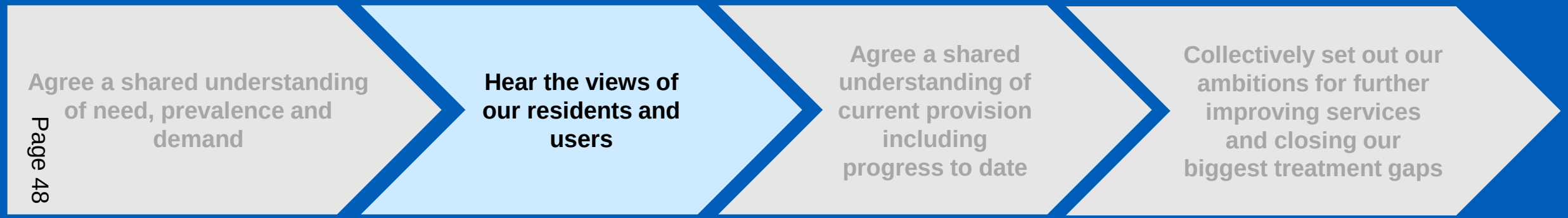



**Note:** Admissions where the ethnicity was unknown have been excluded

- There is variation in the trend of mental health admission rates in NWL boroughs within the Black population, with half of NWL boroughs seeing an increase in rates since 2020/21
- The admission rate within the Black population in Westminster was 2.2 times higher than that of Ealing in 2022/23
- Kensington & Chelsea and Westminster had the highest admission rates within the Black population in 2022/23
- Brent had the highest absolute number of mental health admissions within the Black population in 2022/23



Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis


Agree a shared understanding of need, prevalence and demand
Hear the views of our residents and users
Agree a shared understanding of current provision including progress to date
Collectively set out our ambitions for further improving services and closing our biggest treatment gaps

# Insights from our local residents: Key themes

The heart of our engagement process involved eight pivotal sessions that took place in various locations across each of the eight boroughs. These sessions held from late August to early October, brought together a diverse range of residents and service users to share their experiences. Two online sessions (lunchtime and evening) open to all residents also took place.

These sessions were pivotal in opening a dialogue with our communities as individuals and families to help us understand the positive aspects of services as well as challenges they face in accessing and experiencing mental health services.

A number of **key themes** were highlighted through the engagement sessions.



- **Access**
- **Community mental health offers**
- **Waiting times**
- **System integration**
- **Approach of services**
- **Awareness of services**

# Insights from our local residents: What we heard

**Access**

*"They offer good touchpoints throughout the week and help build people's networks."*

*"A need for more accessible mental health support for inpatients in hospitals and post-hospitalisation community support."*

*"More contacts throughout the week would be good. Hestia and other charity organisations are stepping in where people have nowhere else to turn to."*

**Community mental health offers**

**Waiting times**

*"The IAPT programme is generally effective but requires additional resources."*

*"The wait to see a psychologist or for someone to see a therapist or for talking therapies is way too long. By the point they end up seeing someone, they are now much worse off than when they first ever saw a GP"*

*"Concerns about long waiting lists for assessments, especially when patients are at their breaking points.*

**System integration**

*"There is no accountability. It's passed from one person to another, and I am the one who has to deal with it all."*

*"Need for a social systems approach"*

*"Empowerment, mutual respect, kindness, solidarity, care, and love as essential for improving health and well-being"*

**Approach of services**

*"Wish services were better advertised because there are people that need it that don't know about it."*

*"Suggestions to utilise platforms like TikTok for mental health education, specifically highlighting the need for awareness regarding women's hormones and mental health."*

**Awareness of services**

*"Include community organisations in trauma-informed care"*

# Insights from our local residents: Recommendations

There were several core recommendations arising from the themes gathered through our engagement to support the development of the mental health strategy.

### 1) Improve access and reduce waiting times

- Develop strategies to improve access and significantly reduce waiting times for mental health services.
- Support ‘waiting well’, with clear communication on the stages of the mental health pathway and provision.

### 2) Improve community outreach, connection and communication

- Increase in awareness campaigns about the community mental health support services that are available.
- Promote services through accessible channels such as local libraries, social media, community partners and influencers, to reach diverse audiences.
- Simplify the process for seeking help and connecting to services, particularly at points of transition.

### 3) Foster community resilience

- Provide training for grass roots community organisations and families in how individuals and families can support themselves.
- Support these groups with resources and facilities for effective advocacy and support.

### 4) Prioritise cultural competence

- Ensure cultural competence and awareness in mental health services to serve diverse populations.
- Provide training for healthcare professionals on cultural backgrounds, religion, and inequalities, to enhance patient care.

### 5) Focus on the impact of the wider determinants of health

- Recognise the strong link between housing and employment challenges and mental health problems.
- Invest in housing support programs to alleviate overcrowding and other housing related crises.
- Consider the wider determinants of health’s impact upon residents’ mental health.

### 6) Strengthen a trauma-informed workforce

- Expand the adoption of trauma-informed care and ensure that the voluntary community sector workforce is trained in these approaches.
- Foster collaboration between mental health services and community organisations to provide comprehensive support.




NHS
North West London

# We have focused our work on the following service areas

| | |
|---|---|
| 1 **Adults** in North West London | • Prevention of mental health problems and promoting wellbeing – understanding local plans in place to promote wellbeing and support early intervention to prevent the need for greater intervention |
| 2 Adults with **common** mental health disorders | • Access to Talking Therapies for Anxiety and Depression – understanding current need as well as unmet need against referrals to identify how capacity can address waiting lists and enable reliable recovery and improvement.<br>• Community Care – highlighting the opportunities through Integrated Network Teams. |
| 3 Adults with **severe mental illness (SMI)** | • Community Care – Outlining the need for greater consistency and productivity improvements to ensure services can meet the needs and demand of adults and older adults with serious mental illness.<br>• Early Intervention in Psychosis – services have expanded and there is sufficient capacity to provide early intervention within two weeks however more could be done to optimise service delivery. |
| 4 Adults with **higher acuity** mental health needs | • Care for people in crisis – expansion of community services has enabled a local alternative offer to A&E and admission however more needs to be done to tackle long waits in A&E.<br>• Inpatient care for adults and older adults – modelling demonstrates that demand growth for inpatient services can be addressed through several transformation opportunities |

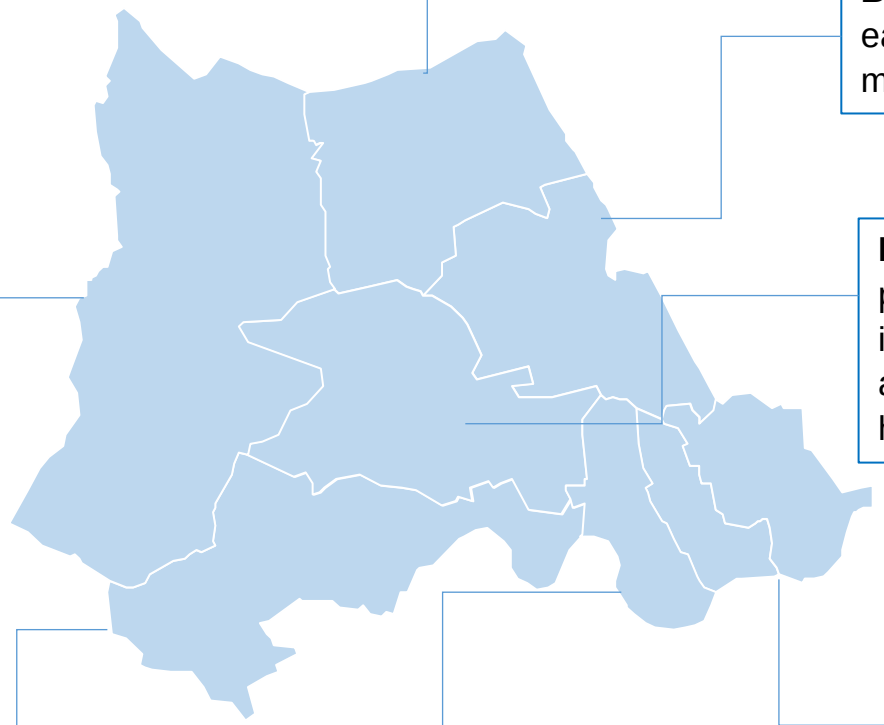
# Prevention of mental health problems

# A review of local Joint Strategic Needs Assessments and local priorities highlights commitment to preventing mental ill health and promoting wellbeing

**Harrow:** Reducing health inequalities through **embedding CORE20Plus5** focus and increasing community capacity for action and strengthening our preventative approach

**Hillingdon: Proactive care and mental health** with a particular focus on the health needs in the south of the borough

**Hounslow: Reduce health inequalities** in the population so that fewer residents miss life opportunities due to avoidable long-term health conditions. Achieved through prevention and early detection of illness to reduce people developing long term conditions.



**Brent:** Increasing access to mental health support earlier for communities and reducing variation in mental health care for the local Brent communities

**Ealing: Prevention and Wellbeing** for the whole population: including reducing stigma and social isolation; identifying mental health needs earlier; addressing the links between physical and mental health; suicide prevention.

**Bi-borough: Prevention and early intervention,** evidence suggests an increase in demand for mental health services. Focusing on prevention as well as early intervention, also addressing the increasing demand by service planning for the future.

**Hammersmith & Fulham: Effective prevention planning** with focus on socio-economic determinants and environmental surroundings as part of the broad range of factors which affect resident's mental health.

North West London Integrated Care System

NHS North West London

# Several actions are already in place to support the prevention of mental illness, however we recognise that there is still more work to be done

**1 Adults in North West London**

**2 Adults with common mental health disorders**

- In the context of this strategy, prevention is defined holistically as **primary, secondary and tertiary prevention*** - recognising that different prevention measures are required for different types of residents and mental health patients.
- Though this MH strategy is focused on adults, we know that evidence suggests that **prevention of mental illness needs to at an early age** – 50% of all mental illnesses present before children turn 14, and 75% present before the age of 24 (WHO[1]). This will need to be addressed in detail in the next phase of this work (refreshing our children and young people's mental health strategy).
- We know the recorded prevalence of **common mental health disorders** is increasing, so as a system we need to better understand the **wider determinants of mental health** (i.e. housing, education, finance, relationships etc.) and develop **joint interventions** (working with our local authority partners and VCSE organisations) to address these issues before a person's mental health deteriorates and requires a formal diagnosis.
- This could include interventions such as **relationship counselling**, **housing interventions**, **financial advice, employment support** and **workplace wellbeing support.** NWL-reported data shows **significant room for improvement for assessments completed**: employment (33% of patients with employment assessments completed); finance status (32% completed); accommodation (9% completed); carer status (32% completed)[2].
- The difficulty of implementing this should not be underestimated and will require **proactive approaches to intervention** and **population health approaches** to managing the overall mental health of our residents. **Primary care has a significant role** in delivering some of these interventions and helping residents navigate the system – however we should recognise the impact of this on a sector that continues to be under significant pressure.
- This will also require ensuring our relevant patient-facing staff across the system have **appropriate training** to support people's mental health.

**3 Adults with severe mental illness (SMI)**

- The **prevalence of SMI is relatively stable** in NWL, and so prevention for this cohort will focus on **preventing the deterioration** of these patients' **overall health.** For example, we know that people with SMI are **3-4 times more likely** to die **before the age of 75** than people without SMI.
- The NHS Long Term Plan outlined the importance of annual physical healthchecks for patients with SMI, and in the most recent published data (for the 12 months preceding March 2024), NWL had a **80% completion rate** for **full physical health checks**, which is higher than the England average and London average. However, there is still room for improvement in this area.
- In addition, we also need to **tackle smoking, alcohol and substance misuse** in this cohort – with only 39%, 3% and 2% of patients with smoking, alcohol and substance misuse (respectively) receiving relevant interventions. Improving in this area will close multi-disciplinary working and coordinated treatment plans.

**4 Adults with higher acuity mental health needs**

- We have invested significantly to help **prevent the deterioration** of patients with higher acuity mental health needs, for example, investing heavily 24/7 community crisis and home treatment teams and **crisis alternative services** (such as our mental health crisis assessment service – MHCAS, our Coves and our Safe Spaces).
- These services were put in place (in part) to prevent unnecessary A&E attendances (that can often result in MH patients waiting over 24 hours for a transfer to another service) and provide a more suitable safe space for patients in crisis.
- Ultimately, these crisis alternatives should prevent further deterioration of these patients and prevent suicide attempts. However, further work is required to understand the **effectiveness** of these crisis alternatives, with a **full evaluation** underway.

***Primary prevention:** preventing illness from developing in the first place; **secondary prevention:** detecting and treating illness at an early stage; **tertiary prevention:** managing illness to slow or stop its progression and limit the extent to which the illness is disabling. **Sources:** 1 - Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, Kessler et al.; 2 – NWL whole systems integrated care dashboard (WSIC)

# Access to Talking Therapies for Anxiety and Depression

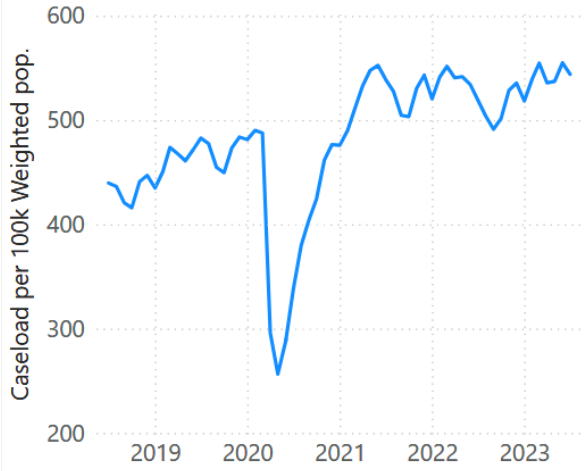
# While North West London meets access targets for Talking Therapies, waits for first contacts indicate significant unmet need

- The proportion of the adult (18+) population in-treatment at any one time has increased and now stands at c.544 per 100k weighted population (+24% on 5yrs ago). We define 'In-treatment' as those service users with at least one contact in the past 60 days*
- About one fifth of the caseload are waiting for first contact, an indicator of unmet demand. For Brent, about two fifths of the caseload are waiting for first contact
- Overall, access (using discharged service users as a proxy) is about 20% higher than the 23/24 access target, with only Ealing falling short (by 4%)



**IAPT In-Treatment Caseload per 100k Weighted Population, Per Month**

*01/07/2018 - 30/06/2023*




**Talking Therapies Treatment Met & Unmet Need**

*Latest 12-Months (01/07/2022 - 30/06/2023)*

| Service | Av. Caseload | Av. In-Treatment Caseload | Av. Waiting List (Caseload Waiting for First Contact) | Discharged in the 12-Month Period | 2023/24 Access Goal | Difference | 18+ Pop. | Discharged as a % of 18+ Pop. |
|---|---|---|---|---|---|---|---|---|
| IAPT - Brent | 3,008 | 1,656 | 1,034 | 11,610 | 9,422 | 2,188 | 236,907 | 5% |
| IAPT - Ealing | 2,637 | 1,990 | 307 | 9,597 | 9,987 | -390 | 243,031 | 4% |
| IAPT - H&F | 2,113 | 1,480 | 471 | 8,416 | 6,861 | 1,555 | 139,004 | 6% |
| IAPT - Harr | 1,223 | 995 | 117 | 7,654 | 5,980 | 1,674 | 181,646 | 4% |
| IAPT - Hill | 1,900 | 1,592 | 153 | 9,125 | 7,072 | 2,053 | 221,491 | 4% |
| IAPT - Hounslow | 2,068 | 1,417 | 518 | 9,199 | 6,812 | 2,387 | 194,848 | 5% |
| IAPT - K&C | 1,843 | 1,320 | 310 | 9,717 | 8,740 | 977 | 120,664 | 8% |
| IAPT - Westm | 2,439 | 1,471 | 483 | 8,525 | 7,158 | 1,367 | 210,025 | 4% |
| **Total** | **17,221** | **11,919** | **3,391** | **73,843** | **62,032** | **11,811** | **1,547,616** | **5%** |

* This reduces caseload across North West London by 31% on average (low 16% (Hillingdon) to high 45% (Brent)

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

# Modelling demonstrates that we can service our Talking Therapies waiting lists and address some unmet need by FY29

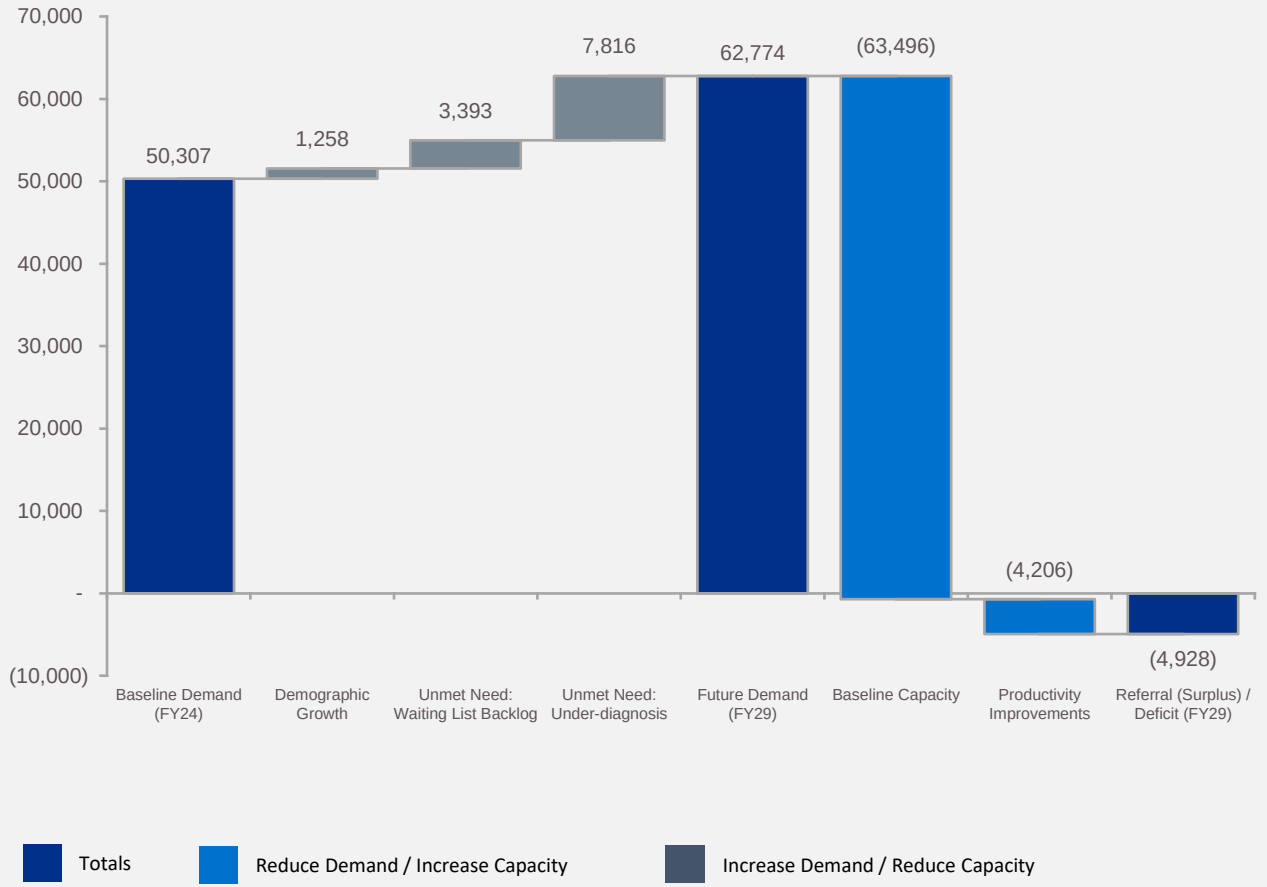
## Talking Therapies Referrals:

- The modelling demonstrates that in **FY29, NWL's** referral surplus / deficit could range from a **deficit of 7k referrals** to a **surplus of 8k referrals**, depending primarily on the level of unmet need in the system that we can service, and the productivity improvements that we can unlock.
- The **'central case' scenario** (which is the most realistic of the three scenarios) concludes that we have plenty of capacity to service a significant level of unmet need.
- Ongoing work will continue to refine inputs and assumptions.



| Scenarios | Worst | Central | Best |
|---|---|---|---|
| **Current Demand** [FY24 outturn] | **50k** | **50k** | **50k** |
| Demographic Growth | 1k | 1k | 1k |
| Unmet Need: Waiting List Backlog | 3k | 3k | 3k |
| Unmet Need: Under-diagnosis | 15k | 8k | 9k |
| **Future Demand** [FY29 'Do Nothing'] | **71k** | **63k** | **60k** |
| Current Capacity [FY24] | (63k) | (63k) | (63k) |
| Productivity Improvements | - | (4k) | 4k |
| **Referral (Surplus) / Deficit** [FY29 'Do Something'] | **7k** | **(5k)** | **(8k)** |

## Talking Therapies Referrals: 'Central' Case Modelling Scenario




**Sources:** CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

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# Work is underway to increase access to talking therapies – only 1.11% of people estimated to have anxiety or depression receive talking therapies, with variation across North West London

.
North West London has continued to improve access to talking therapies for those with common mental health problems, such as anxiety and depression. Whilst capacity has expanded rapidly in recent years, people's access to care remains relatively low compared with prevalence and nationally, the attrition rate of 45% between one and two contacts.

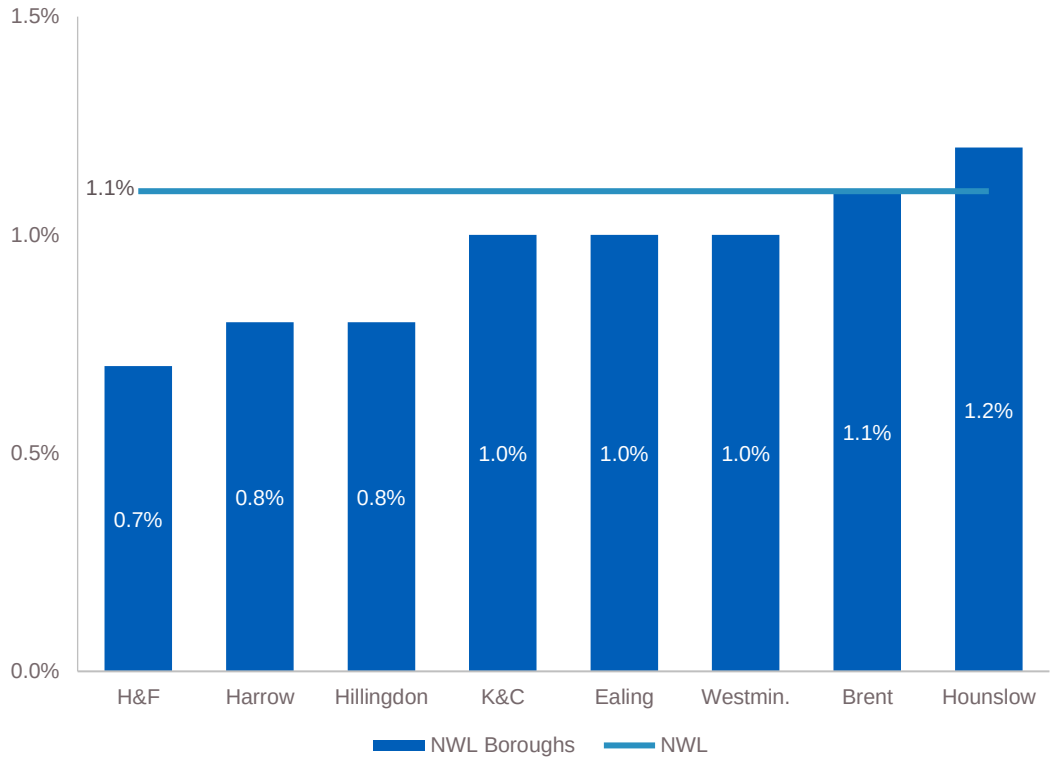
- We will reach more people by flexing the approach e.g. accessibility, group work, particularly tailoring the service to differing local communities and ensuring that the workforce is reflective of the local population.

- We must also expand our reach through other organisations, sectors and industries, to further develop the broader health, social and economic improvements of NW London.

- We will ensure closer alignment with community mental health and primary care to reduce the attrition so that more people to get to the right service first time, enabling reliable recovery and improvement.

**Access to Talking Therapies:** People entering Talking Therapies as a percentage of those estimated to have anxiety / depression

**Source:** NWL local data, August 2023



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# Community care

# Community Mental Health Care in North West London is now more focused on treatment and recovery

- Community mental health is increasingly joined up with primary care and community assets and will become part of the services on offer through our Integrated Neighbourhood Teams, which are central to development community based models of care.

- This enables people to receive more holistic, person centered care based on individual need – joining up physical health, social and mental health interventions closer to their homes that address underlying issues and problem.



## 10 principles for Community Mental Health Transformation

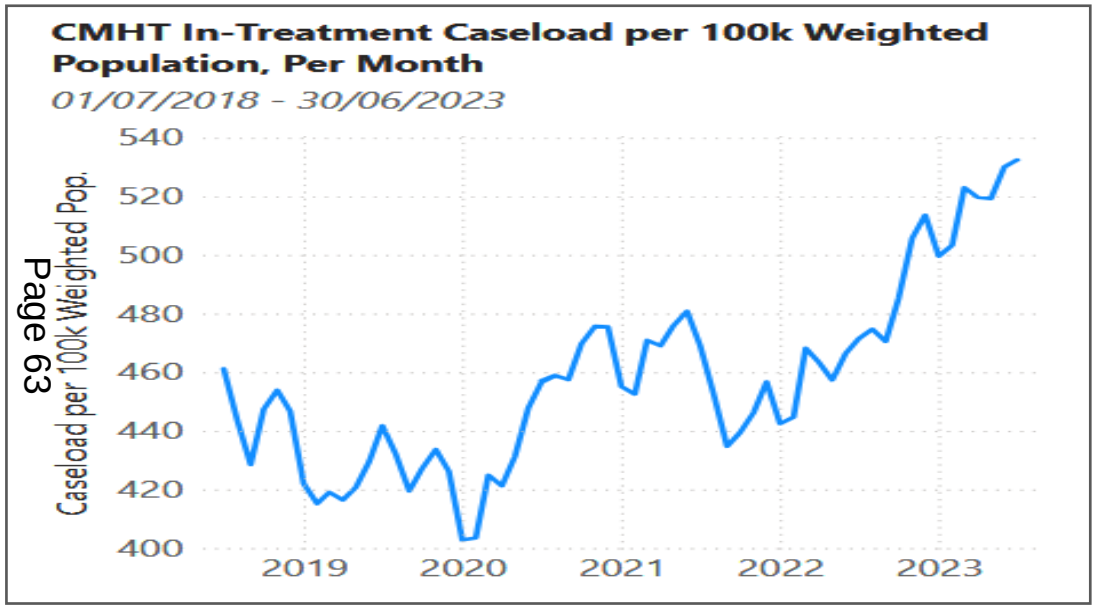
1. A local delivery model. All resource will be **'place based'** positioned in the Hubs and MINT Locality Teams.
2. There will be a 24/7 **referral route.**
3. Community Hubs and MINT Locality Teams **aligned to Primary Care Networks** (PCNs) with shared care protocols and records where necessary.
4. Regular Community Hub/MINT Locality Team and PCN **catch ups.**
5. Less focus on caseloads and more on responsive and **timely easy to access** support offers, including a therapeutic menu and **voluntary sector led provision**.
6. Daily **senior triage meetings**.
7. **DIALOG+** to be used to inform every assessment with a stepped care model reducing repeat assessments and multiple referrals.
8. Every person to have a named worker with **individualised care**.
9. Delivery of intervention based care meeting clinical and social needs which make use of existing **community assets and individual strengths**, not generic care coordination.
10. Every member of staff dedicated to **empowering their service user** to maintain good physical health and working to enhance mental health equalities.

**Opportunities for community mental health in INTs:**

- Information sharing between mental health services, primary care teams, community services and VCSE providers.
- Strong promotion of good mental health and wellbeing with a focus on the most at-risk populations.
- Consider the role of INTs in the commissioning of VCSE led mental health services in the community.
- Making the right connections with housing services, to prevent homelessness and address need arising from housing issues.
- Address a holisitic approach to care through addressing physical and mental health needs through integrated complex care.

# Capacity in community mental health teams has expanded to enable greater access

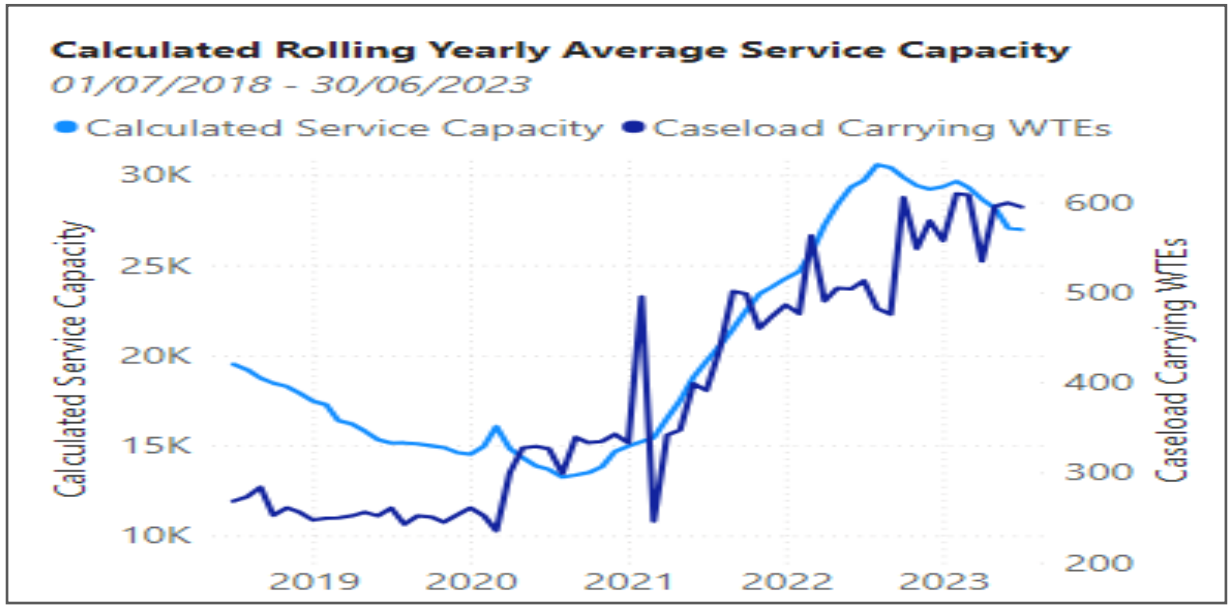
**The proportion of adults 18+ [1] in community mental health treatment at any one time has increased by ~16% on 5 years ago**




In-treatment caseload is determined by excluding service users on caseload without at least one contact in the past 60 days; this reduces the caseload by -50%. This varies greatly between CMHH (-36%) & MINT (-65%[2]).

CMHH/MINT teams will have services users on their caseloads that do not require high contact intensity, e.g. a 6 monthly medication review. Of 11,219 excluded service users 4,569 were waiting for first contact, a measure of unmet need

**Caseload carrying WTEs has increased by ~150% – we have calculated what this should mean for our capacity**




We have calculated service capacity as the number of cases a team appear to be able to complete in a year. This is a function of the clinical workforce size, each team's average caseload per clinician and average case length (at discharge) – see details on next page

Capacity has generally moved in line with the caseload carrying WTE increase in recent years

*(1) AWA and OA services are merged for comparison as the cut off age differs between CNWL and WLT*
*(2) WLT's MINT teams operate across two EPR systems, which does affect contact capture completeness*

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

# There is variation in access to community teams between boroughs, while just under one third of service users are awaiting first contact

- Service users with 2+ contacts is lower than planned access with Westminster as the exception in surpassing its access goal.
- Further work has taken place to understand workforce differences between teams to inform service improvements and productivity.

**CMHT Treatment Met & Unmet Need**

*Latest 12-Months (01/07/2022 - 30/06/2023)*

| Service | Av. Caseload | Av. In-Treatment Caseload | Av. Waiting List (Caseload Waiting for First Contact) | SUs With At Least 2 Contacts in the 12-Month Period | 2023/24 Access Goal | Difference | 18+ Pop. | Discharged as a % of 18+ Pop. |
|---|---|---|---|---|---|---|---|---|
| CMHT - Brent | 2,503 | 1,770 | 476 | 3,506 | 4,235 | -729 | 236,907 | 1.48% |
| CMHT - Harr | 2,182 | 1,342 | 460 | 2,635 | 2,842 | -207 | 181,646 | 1.45% |
| CMHT - Hill | 2,562 | 1,349 | 519 | 2,469 | 3,581 | -1112 | 221,491 | 1.11% |
| CMHT - K&C | 1,700 | 1,217 | 252 | 2,388 | 2,767 | -379 | 120,664 | 1.98% |
| CMHT - Westm | 2,621 | 1,736 | 403 | 3,390 | 2,370 | 1020 | 210,025 | 1.61% |
| MINT - Ealing | 4,313 | 1,710 | 933 | 3,419 | 4,751 | -1332 | 243,031 | 1.41% |
| MINT - H&F | 3,178 | 1,053 | 739 | 2,034 | 2,525 | -491 | 139,004 | 1.46% |
| MINT - Hounslow | 3,668 | 1,185 | 787 | 2,766 | 3,361 | -595 | 194,848 | 1.42% |
| **Total** | **22,565** | **11,346** | **4,569** | **22,607** | **26,433** | **-3826** | **1,547,616** | **1.46%** |

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

*(1) AWA and OA services are merged for comparison as the cut off age differs between CNWL and WLT*
*(2) WLT's MINT teams operate across two EPR systems, which does affect contact capture completeness*



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# Unless significantly higher productivity improvements can be made in community mental health teams, there could be a significant capacity gap in FY29

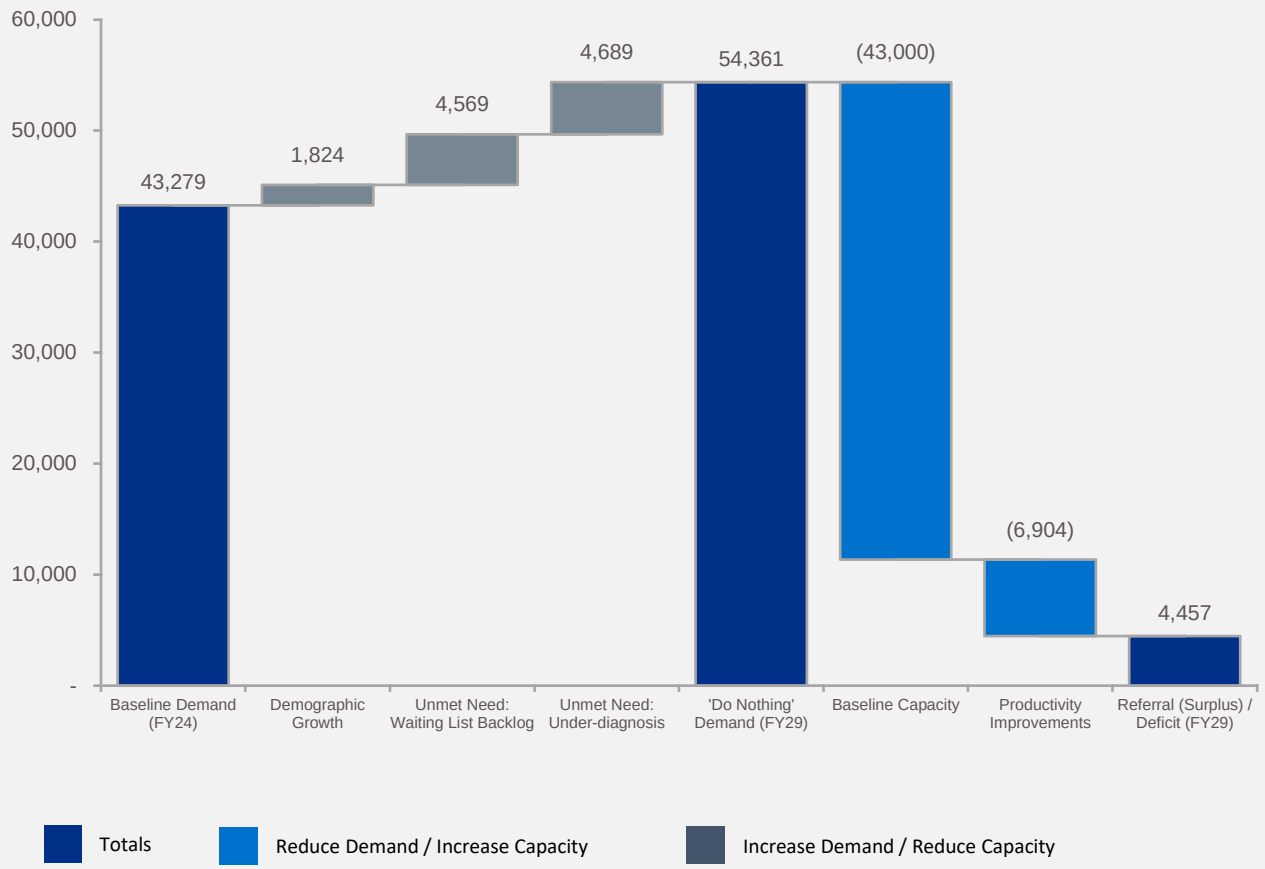
## CMHH / MINT Referrals:

- The modelling demonstrates that in **FY29, NWL's** referral surplus / deficit could range from a **deficit of 12k referrals** to a **deficit of 3k referrals** depending primarily on the level of unmet need in the system that we can service, and the productivity improvements that we can unlock.
- The **'central case' scenario** (which is the most realistic of the three scenarios) concludes that we need to make higher productivity improvements to meet the currently estimated level of unmet need in the system.
- Work continues to refine inputs and assumptions, particularly around the existing CMHH / MINT capacity.

| Scenarios | Worst | Central | Best |
|---|---|---|---|
| **Current Demand** [FY24 outturn] | **43k** | **43k** | **43k** |
| Demographic Growth | 2k | 2k | 1k |
| Unmet Need: Waiting List Backlog | 5k | 5k | 5k |
| Unmet Need: Under-diagnosis | 5k | 5k | 4k |
| **Future Demand** [FY29 'Do Nothing'] | **55k** | **54k** | **53k** |
| Current Capacity Estimate* [FY24] | (43k) | (43k) | (43k) |
| Productivity Improvements | - | (7k) | (7k) |
| **Referral (Surplus) / Deficit** [FY29 'Do Something'] | **12k** | **5k** | **3k** |

**CMHH –** Community Mental Health Hubs (CNWL)
**MINT –** Mental Health Integrated Network Teams (WLT)
***NOTE:** Further work is required to refine this capacity estimate.
**Sources:** CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

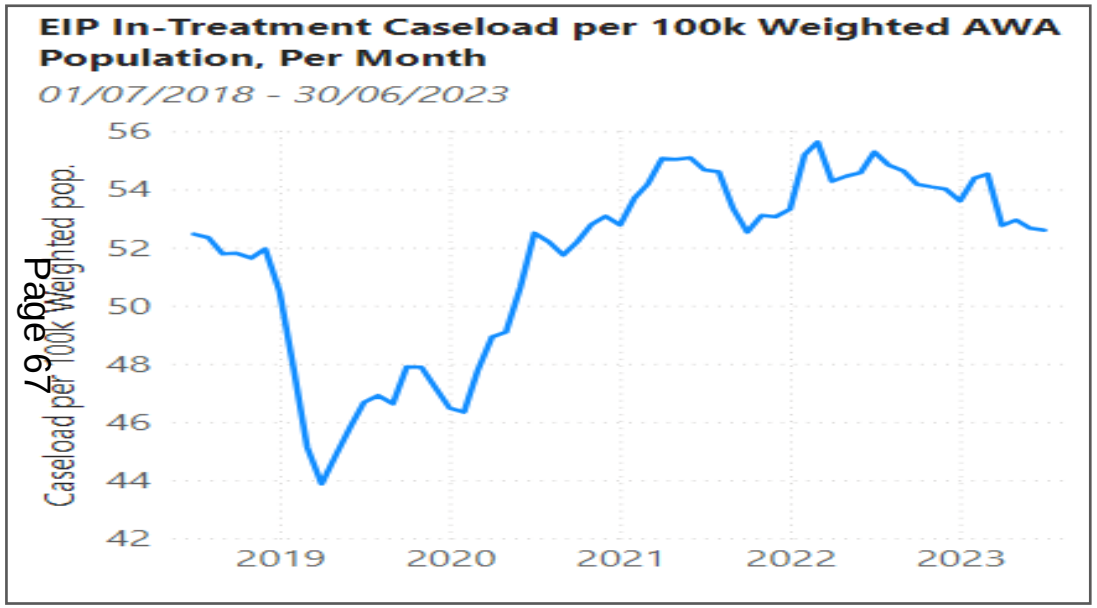
## CMHH / MINT Referrals: 'Central' Case Modelling Scenario



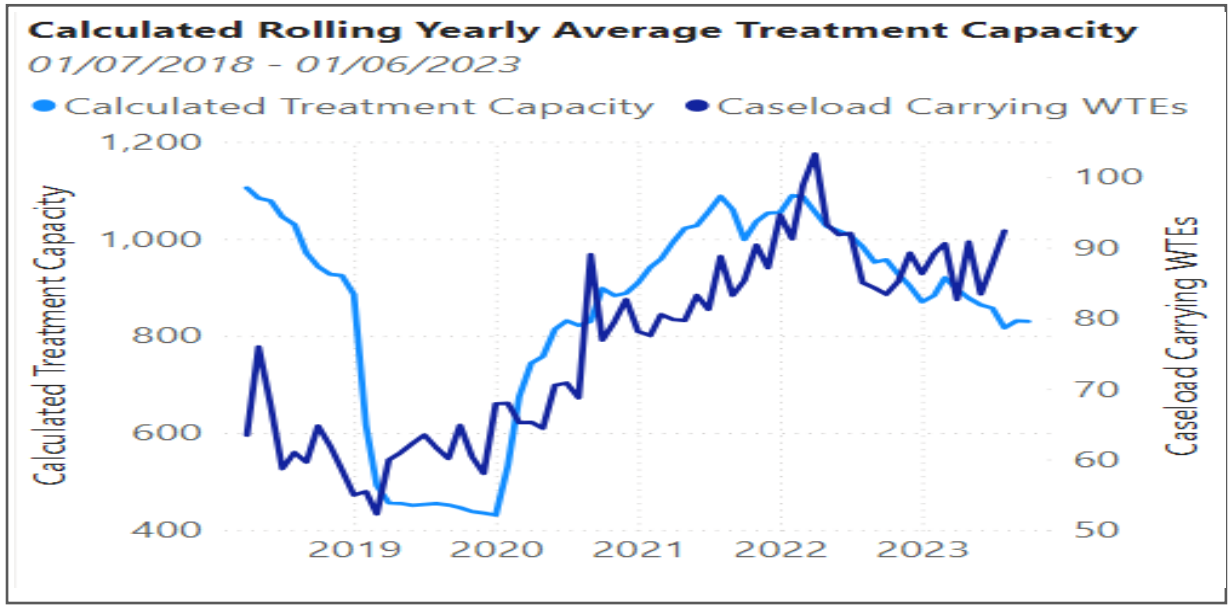
# Early Intervention in Psychosis

# Capacity in early intervention services has expanded to enable greater access

**The proportion of the adult working age (AWA) population in-treatment for EIP is largely back to pre-Covid levels**




**Caseload carrying WTEs for EIP has increased by ~30%**




In-treatment has been determined by excluding Service Users (SUs) on caseload without at least one contact in the past 60 days, EIP will have a cohort at any one time not engaged with the service

Very few SUs are waiting for first contact, our first indicator of unmet demand.



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Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.



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Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

# North West London appears to have sufficient capacity to support early intervention in psychosis

- We have calculated treatment capacity as the no. of cases a team appear to be able to complete in a year. This is a function of the clinical workforce size, each team's average caseload per clinician & average case length (at discharge).
- Capacity has generally moved in line with the caseload carrying WTE increase in recent years. The pandemic did reduce capacity by elongating case length. Case length increase is also the prime driver of capacity decline since Feb-22. This is not, however, necessarily a concern if EIP is adhering to its evidence-based model of intense support for up to 3 years. However, only WLT EIP services seem to be adopting 3 year model when we review team discharge profiles.
- Brent and Hammersmith & Fulham place lower caseload demands on staff, which reduces treatment capacity.



**Calculated Service Treatment Capacity and Estimated Service Deficit**

*Latest 12-Months (01/07/2022 - 30/06/2023)*

| Service | Caseload Carrying WTEs (A) | In-Treatment Caseload per Caseload Carrying WTE (B) | Av. Case Length (C) | Annual Treatment Capacity (A*B*365)/C | Treatment Capacity per 100k Weighted AWA Pop. | Treatment Capacity Deficit per 100k Weighted AWA Pop. | Treatment Capacity per 100k AWA Pop. | Treatment Capacity Deficit per 100k AWA Pop. |
|---|---|---|---|---|---|---|---|---|
| Early Intervention - Brent | 16 | 9 | 459 | 117 | 39 | | 59 | |
| Early Intervention - Hill /Harr | 15 | 13 | 390 | 178 | 60 | | 54 | |
| Early Intervention - KCW | 17 | 12 | 495 | 156 | 33 | | 56 | |
| EIP - Ealing | 15 | 14 | 404 | 195 | 51 | | 96 | |
| EIP - H&F | 10 | 10 | 400 | 93 | 39 | | 77 | |
| EIP - Hounslow | 13 | 14 | 414 | 157 | 65 | | 95 | |
| **Total** | **87** | **12** | **429** | **886** | **46** | | **68** | |

Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.

Sources: Activity Data – EPR System Feeds; WTEs – NWL Trial Balance Data; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1



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# Optimising the delivery model would increase capacity by 24%

- If we look at the efficacy of services as measured by step down success (a recovery pathway) and avoidance of A&E crisis presentations. Then replicating Ealing's results would appear to raise standards, it currently has a high step-down success rate of 81% and a crisis presentation rate lower than most at 2%.
- If we, for illustration purposes, align all services to Ealing's operating model metrics then the treatment capacity would increase by 213 (24%) across North West London per the table below.

**Optimising Treatment Capacity**

*Latest 12-Months (01/07/2023 - 30/06/2023)*

| Service | Caseload Carrying WTEs | In-Treatment Caseload per Caseload Carrying WTE | Av. Case Length | Annual Treatment Capacity | Annual Optimised Treatment Capacity | Optimised Capacity Per 100k Weighted AWA Pop. | Optimised Treatment Capacity Deficit Per 100k Weighted AWA Pop. | Optimised Capacity Per 100k AWA Pop. | Optimised Treatment Capacity Deficit Per 100k AWA Pop. |
|---|---|---|---|---|---|---|---|---|---|
| Early Intervention - Brent | 16 | 9 | 459 | 117 | 200 | 66 | | 100 | |
| Early Intervention - Hill | 15 | 13 | 390 | 178 | 191 | 65 | | 58 | |
| Early Intervention - KCW | 17 | 12 | 495 | 156 | 219 | 47 | | 79 | |
| EIP - Ealing | 15 | 14 | 404 | 195 | 195 | 51 | | 96 | |
| EIP - H&F | 10 | 10 | 400 | 93 | 128 | 54 | | 106 | |
| EIP - Hounslow | 13 | 14 | 414 | 157 | 165 | 68 | | 100 | |
| **Total** | **87** | **12** | **429** | **886** | **1099** | **57** | | **85** | |

Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1



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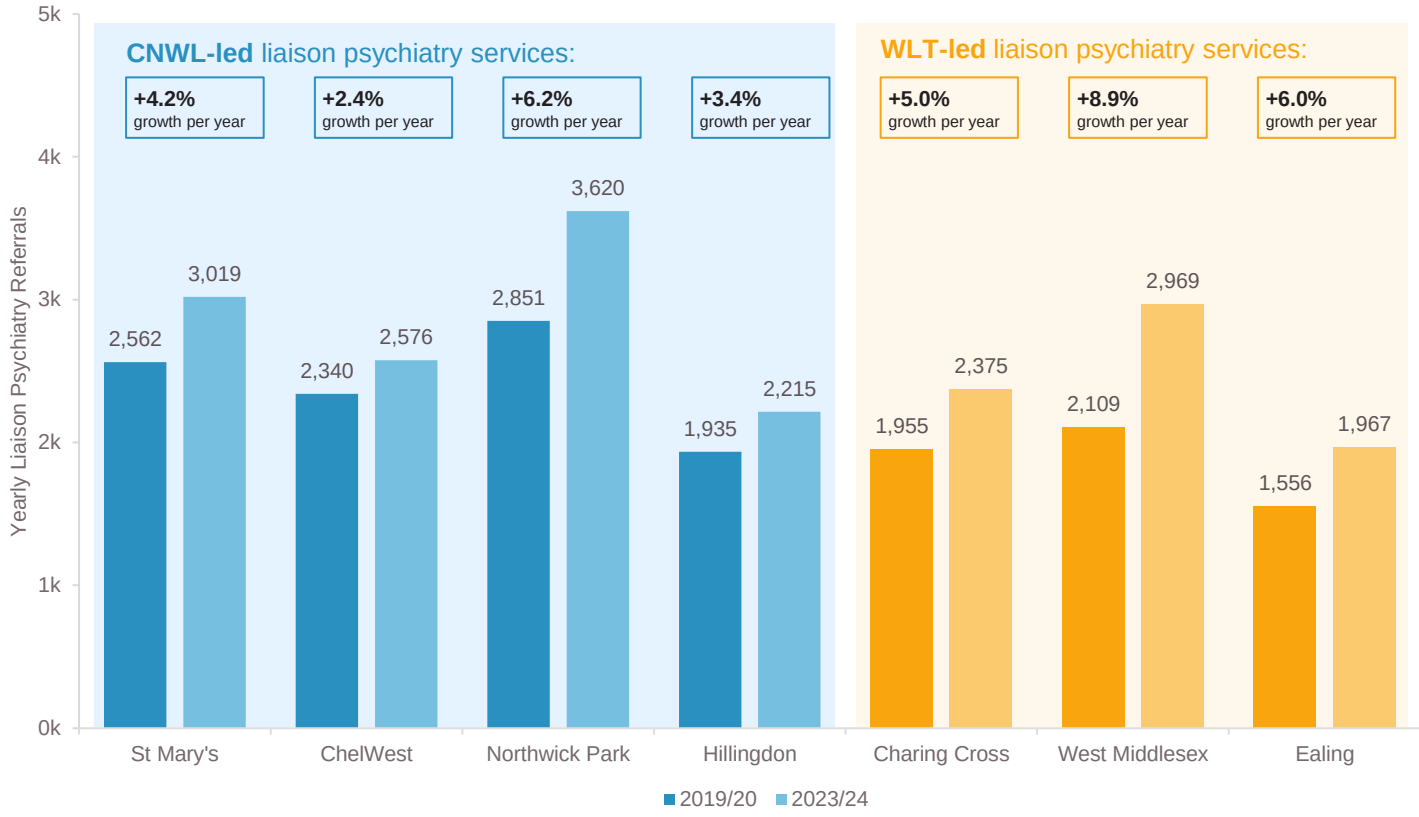
# Care for people in crisis

# Demand for mental health crises in A&E departments has also grown significantly over the last 5 years – at 5.2% per year

- There are now **51 patients** attending NWL A&E departments **every day** for a mental health crisis – this is up 25% from 2019/20 (41 patients per day), equivalent to 5.2% growth per year.
- This figure is derived purely from A&E referrals to liaison psychiatry teams. There are likely to be even more patients who are attending A&E departments for a physical health condition, but also have an underlying mental health condition.
- As shown previously, the **recorded prevalence** of depression and SMI has grown by **6.6% per year**, and therefore liaison psychiatry demand tracks broadly in line with overall mental health prevalence – as expected.
- **25% of overall liaison psychiatry demand** is associated with patients **registered outside of NWL**, foreign nationals, or patients with unknown GP registration status. This varies significantly by site – **40%** of patients attending **Chelsea & Westminster Hospital** for a mental health crisis are considered to be non-NWL patients.
- Growth in mental health demand in Type 1 A&E departments is significantly higher than physical health demand (**1.6% per year**).



**Growth in liaison psychiatry referrals by A&E department:** 2019/20 – 2023/24 [4 years]




**Source:** CNWL and WLT internal liaison psychiatry referral data, Type 1 A&E departments only (2019/20 – 2023/24)

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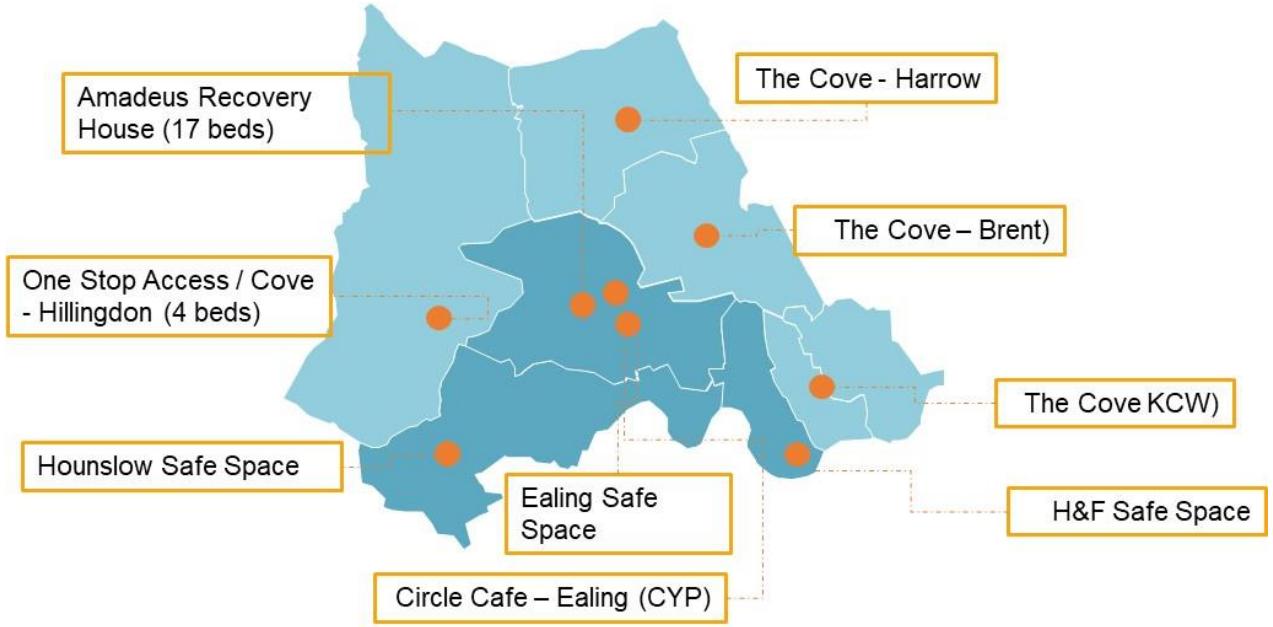
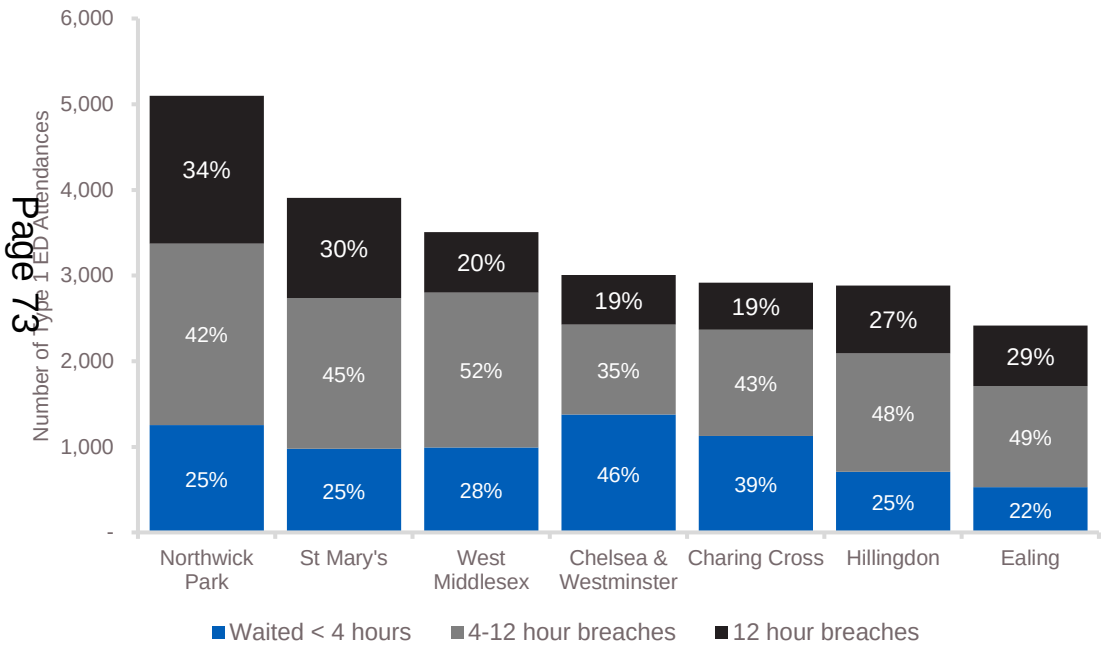
# Mental Health Crisis Care has continued the shift to community based models of care and investing in alternatives to admission

- For those experience mental health crisis, our aim is, and always will be, to ensure that we provide the highest quality, compassionate, trauma-informed and most appropriate mental health care for people who need it across our boroughs.
- Mental health crisis care has significantly expanded with 24/7 community teams, a range of crisis alternatives to A&E and inpatient care available across the ICS. The expansion of liaison psychiatry teams means that every A&E department in NW London has a team in place that meets Core 24 standards.
- There is a growing need to further promote and improve professional and public knowledge of alternative crisis services to better direct people to the most appropriate service and prevent the need for A&E attendances and admission. Added to this, we continue to improve the existing 24/7 open access urgent mental health helplines.

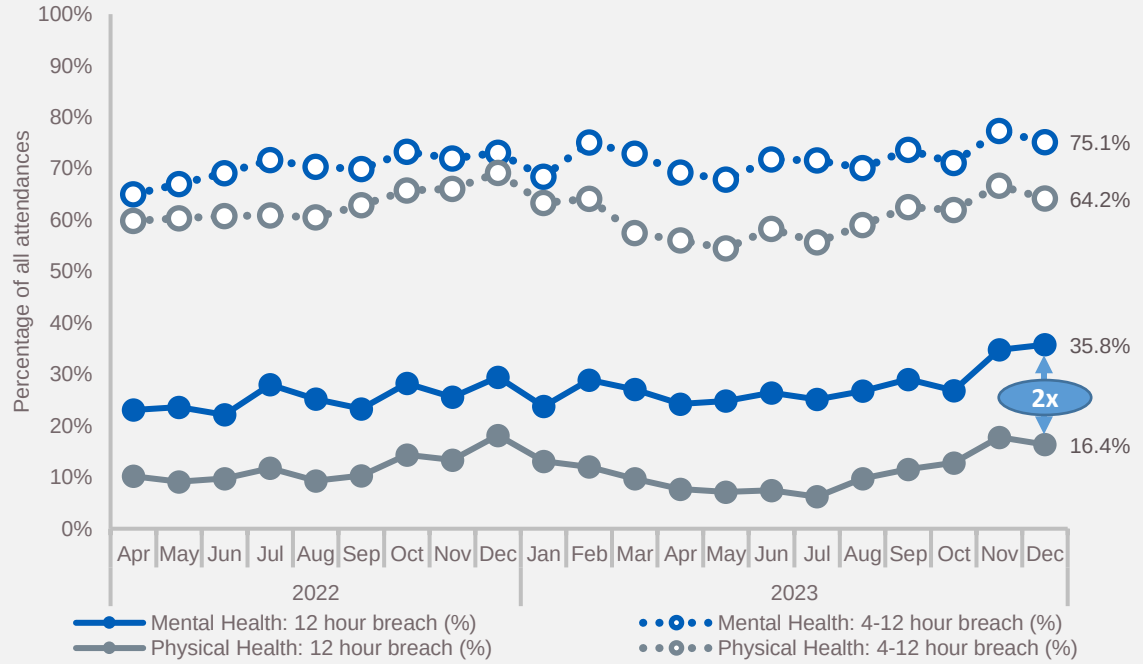


# Residents attending A&E departments with a mental health diagnosis are twice as likely to wait more than 12 hours compared to those without such a diagnosis

**Patients attending ED with a MH diagnosis**
Split by waiting time bracket [Jan – Dec 2023]




**Mental Health breaches compared to Physical Health breaches**
Split by 4-12 hour breaches and 12 hour breaches [Jan – Dec 2023]

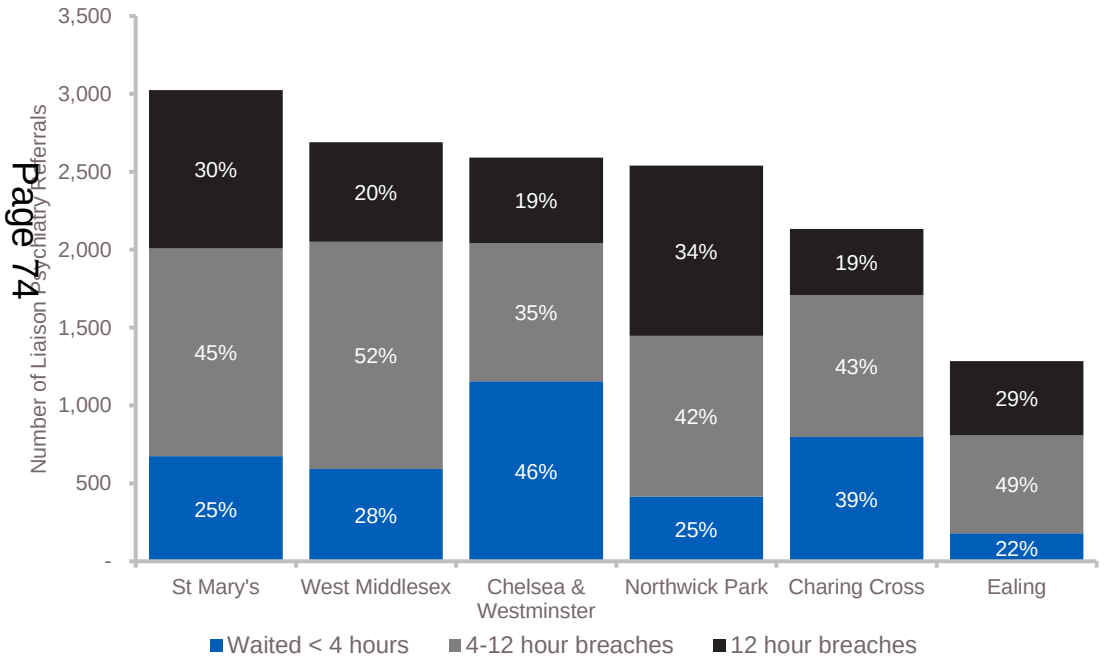



**Source:** NWL ECDS Data [Jan 2023 – Dec 31st 2023] used to quantify daily MH ED attendances using custom NWL logic (through use of primary and secondary diagnoses and other logic.
**Note:** ECDS data is currently part of a thorough data quality improvement programme.

# Patients being referred to Liaison Psychiatry wait on average 8-12 hours in ED, with those breaching 12 hours spending c. 24 hrs in ED

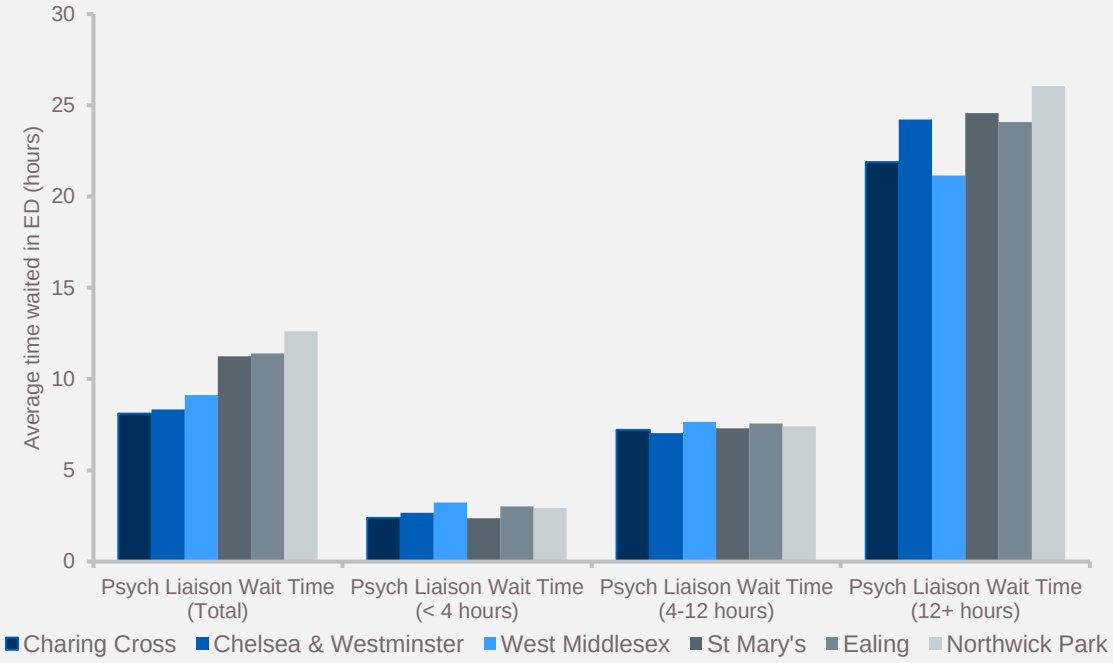
## Patients referred to Liaison Psychiatry

Split by waiting time bracket [Jan – Dec 2023]




## Waiting times for patients referred to Liaison Psychiatry

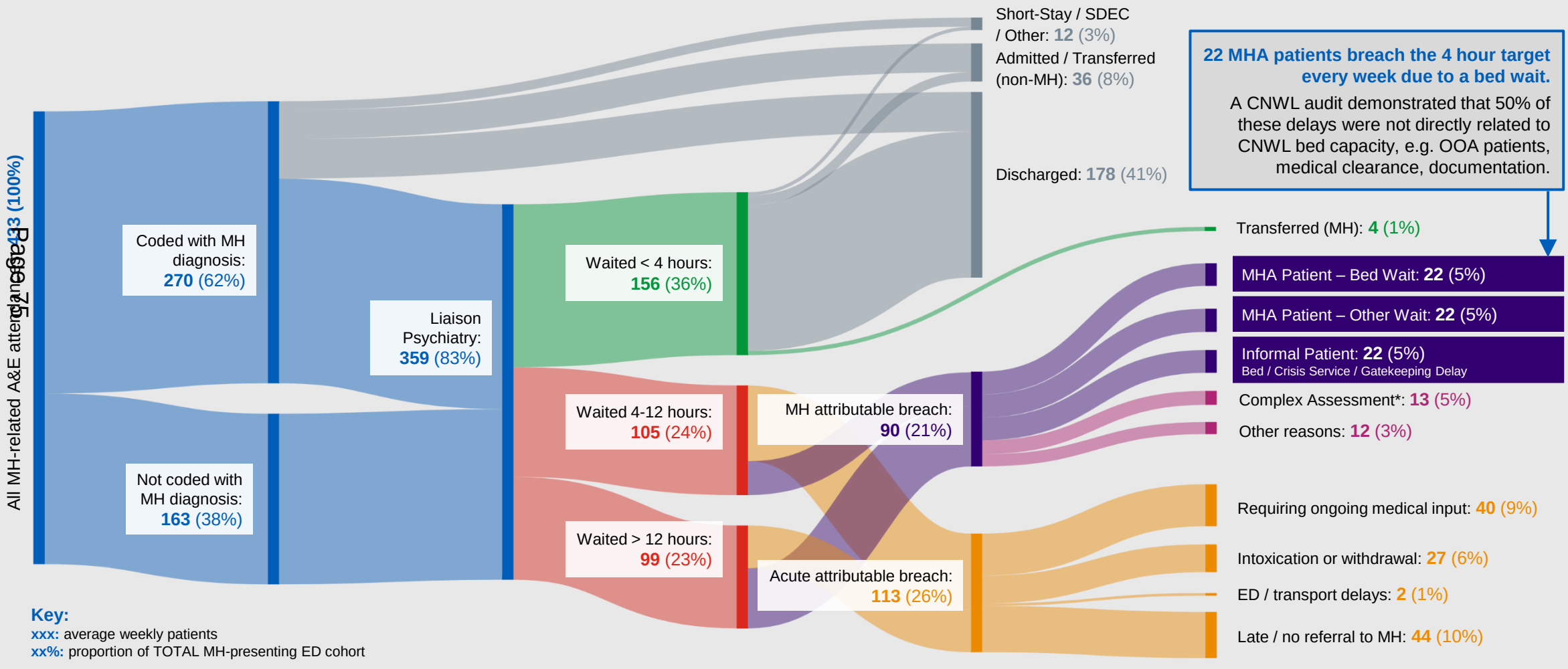
Split by waiting time bracket [Jan – Dec 2023]




**Source:** NWL ECDS Data [Jan 2023 – Dec 31st 2023] filtered by patients referred to Liaison Psychiatry.
**Note:** ECDS data is currently part of a thorough data quality improvement programme.

# On average, over 98 mental health patients are required to wait over 12 hours in our A&E departments every week with 22 waiting over 4 hours due to a lack of mental health beds

- **433** patients attend our A&E departments every week with an urgent mental health need.
- **359** of these patients are referred to our Liaison Psychiatry teams, with **156** of these patients waiting less than 4 hrs, **105** patients waiting between 4 and 12 hrs, and **99** patients waiting over 12 hrs.

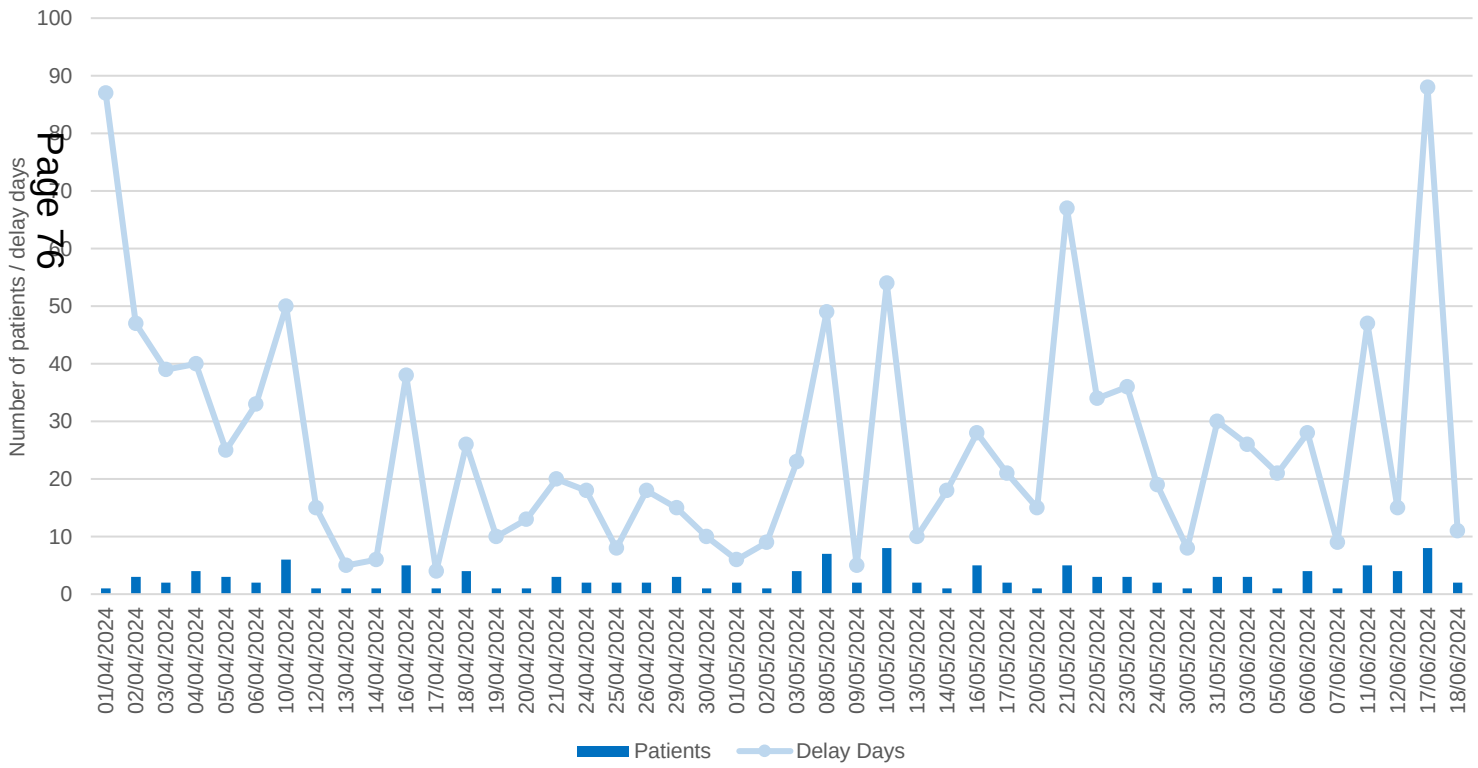



**Sources:** ***NWL ECDS Data (June 1st 2023 – May 31st 2024)*** used to quantify daily MH ED attendances and Liaison Psychiatry referrals using national logic. Breach reasons analysis derived from ***manual reporting collated by CNWL (June 5th 2023 – June 4th 2024)***. Note: ECDS data is currently part of a thorough data quality improvement programme. Where available, manual reporting takes precedence in quantifying total liaison psychiatry referrals, 4-12hr breaches and 12hr breaches.
*Complex assessments include items such as multiple reviews, interpreters required, appropriate adult required, medical queries, etc.

# Across all NWL acute hospital wards, 129 patients were identified with discharge delays attributed to transfer to a mental health bed

**Number of mental health patients admitted to an acute ward (physical health and the number of delay days**

Snapshot [01 Apr- 18 Jun 2024]

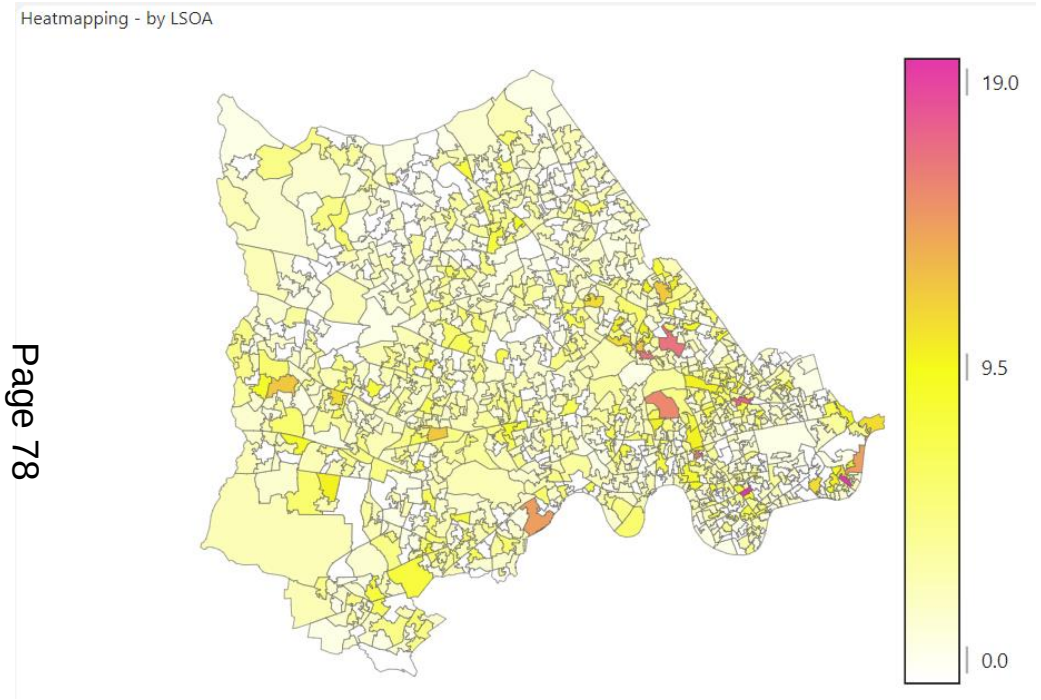



- A snapshot (01 April 2024 to 18 June 2024) of mental health patients in acute physical health beds awaiting admission to a mental health bed highlights that 129 discharge delays were attributed to waits for mental health beds.
- Approximately 26 patients (20%) were from a borough outside NW London but these were not generally the patients waiting the longest.
- Overall, the 129 patients were delayed for **1,204** days overall, which equates to approximately **15 beds** of **acute hospital capacity per day** over that period (0.5% of NWL's acute bed base).
- Each patient was delayed for an average of **9.3 days.**
- **Further work** is being completed to understand how many of these patients still required some level of acute care (e.g. intravenous fluids) that cannot be provided in acute mental health wards.

**Source:** NWL PM scorecard, 01 April 2024 to 18 June 2024

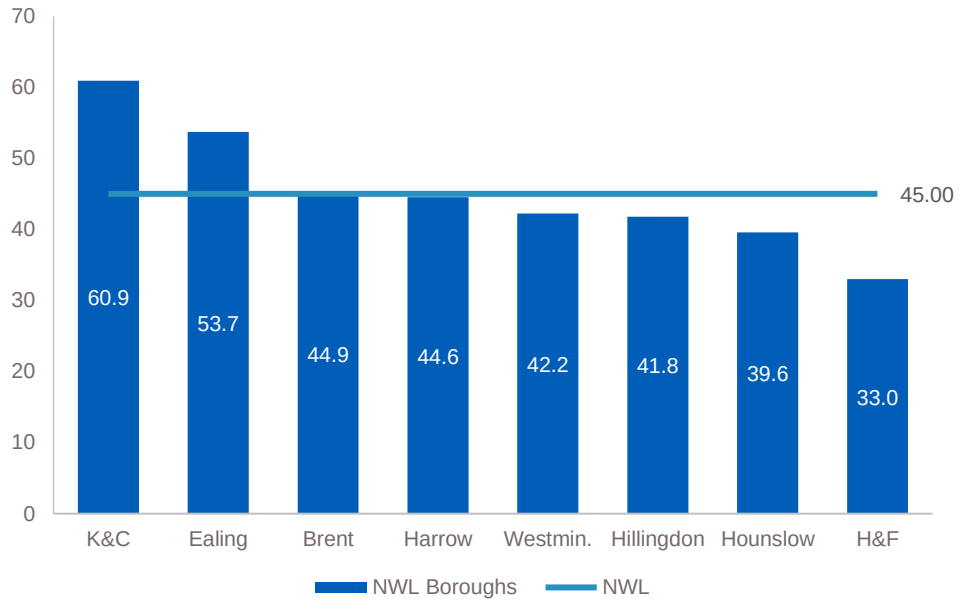
# Acute/ inpatient care

# There is variation in admissions and inpatient lengths of stay across our boroughs




**Occupied bed days in acute mental health services**
Per 100,000 population

**Source:** NWL local data, August 2023




- Our aim across North West London ICS is, and always will be, to ensure that we provide the highest quality, compassionate, trauma-informed and most appropriate mental health care for people who need it across our boroughs.

- This includes increased access to integrated services in the community, inpatient facilities that meet modern standards of acute mental health care, supporting patient dignity and privacy, with ease of access where required. We follow the principles laid out in the Mental Health Capacity Act 2005 that mental health care should be in the least restrictive setting and acute inpatient care should only be used where there is no better alternative.

# Modelling demonstrates that demand growth for inpatient services can be addressed through several transformation opportunities

## MH Inpatient Services: Central Case Modelling Summary

| Service | Current Demand [FY24 Outturn] | Demographic Growth [5 yrs] | Unmet Need Estimate [p.a.] | Future Demand [FY29 – 'Do Nothing'] | Capacity [Current + Plan] | Transformation opportunities [p.a.] | (Surplus) / Deficit [FY29 – 'Do Something'] |
|---|---|---|---|---|---|---|---|
| **Adult Acute** | **330** beds | **11 beds** | **8 beds for OOA patients**<br>**4 beds to better service ED long waits** | **353** beds | **(343)** current<br>**(8)** future | **(20)** [-6% admissions]<br>**(20)** [-6% Av LoS]<br>**+35** [adjustment to hit target occupancy of 90%] | **(2)** bed surplus |
| **Older Adult Acute** | **86** beds | **6 beds** | - | **93** beds | **(102)** current | **(12)** [-13% admissions]<br>**(23)** [-28% Av LoS]<br>**+6** [adjustment to hit target occupancy of 90%] | **(37)** bed surplus |
| **Rehab** | **144** beds | **6 beds** | - | **151** beds | **(144)** current | **(10)** [-6% Av LoS]<br>**+16** [adjustment to hit target occupancy of 90%] | **13** bed deficit |
| **PICU** | **48** beds | **1 bed** | - | **49** beds | **(54)** current | **(0.3)** [-1% Av LoS]<br>**+5** [adjustment to hit target occupancy of 90%] | **1** bed deficit |
| **LTC / CC** | **17** beds | **3 beds** | - | **20** beds | **(37)** current | **(9)** [-1% Av LoS]<br>**+5** [adjustment to hit target occupancy of 90%] | **(25)** bed surplus |

**PICU:** Psychiatric Intensive Care Unit; **LTC / CC:** Long-Term Complex / Continuing Care; **AvLoS:** Average Length of Stay.
**Note:** Demographic growth for each service differs due to the varying age profile and borough breakdown of demand for those service.

# Adult Acute: Our ‘Central’ scenario demonstrates we can manage future demand through realising several transformation opportunities

## Adult (18-64) Acute Beds:

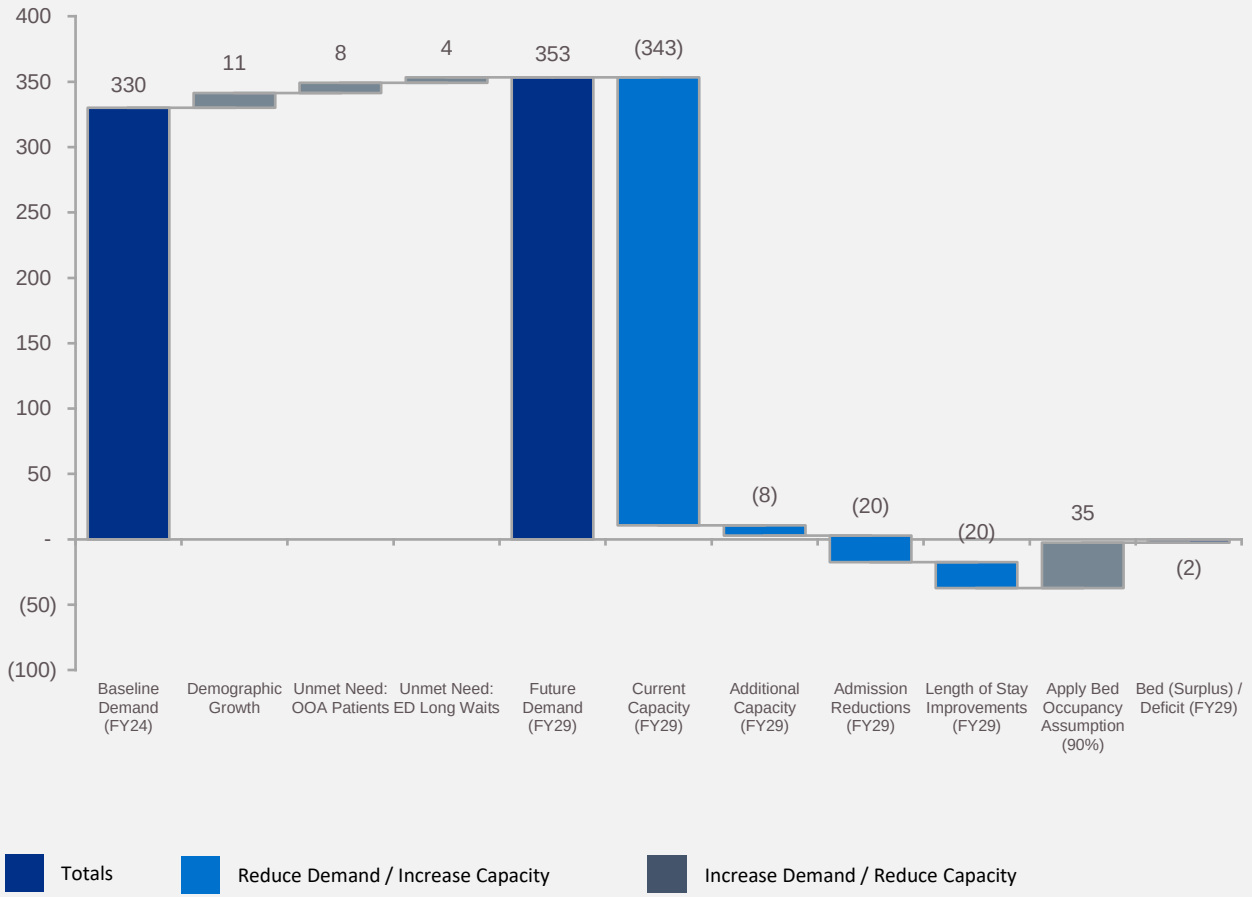
- The modelling demonstrates that in **FY29, NWL’s** bed surplus / deficit could range from a **deficit of 50 beds** to a **surplus of 38 beds**, depending primarily on our ability to transform our services through reducing length of stay, reducing bed occupancy, and reducing admissions through providing alternative, more suitable settings for patients in crisis.
- The **‘central case’ scenario** (which is the most realistic of the three scenarios) concludes that we currently have sufficient adult acute MH beds, assuming that we can appropriately transform our services.



| Scenarios | Worst | Central | Best |
|---|---|---|---|
| **Current Demand** [FY24 outturn] | **330** | **330** | **330** |
| Demographic Growth [FY24-FY29] | 11 | 11 | 2 |
| Unmet Need: OOA Patients [FY29] | 8 | 8 | 8 |
| Unmet Need: ED Long Waits [FY29] | 4 | 4 | 4 |
| **Future Demand** [FY29 ‘Do Nothing’] | **353** | **353** | **343** |
| Current Capacity [FY24] | (343) | (343) | (343) |
| Additional Capacity [FY24-FY29]** | (8) | (8) | (8) |
| Admission reductions [FY29] | - | (20) | (36) |
| Length of stay improvement [FY29] | - | (20) | (18) |
| Apply bed occupancy assumption | 39 | 35 | 15 |
| **Bed (Surplus) / Deficit** [FY29 ‘Do Something’] | **50** | **(2)** | **(38)** |

**Sources:** CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].
*Further **Relates to a 16 bed ward being built at Park Royal, though 8 beds are currently temporarily being provided at Kingswood.

## Adult (18-64) Acute Beds: ‘Central’ Case Modelling Scenario



# Older Adult Acute: Our ‘Central’ scenario demonstrates we could have a bed surplus through achieving transformation opportunities

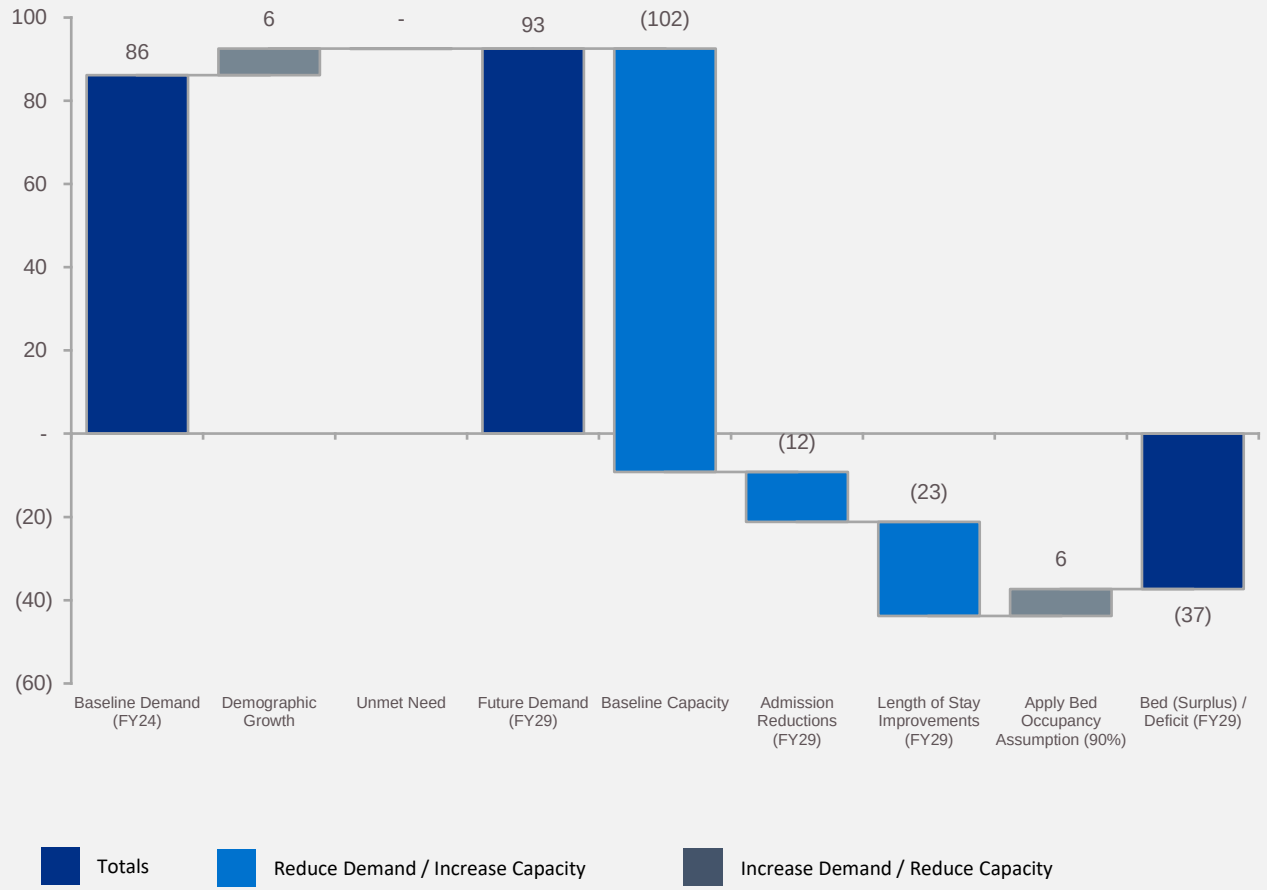
## Older Adult (65+) Acute Beds:

- The modelling demonstrates that in **FY29, NWL’s** bed surplus / deficit could range from a **deficit of 1 bed** to a **surplus of 46 beds**, depending primarily on our ability to transform our services through reducing length of stay, reducing bed occupancy, and reducing admissions through providing alternative, more suitable settings for older adults.
- The **‘central case’ scenario** (which is the most realistic of the three scenarios) concludes that we will have plenty of beds for older adult acute patients, assuming we can transform our services appropriately.

| Scenarios | Worst | Central | Best |
|---|---|---|---|
| **Current Demand** [FY24 outturn] | **86** | **86** | **86** |
| Demographic Growth [FY24-FY29] | 6 | 6 | 10 |
| Unmet Need | - | - | - |
| **Future Demand** [FY29 ‘Do Nothing’] | **93** | **93** | **97** |
| Current Capacity [FY24] | (102) | (102) | (102) |
| Admission reductions [FY29] | - | (12) | (22) |
| Length of stay reductions [FY29] | - | (23) | (21) |
| Apply bed occupancy assumption | 10 | 6 | 3 |
| **Bed (Surplus) / Deficit** [FY29 ‘Do Something’] | **1** | **(37)** | **(46)** |

**Sources:** CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

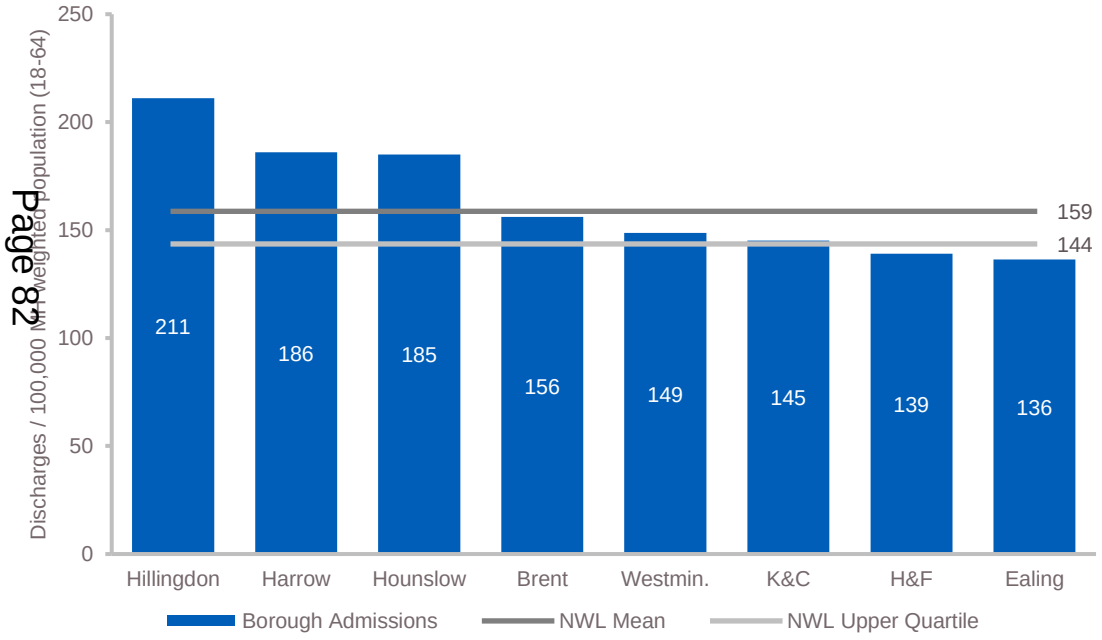
## Older Adult (18-64) Acute Beds: ‘Central’ Case Modelling Scenario



# Acute Admissions: Benchmarking within North West London shows some room for improvement in preventing admissions (e.g. by aligning care models)

## Adult Acute Admissions

per 100,000 MH weighted population (18-64): Jan – Dec 2023 benchmark

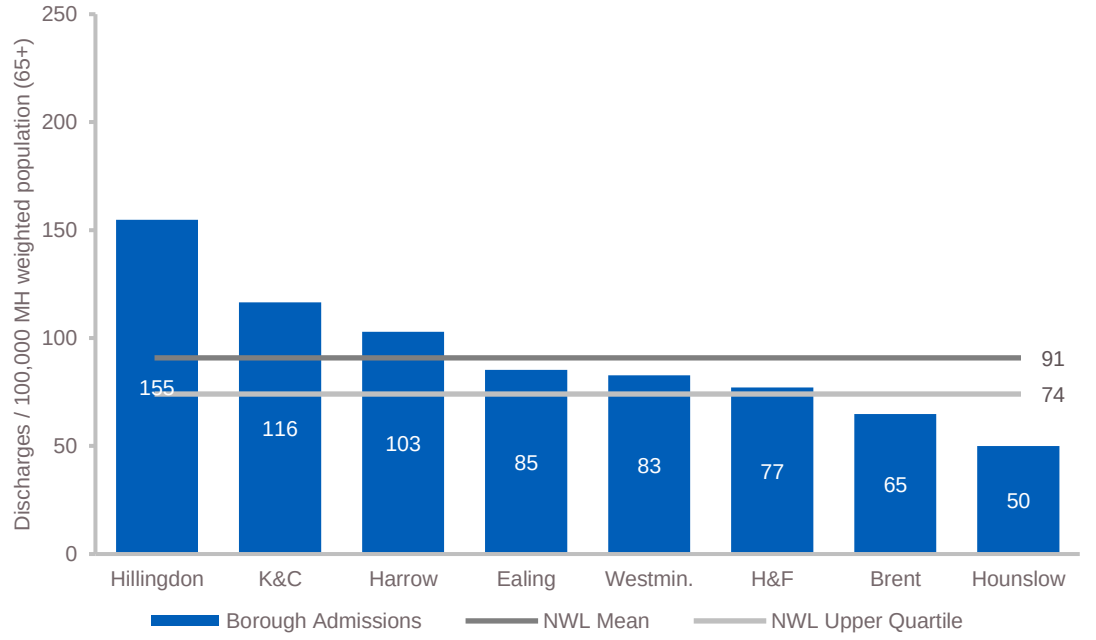



**Reducing unwarranted variation:**

- Internal benchmarking estimates an improvement opportunity of **6% fewer admissions** across NWL, if all boroughs are able to achieve the NWL mean level of admissions – i.e. Hillingdon, Harrow and Hounslow are able to prevent unnecessary admissions.
- Boroughs achieving the NWL upper quartile would result in **11%** fewer admissions.
- This could be achieved by aligning care models, focusing on prevention, and/or providing alternative services such as the Mental Health Crisis Assessment Service (MHCAS).

## Older Adult Acute Admissions

per 100,000 MH weighted population (18-64): Jan – Dec 2023 benchmark




**Reducing unwarranted variation:**

- Internal benchmarking estimates an improvement opportunity of **13% fewer admissions** across NWL, if all boroughs are able to achieve the NWL mean level of admissions – i.e. Hillingdon, Harrow and Hounslow are able to prevent unnecessary admissions.
- Boroughs achieving the NWL upper quartile would result in **23%** fewer admissions.
- This could be achieved by aligning care models, focusing on prevention, etc.



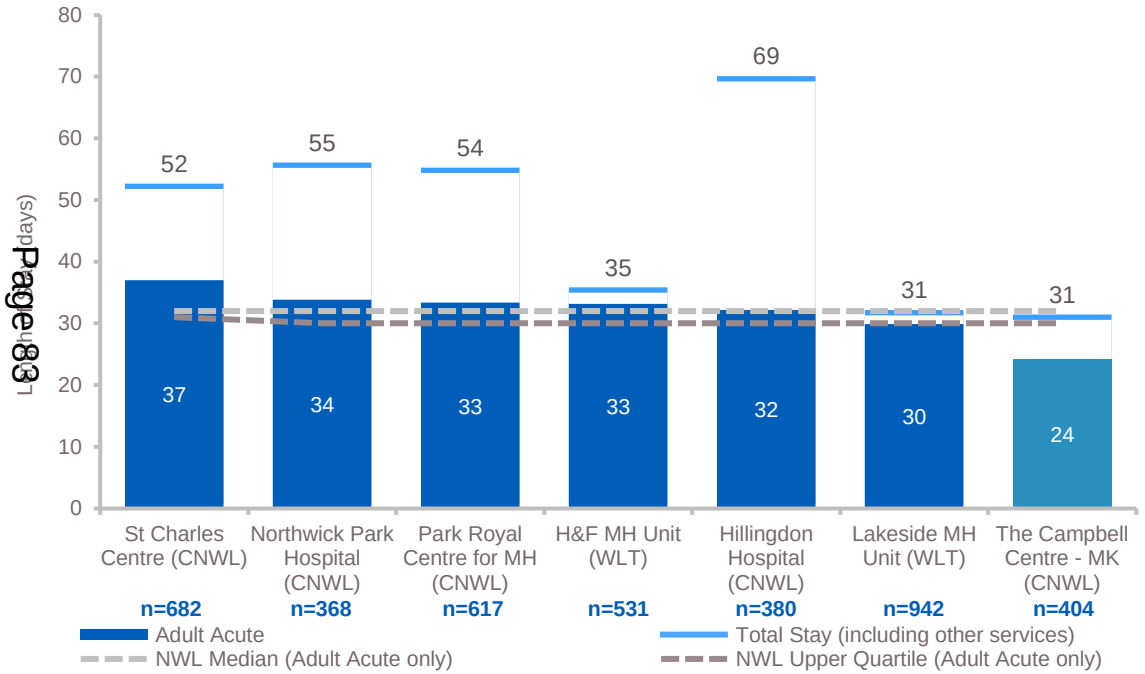


**Sources:** CNWL / WLT patient-level activity data [Jan 2023 – Dec 2023]. Av. LoS excludes leave.

# Average Length of Stay for Acute Services: Benchmarking within North West London indicates some room for improvement in reducing average length of stay

## Adult Acute:

Average length of stay by NWL (+ Milton Keynes) site [Jan – Dec 2023]

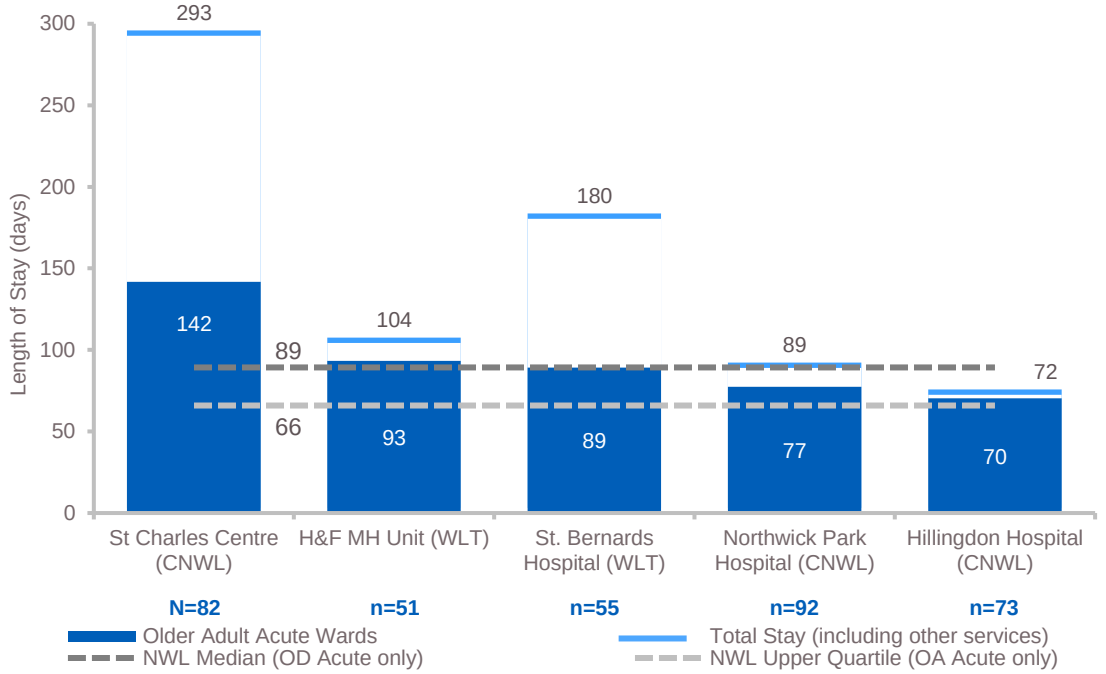



**Reducing unwarranted variation:**

- Benchmarking estimates an improvement opportunity of **3% fewer bed days across NWL** if each site achieved the NWL median Av. LoS of **32 bed days** (from an Av. LoS of 33.1).
- Benchmarking estimates an improvement opportunity of **7% fewer bed days across NWL** if each site achieved the NWL upper quartile Av. LoS of **31 bed days.**
- Av. LoS could be reduced by 16% if each site were able to achieve the NWL upper decile performance (27.6 bed days).

## Older Adult Acute:

Average length of stay by NWL site [Jan – Dec 2023]




**Reducing unwarranted variation:**

- Benchmarking estimates an improvement opportunity of 1**3% fewer bed days across NWL** if each site achieved the NWL median Av. LoS of **89 bed days** (from an Av. LoS of 91.6).
- Benchmarking estimates an improvement opportunity of **20% fewer bed days across NWL** if each site achieved the NWL upper quartile Av. LoS of **77 bed days.**

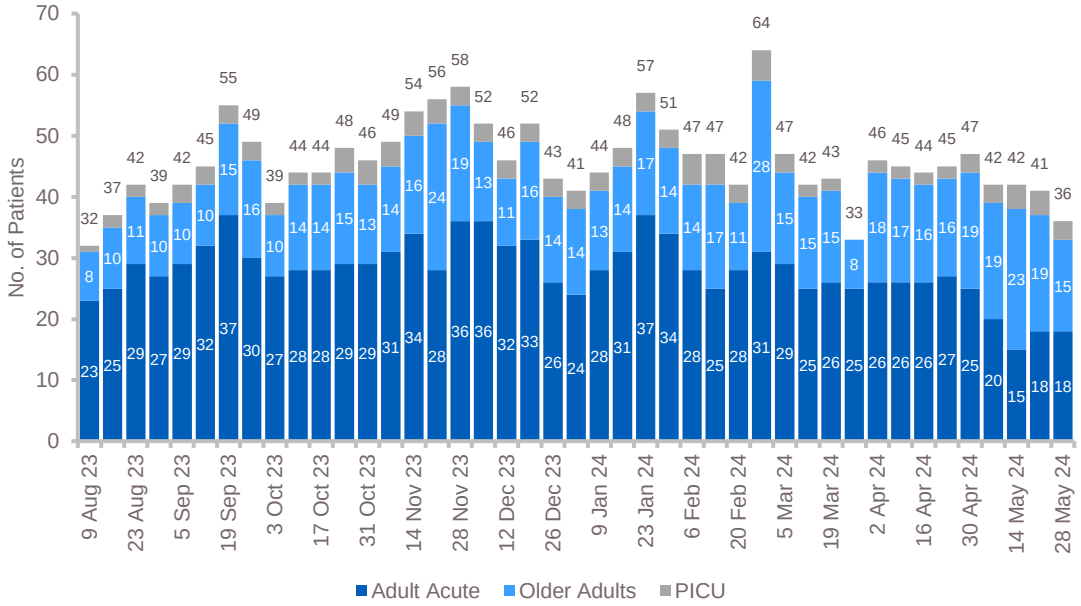


**Sources:** CNWL / WLT patient-level activity data [Jan 2023 – Dec 2023]. Av. LoS excludes leave.

# At any time over the past 10 months there were c. 43 patients that were clinically ready for discharge from a mental health bed

## Patients Clinically Ready for Discharge (CRFD)

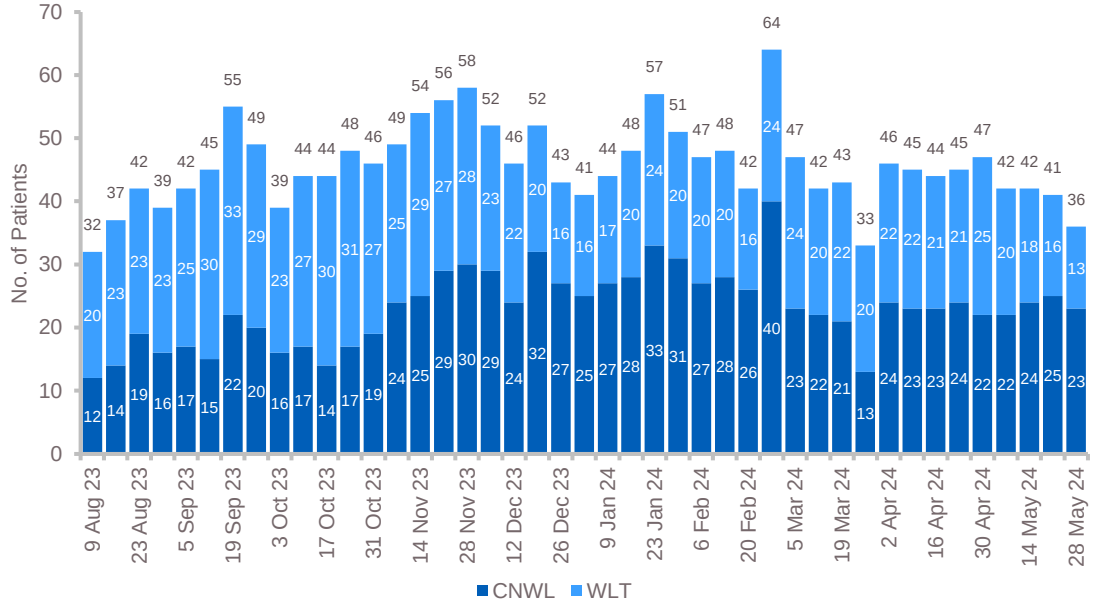
Split by service / bed type: Manual weekly audits [Aug 2023 – May 2024]




- On any given day, there has been 32 – 64 patients that are clinically ready for discharge (CRFD) over the period August 2023 to May 2024.
- This is driven primarily by patients in Adult Acute beds and Older Adult Acute beds (approximately in line with our overall bed base).

## Patients Clinically Ready for Discharge (CRFD)

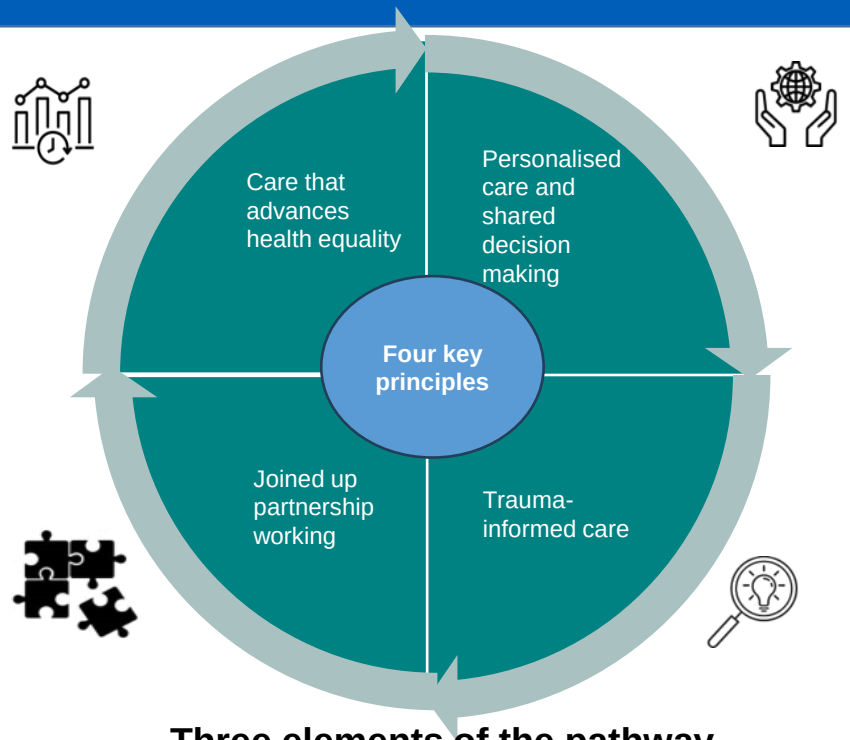
Split by service / bed type: Manual weekly audits [Aug 2023 – May 2024]




- The chart above shows a steady increase in CRFD over the winter period, with approximately 45-55 CRFD patients, though this has started to decrease in recent weeks.
- This implies that average length of stay (and therefore our overall requirement for MH beds) could be reduced substantially by carefully diagnosing and resolving delays in discharge – for example through working with our ICS housing partners.

**Sources:** NWL CRFD Dataset (manually submitted weekly since Aug 2023)

# As part of the Quality Transformation Programme, NWL is developing a plan to localise and realign mental health, learning disability and autism inpatient services




**Three elements of the pathway**

**Purposeful admissions**

**Therapeutic inpatient care**

**Proactive discharge planning an effective post discharge support**

**Two key enablers**

**A fully multidisciplinary, skilled and supported workforce**

**Continuous improvement of the inpatient pathway. Using data, co-production and quality improvement methodology**

**Purposeful admissions**

People are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available bed for the persons needs and there is a clearly stated purpose for the admission.

**Therapeutic inpatient care**

Care is planned and regularly reviewed with the person and their chose carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission.

**Proactive discharge planning an effective post discharge support**

Discharge is planned with the person and chosen carer/s from the start of their inpatient stay, so they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an in-patient setting, with all planned post-discharge support provided promptly on leaving hospital.


Agree a shared understanding of need, prevalence and demand
Hear the views of our residents and users
Agree a shared understanding of current provision including progress to date
Collectively set out our ambitions for further improving services and closing our biggest treatment gaps

# We have four key themes

We will work together in trusted partnership to build a supportive community environment that harnesses a broad range of roles, providers and sectors to enable care and support, recognising and advocating for the skills, expertise and benefit of the whole community. We will improve access to education, training, employment and broader health settings and interventions to promote good mental wellbeing for all.

Organisations and services that support residents' mental health, in both statutory and VCSE sector, will be equipped to meet the diverse health and social needs of the local population in a culturally effective manner. There will be a clear emphasis on prevention, early intervention, maximising independence and embedding strengths based approaches to both community and individual interventions.

For people (including carers) in crisis or requiring an urgent response, they will be able to access a multi-agency response that supports a holistic psycho, social and welfare approach to preventing, supporting and managing the crisis.

Care will be delivered in the least restrictive setting, but when hospital based care is required, it will be delivered in a timely way, by an expert team, within a therapeutic and compassionate environment.

# Detailed recommendations (1)

1) **Prioritise equity and equality of access** to services, using local data to drive co-produced service developments that meet the needs of specific communities; ensuring locally tailored and culturally appropriate solutions to improve access for these groups.

2) **Raise awareness** across North West London so that **every resident knows how to access mental health support** both in crisis and more widely in the community, also aiming to reduce stigma in all communities and prevent suicides.

3) Ensure **local community mental health offers are provided more widely** in each borough where people can access help with social issues and gain meaningful employment, with a view to seeking help earlier to prevent mental health problems and crisis.

4) Provide **signposting to mental health support in each local authority housing department** in North West London and ensure close liaison between mental health and housing services by having named link staff with expertise in this area.

5) Support further **integration between primary care and mental health services** to facilitate better joined up working so that care can be delivered in the right setting, at the right time, to respond to the needs of patients.

6) **Reduce waiting times** for therapeutic interventions within our community services to be better than the London average, and where waiting is necessary, **support patients and carers to 'wait well'** with up to date information on waiting times, self help information and community resources that can provide additional engagement and support.

# Detailed recommendations (2)

7) Ensure equitable access and **consistent provision in North West London of crisis alternative services to A&E and admission**, and raise awareness so that all residents know where and how to access these in times of crisis.

8) Ensure **appropriately adjusted mental health services that use trauma informed approaches** are available for different groups, such as young adults and neuro-diverse adults, informed by local and national analysis.

**9)** **Review the quality of our inpatient services** to ensure we are providing timely care, by an expert team in a therapeutic and compassionate environment.

**10)** **Continue to push productivity, in particular:**

**a)** **Optimising inpatient lengths of stay** so that no patient stays in hospital longer than they need to, by improving early discharge planning with system partners and post discharge support in order to reduce re-admission to hospital.

**b)** **Reducing unwarranted variation** in caseloads and staffing so that patients receive person-centred and timely care from community mental health teams.

**11)** **Improve staff retention** and continue our good track record with growing our own. Review the impact of service change on staff, with a view to supporting culture change and managing workloads so that staff vacancies and turnover does not reduce the effectiveness of service developments.

**12)** **Invest in and support the Voluntary, Community and Social Enterprise Sector (VCSE)** to enable locally tailored and visible, community support services; building capacity in providers to plan and develop their services for patients.

# Our shared aims and ambitions for adult mental health services for the future

**By 2028/29 we will have:**

| Ambitions | Outcomes |
|---|---|
| **RAISED AWARENESS AND PROMOTING WELLBEING**<br>• Raised awareness across North West London so that every resident knows how to access mental health support both in crisis and more widely in the community.<br>• Developed an assets-based approach to promoting mental health, wellbeing and independent living, partnering with and investing in local community organisations. | • Services responsive to population health needs and flexibly delivering changes with no unwarranted variation in outcomes.<br>• Locally tailored and visible, community support services; built capacity in providers to plan and develop their services for patients.<br>• Patients and staff reporting better experiences.<br>• Optimal community and inpatient capacity to respond to growth in need whilst delivering our transformation goals and increasing care in a community setting.<br>• All people known to mental health services with a crisis management plan that supports them to use crisis alternatives to A&E for de-escalating their needs, where there is no physical health need.<br>• No person staying longer in a mental health bed than they need to.<br>• Integrated solutions to housing pathways.<br>• More people gaining and staying in meaningful employment.<br>• Zero adult inappropriate acute inpatient stays outside of North West London. |
| **INCREASED EQUITY AND EQUALITY OF ACCESS**<br>• Increased equity and equality of service access to reflect different needs of our local and diverse communities, with greater targeted support to those with severe mental illness.<br>• A consistent core offer for community and crisis care for adults, with a focus on severe mental illness, that also enables flexibility for local and diverse needs.<br>• Reduced variation and increased productivity in caseloads and staffing across community services.<br>• Improved staff recruitment and retention.<br>• Waiting times measuring in the top quartile in England. | |
| **CARE IN THE RIGHT PLACE**<br>• Integrated care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness.<br>• High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment.<br>• Worked together with our Local Authority partners to develop solutions to the housing and employment pathway challenges. | Enabled by:<br>• Increased funding into mental health, benchmarked with other areas nationally, in line with the medium-term financial plan, alongside increased productivity of services<br>• Allocated resource based on need.<br>• Consistent suite of outcome measures to demonstrate the value delivered |

# Proposed phasing

| | Ambition | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|
| **RAISED AWARENESS AND PROMOTING WELLBEING** | Every resident knows how to access mental health support both in crisis and more widely in the community | • Agree local demographic data and local insights to understand barriers to access<br>• Identify target groups with lower access | • Develop outreach models | • Implement outreach models for target groups with barriers to access/ lower levels of access | | |
| | An assets-based approach to promoting mental health, wellbeing and independent living | • Review community mental health support offer<br>• Develop common support offer | • Review delivery partner capacity | • Build capacity in VCSE to enable greater testing/ delivery of models | | |
| **INCREASED EQUITY AND EQUALITY** | Increased equity and equality of service access to reflect different needs of our local and diverse communities, with targeted support for SMI | • Identify target groups with largest variation<br>• Identify actions to reduce variation | • Take forward actions to reduce variation in outcomes and experience | | | |
| | A consistent core offer for community and crisis care for adults, with focus on SMI, that also enables flexibility for local and diverse needs | • Review current offer(s)<br>• Develop common community and crisis offer | • Move towards common offers using productivity improvements and/ or resource | | | |
| | Reduced variation and increased productivity in caseloads and staffing across community services | • Single approach to monitoring, baselining and evaluation to identify areas for action | • Embed QI approach, with initial focus on older adults | • Agree further set of initiatives, with continued shared learning | | |
| | Improved staff recruitment and retention | • Recruitment to the top five hard to fill vacancies (MH nurses) | | | | |
| | Waiting times measuring in the top quartile in England | • Develop standard approach to waiting well information across all services | • Identify services that have the longest waits or greatest need, along with indicative opportunities | • Take forward opportunities, better informed by population health management | | |
| **CARE IN THE RIGHT PLACE** | Integrated care between primary care and mental health teams, with focus on SMI | | • Consider further opportunities of Mental Health ARRS in primary care | • Mapped to the further development of Integrated Neighbourhood Teams | | |
| | High quality inpatient facilities | • Review inpatient facilities in line with developing plan | • Implement as per Inpatient Quality Transformation Plan | | | |
| | Develop solutions to the housing and employment pathway challenges | • Expansion in employment advisors in Talking Therapies | • Identify opportunities with LA on housing pathway | • Take forward opportunities, better informed by population health management | | |

# Appendix 1 – supporting information for needs assessment

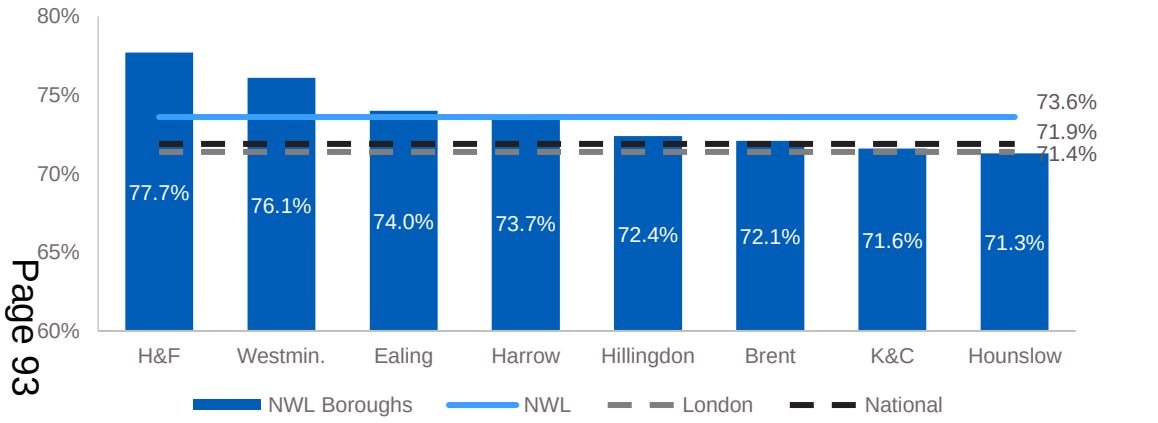


NHS
North West London

# ~75% of people in North West London self report high happiness/ satisfaction this drops to below 30% for those with a high anxiety score

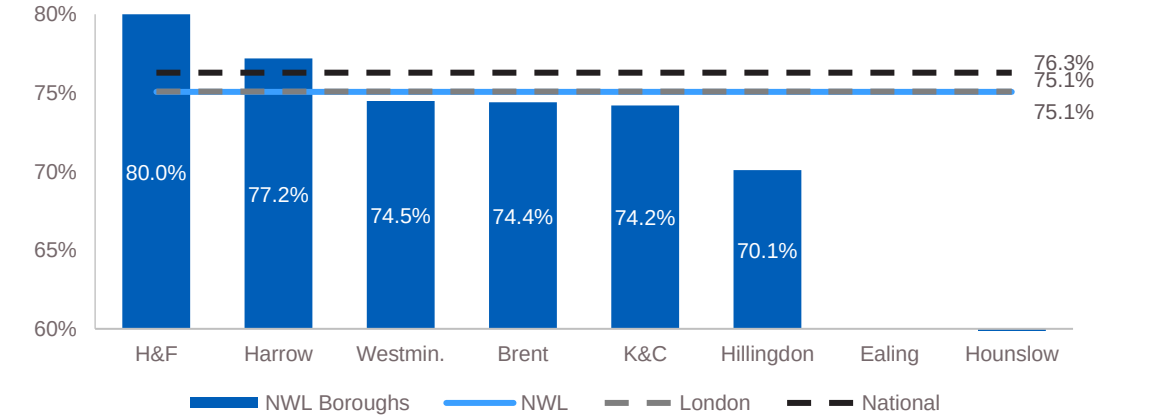
**Self-reported happiness**
Percentage of respondents with a high score [2020/21]

**Source:** Public health profiles, OHID, 2020/21



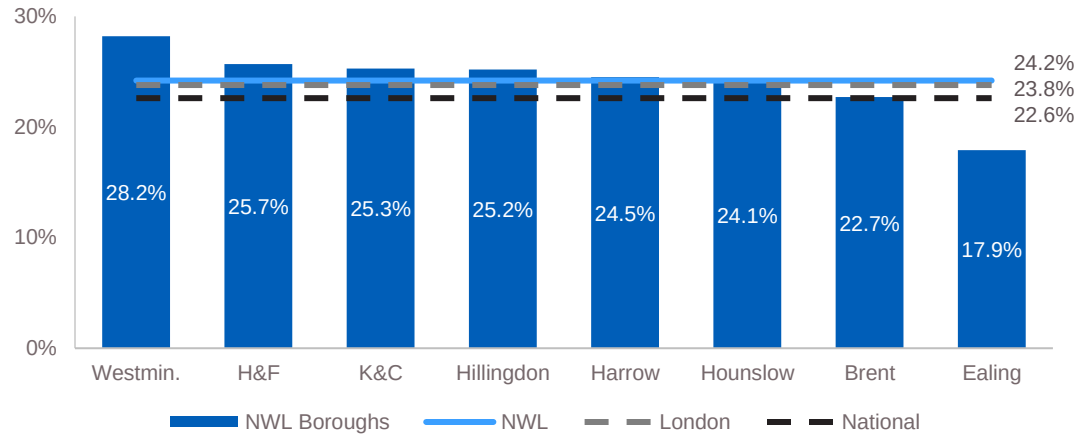

**Self-reported satisfaction**
Percentage of respondents with a high score [2020/21]

**Source:** Public health profiles, OHID, 2020/21




**Self-reported anxiety**
Percentage of respondents with a high score [2020/21]

**Source:** Public health profiles, OHID, 2020/21





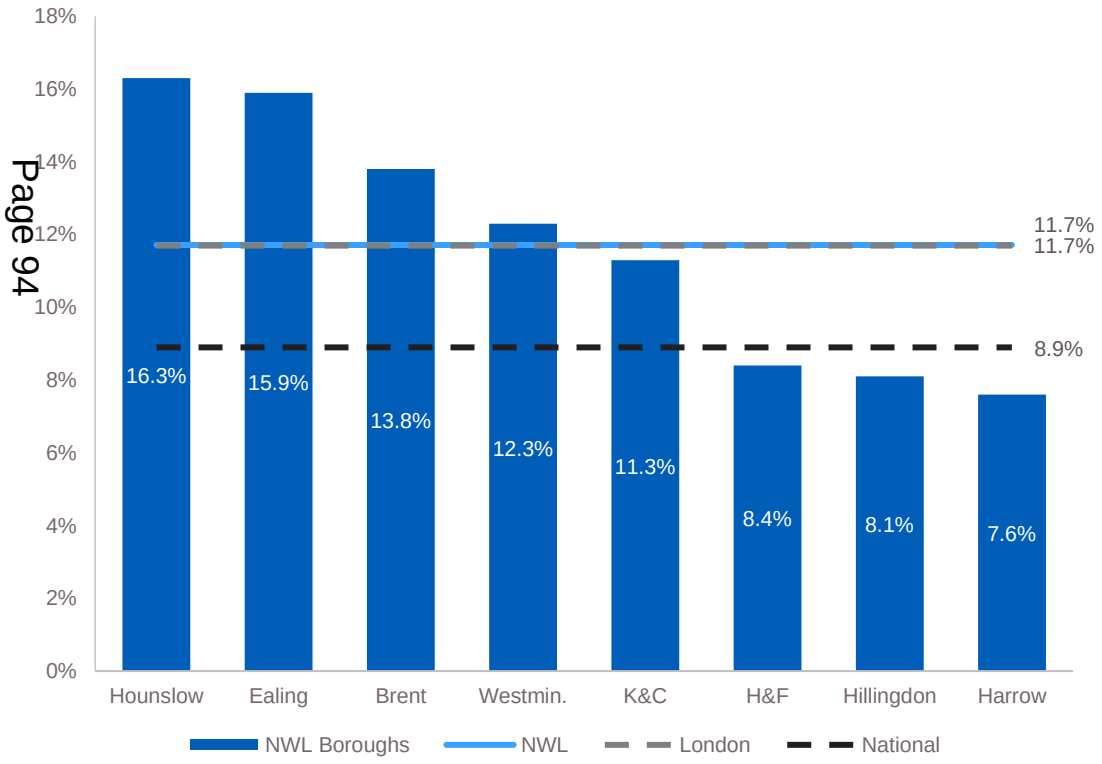



NHS North West London

# Smoking rates are higher amongst adults with a long term mental health condition – and vary across Boroughs

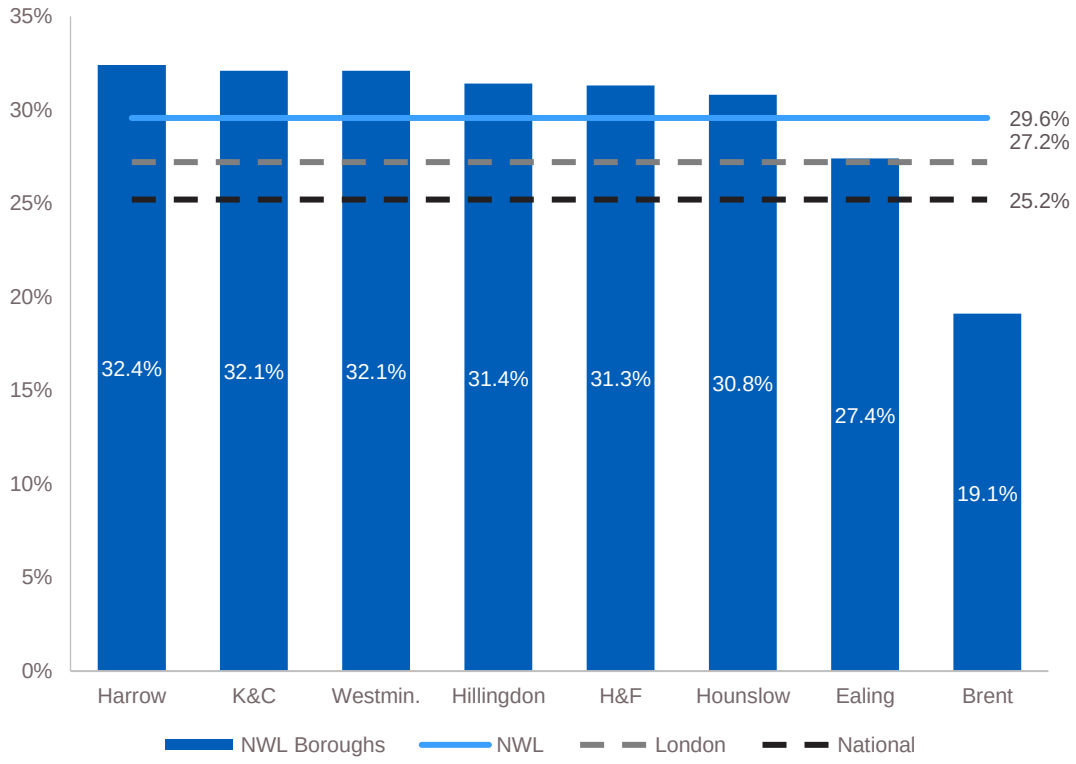
**Smoking prevalence in adults (18+)**
Current smokers as a percentage of adult population [2022]

**Source:** Public Health England, 2022




**Smoking prevalence in adults with a long-term MH condition:**
Current smokers as a percentage of population with MH conditions [2021/22]

**Source:** Public Health England, 2021/22





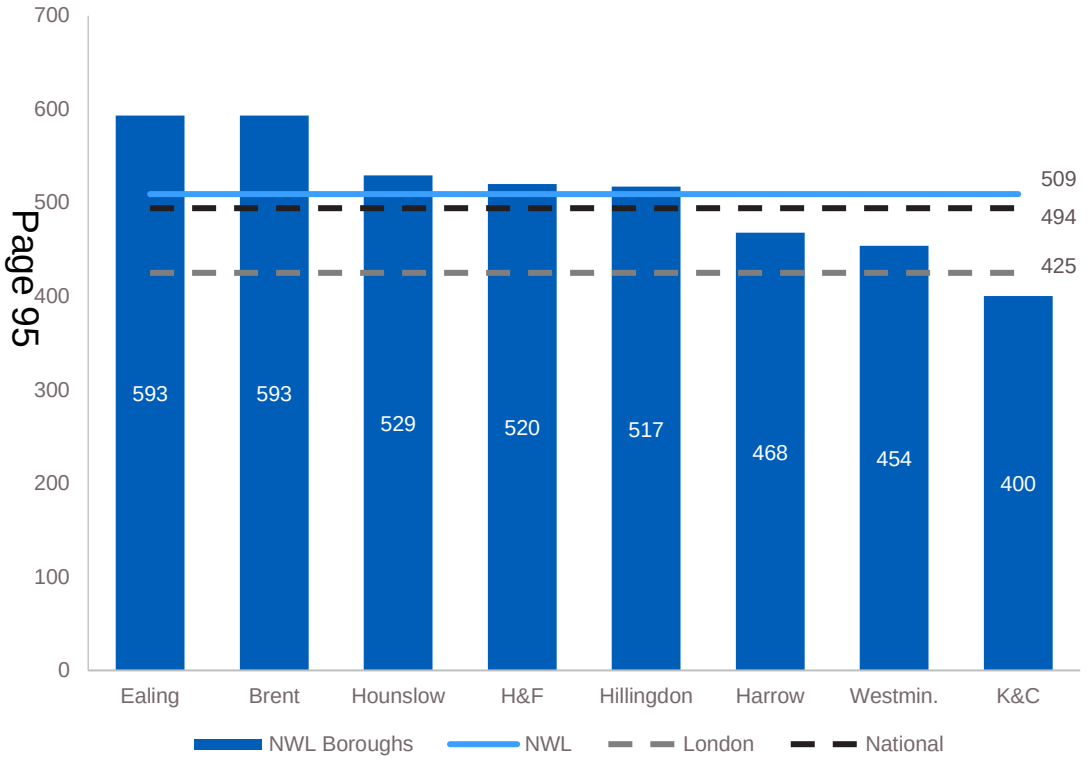



NHS North West London

# Alcohol misuse is a risk factor for poor mental health, with variable levels of prevalence and variable success rates

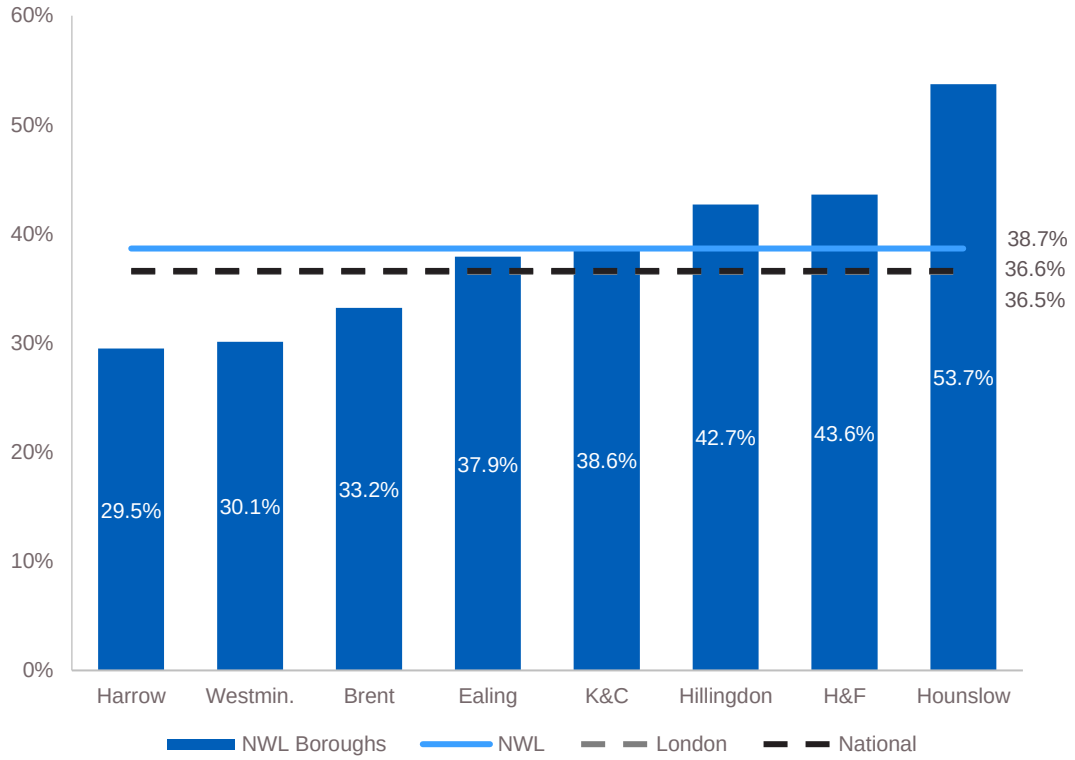
**Admission episodes for alcohol-related conditions:** Number of episodes (primary diagnosis) per 100,000 standardised population [2021/22]

**Source:** Public Health England, 2021/22




**Successful completion of structured alcohol treatment:** Percentage of alcohol users that left treatment successfully [2021]

**Source:** Public Health England, 2021/22





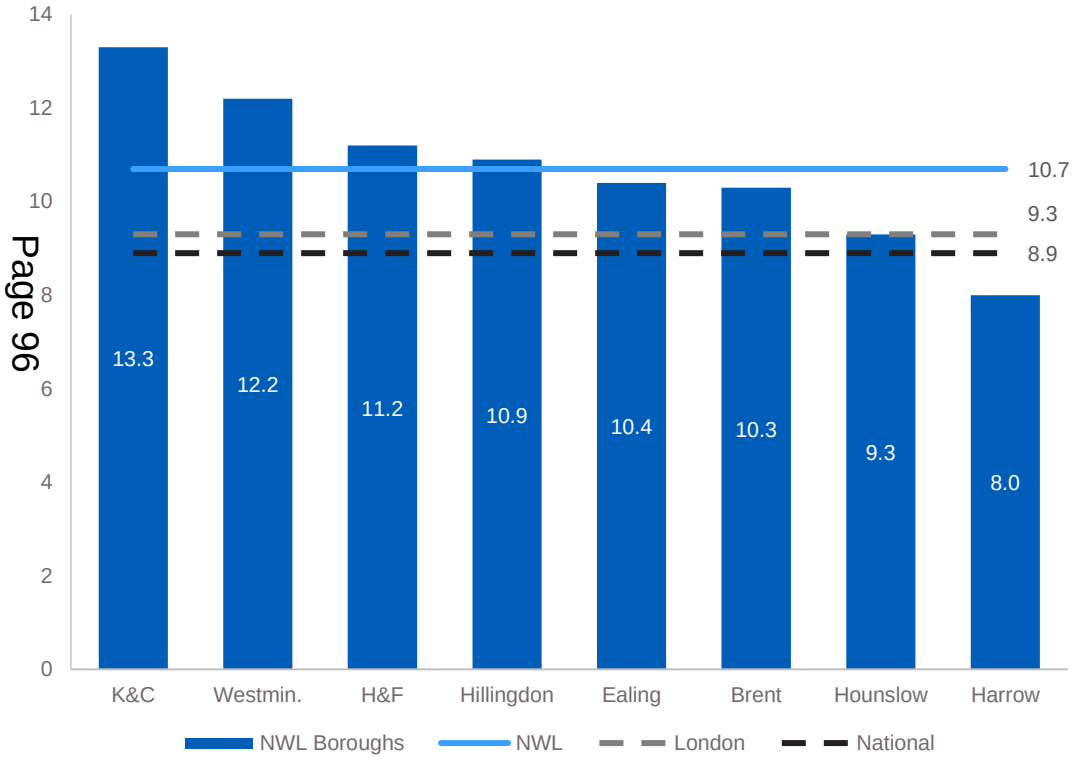



NHS North West London

# Drug misuse is also a risk factor for poor mental health, with variable levels of prevalence and variable success rates

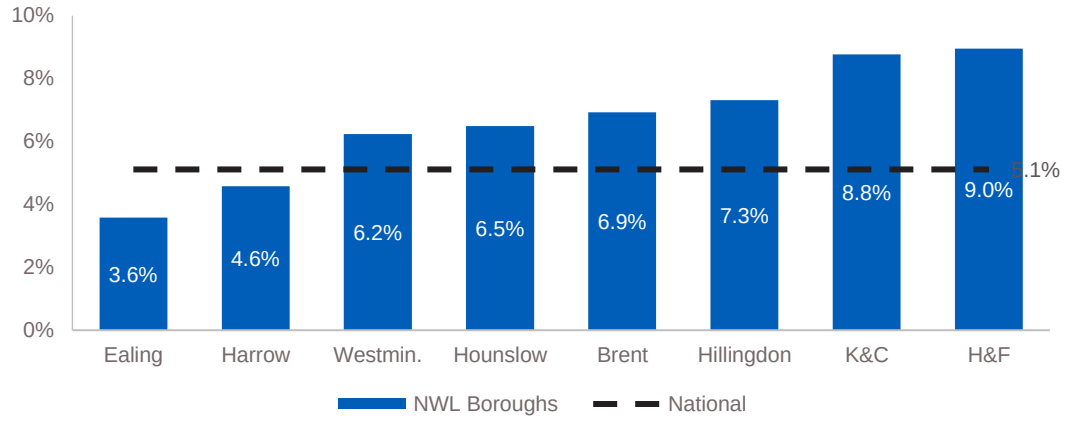
**Estimated prevalence of opiate and/or crack cocaine use**
Crude rate per 1,000 population aged 15-64 [2016/17]

**Source:** Public Health England, 2016/17



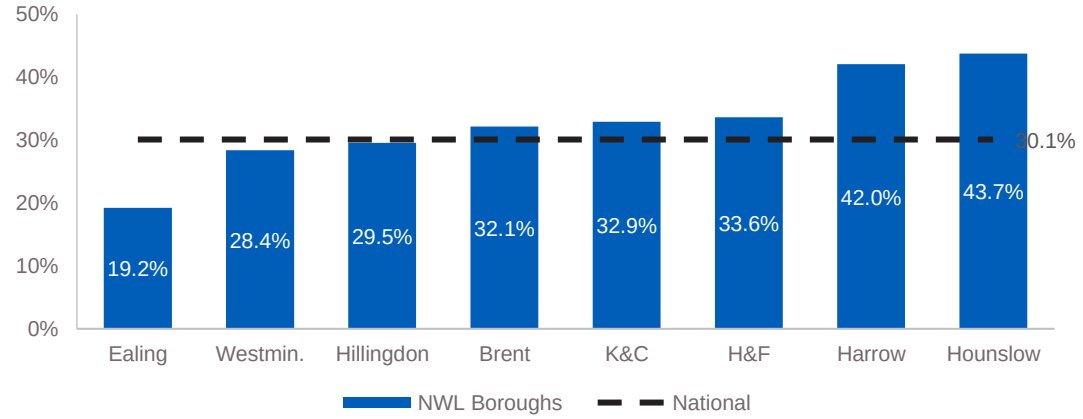

**Successful completion of opiate treatment:**
Percentage of treatment plans completed [August 2022 – July 2023]

**Source:** National Drug Treatment Monitoring System (NDTMS), 2023




**Successful completion of non-opiate treatment**
Percentage of treatment plans completed [August 2022 – July 2023]

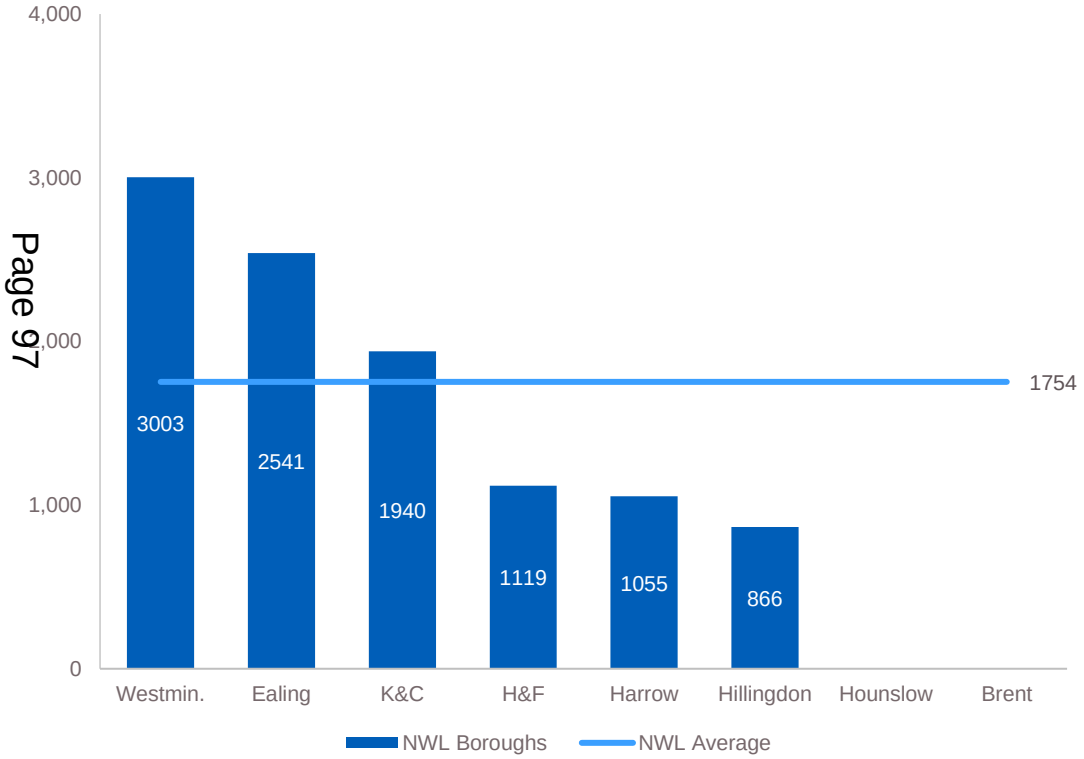
**Source:** National Drug Treatment Monitoring System (NDTMS), 2023



# Housing is a challenge for c. 1/3 of people with more severe mental health conditions

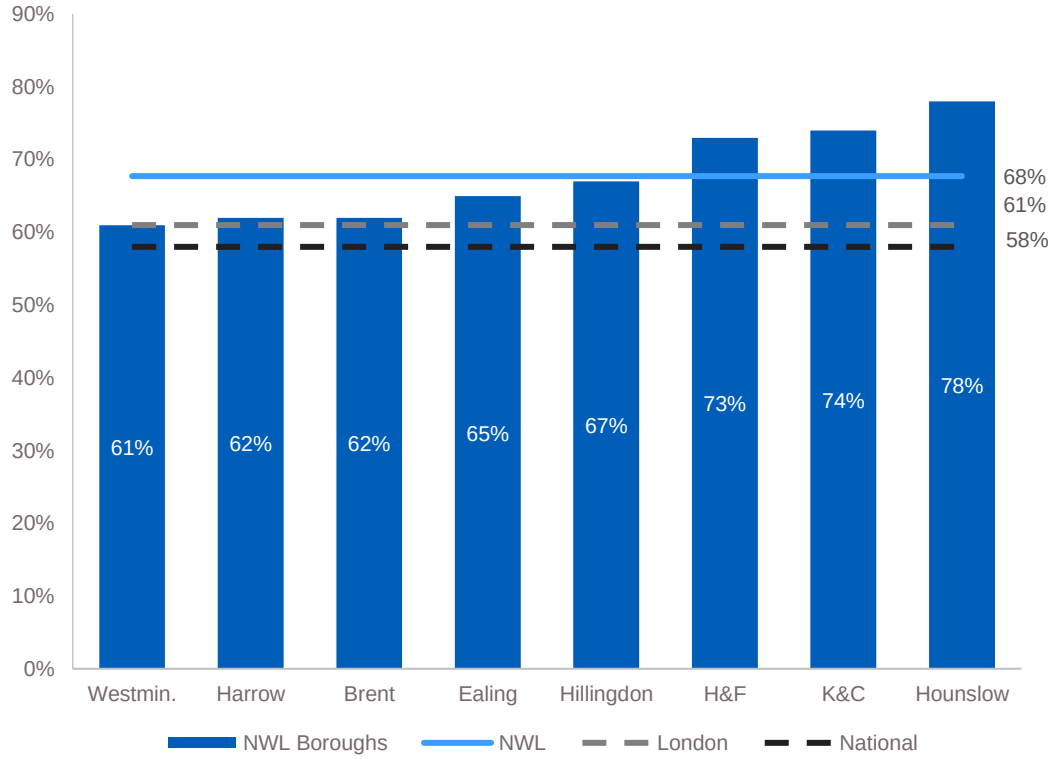
**Homelessness: households in temporary accommodation**
Total number of households [2023 Q1]

**Source:** Gov.uk, 2023 Q1




**Adults receiving secondary MH services who live in stable and appropriate accommodation:** Proportion of adults [2020/21]

**Source:** Public Health England, 2020/21





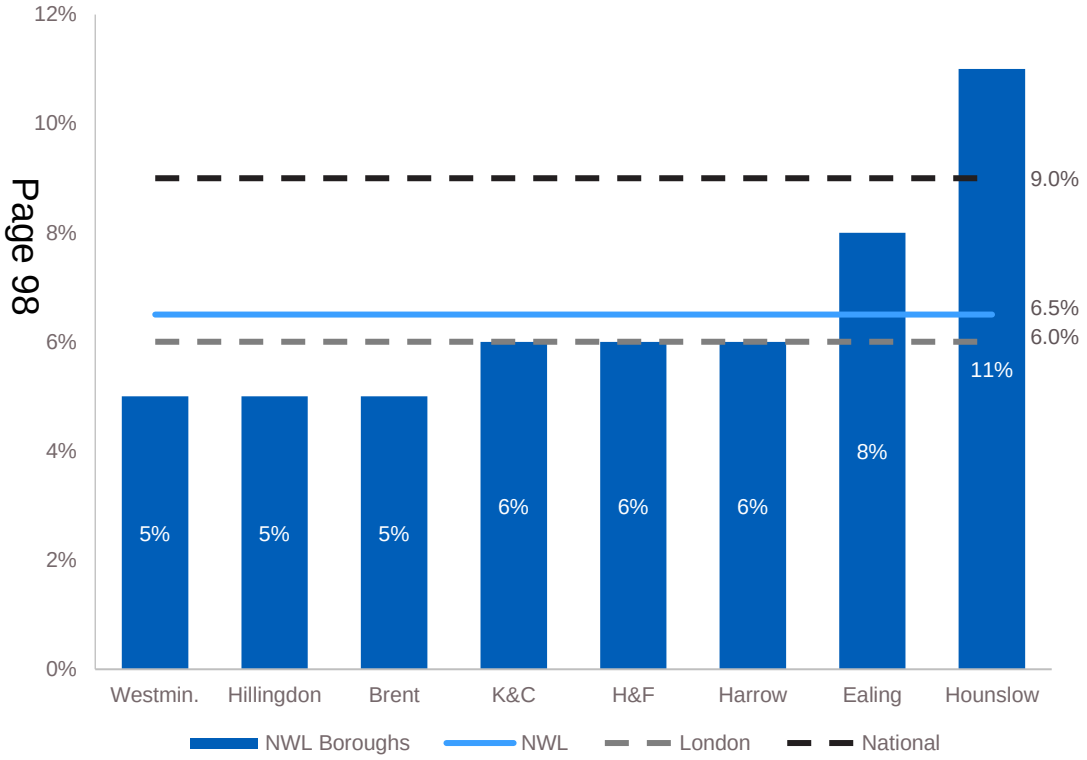



NHS North West London

# Less than 3% of people in contact with secondary mental health services are in paid employment – versus over 60% with a physical/mental long term condition

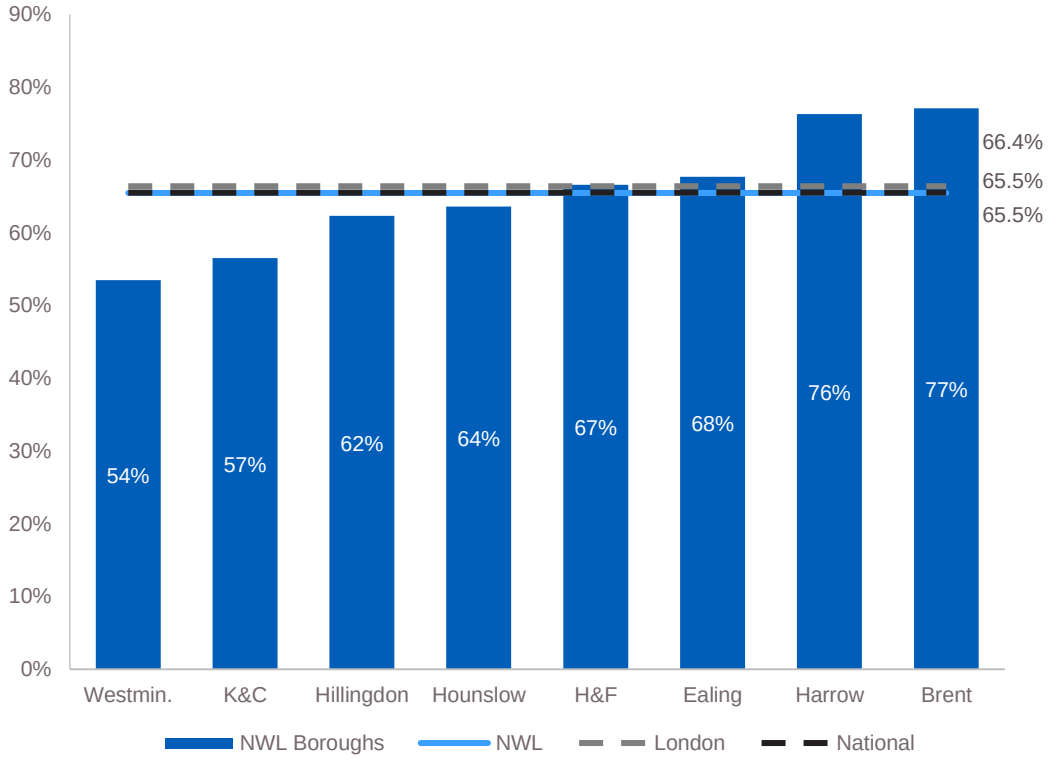
**People receiving secondary MH services who are in paid employment:** Proportion of people [2021/22]

**Source:** Public Health England, 2021/22




**People with physical / mental LTC who are in paid employment:** Proportion of people [2021/22]

**Source:** Public Health England, 2021/22





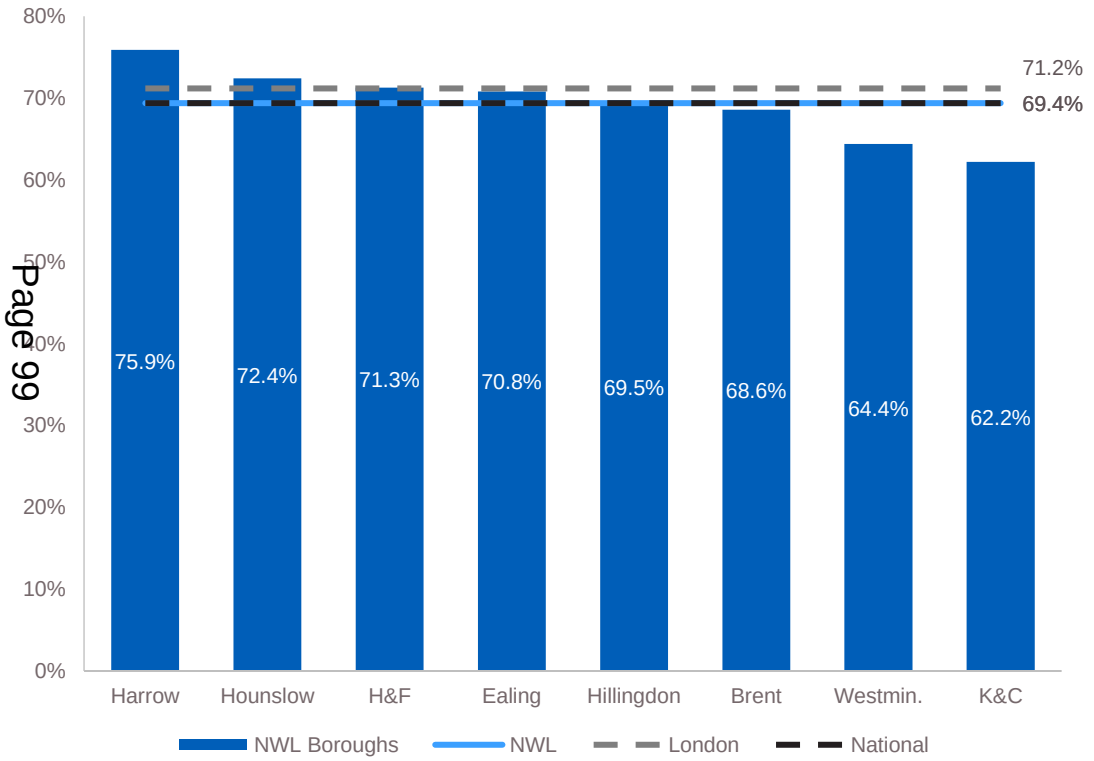



NHS North West London

# People helped into employment are less likely to need support from community mental health services and have further inpatient admissions

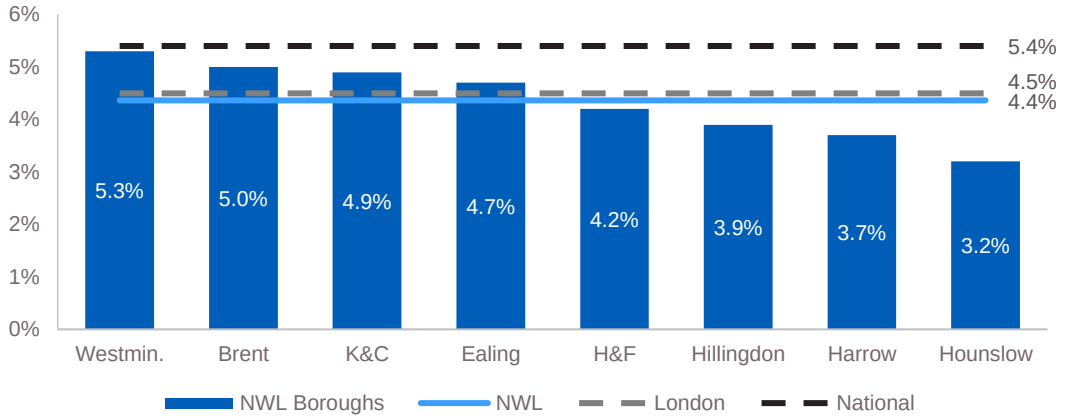
**Gap in employment rate for those who receive secondary MH services:** Percentage point difference with overall rate [2021/22]

**Source:** Public Health England, 2021/22



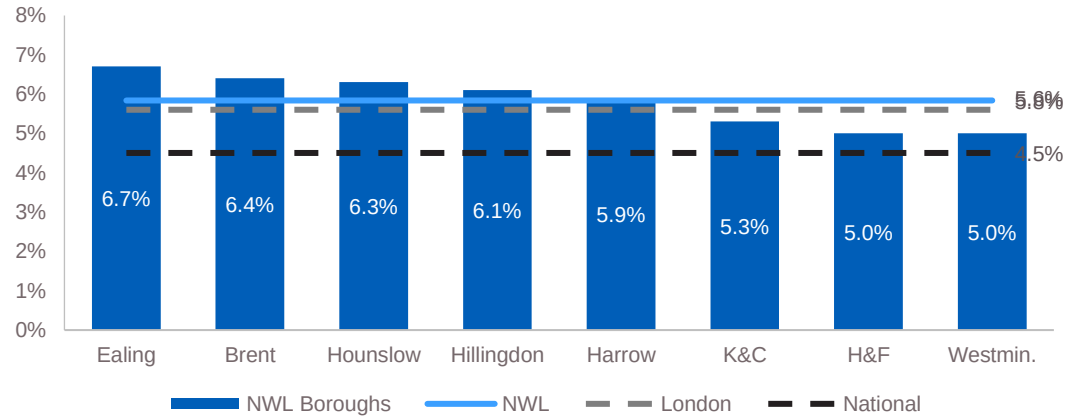

**Employment and support allowance claimants:** Proportion of population [2018]

**Source:** Public Health England, 2018




**Unemployment rate:** Percentage of over 16 population who are unemployed

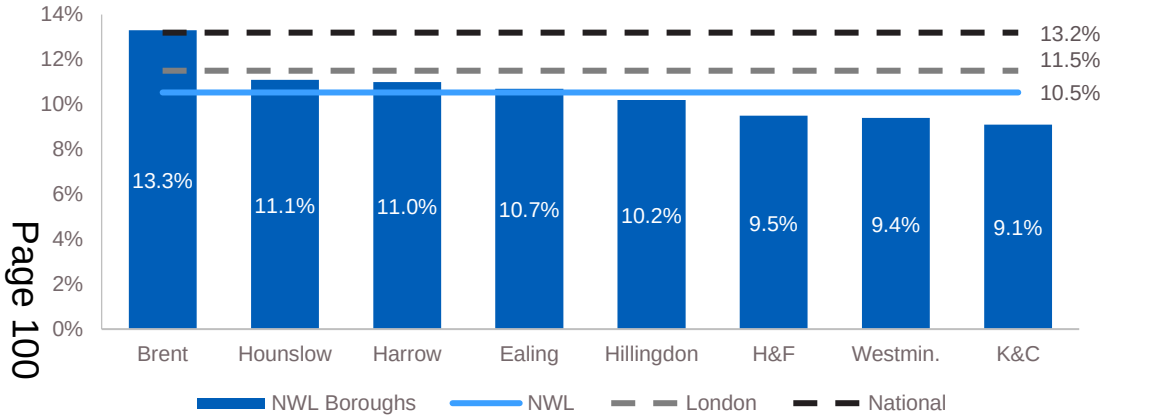
**Source:** NOMIS – Labour Force Survey, 2021-22



# Other risk factors related to mental health problems

**Fuel poverty (households with low income, poor energy efficiency, energy prices):** Proportion of households in fuel poverty [2020]

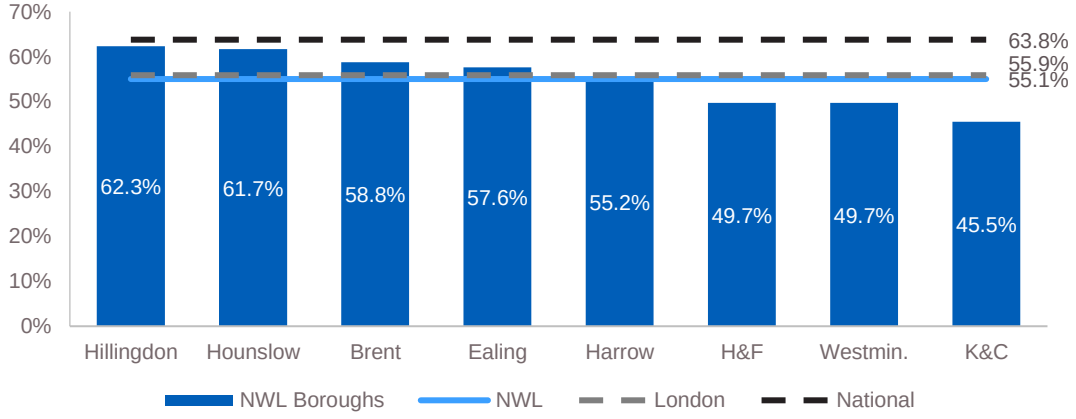
**Source:** Gov.uk, 2020




**Percentage of population classified as overweight or obese**

Percentage of over 18 population [2021/22]

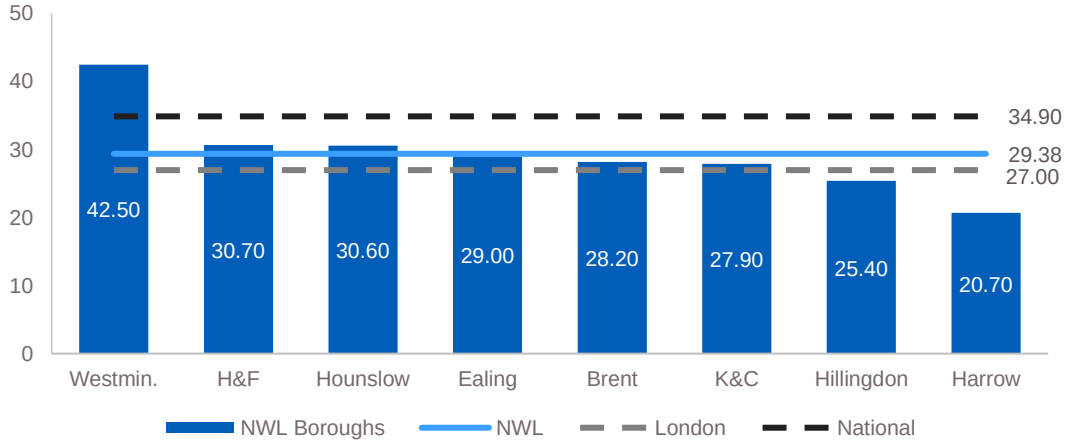
**Source:** Public Health Outcomes Framework, 2021/22




**Violent crime rate:**

Violent offences per 1,000 population [2021/22]

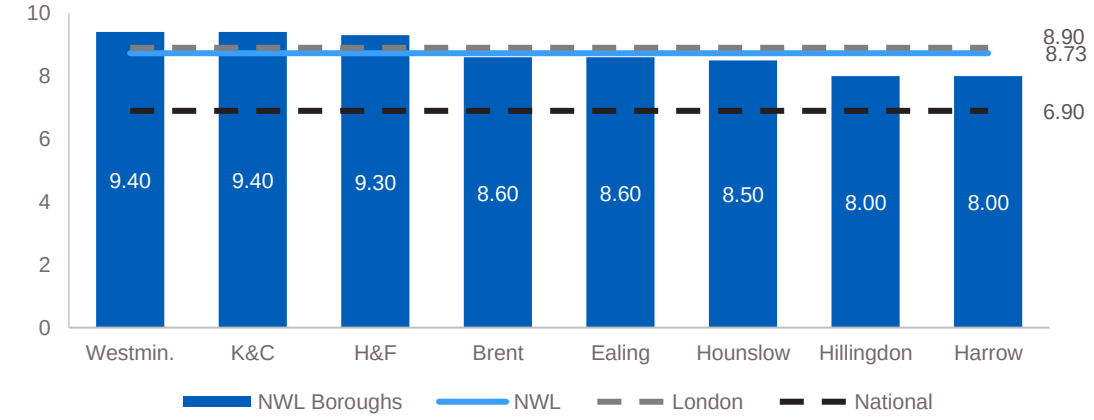
**Source:** Public Health Outcomes Framework, 2021/22




**Air pollution:**

Mean fine particulate matter in micrograms per m3

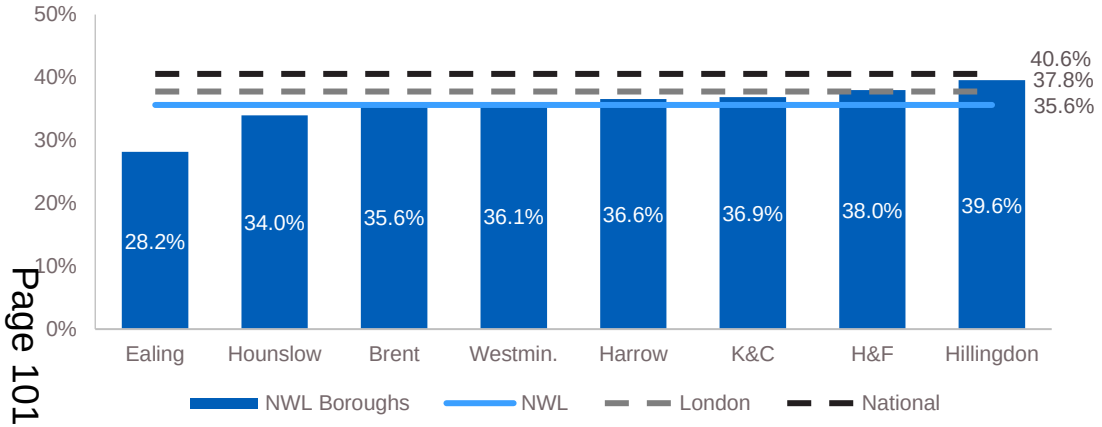
**Source:** Public health profiles, 2020



# Social interaction and physical activity are vital to good mental health

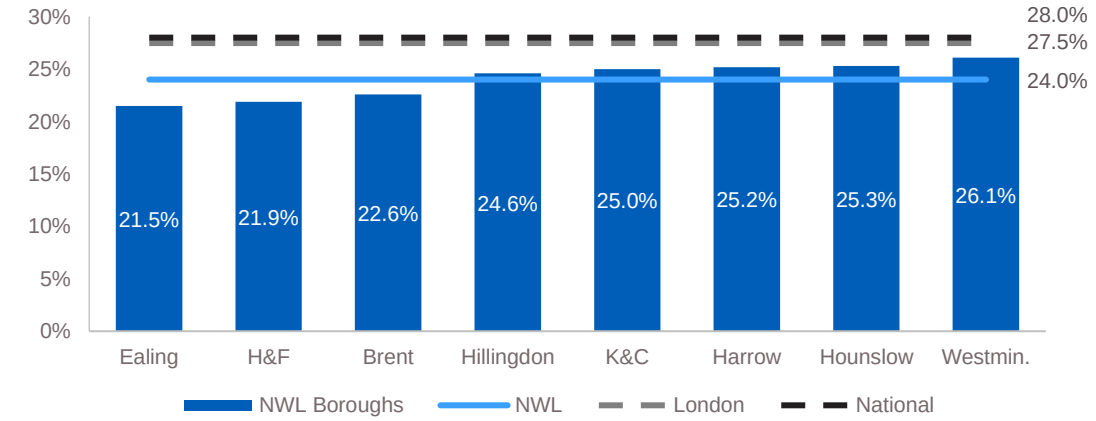
**Social isolation (adult social care):** Proportion of adult social care users who have as much social contact as they would like [2021/22]

**Source:** Public Health Outcomes Framework, 2021/22



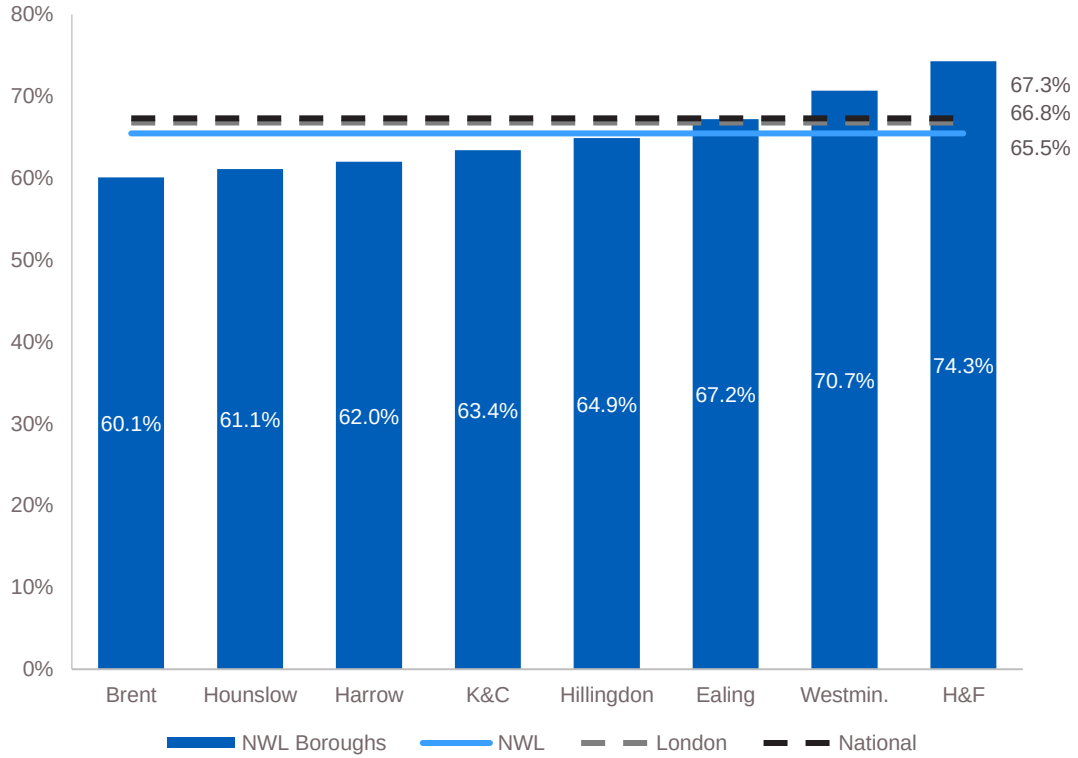

**Social isolation (adult carers):** Proportion of adult carers who have as much social contact as they would like [2021/22]

**Source:** Public Health Outcomes Framework, 2021/22




**Physical activity:**
Percentage of adults who are physically active [2021/22]

**Source:** Public Health Outcomes Framework, 2021/22





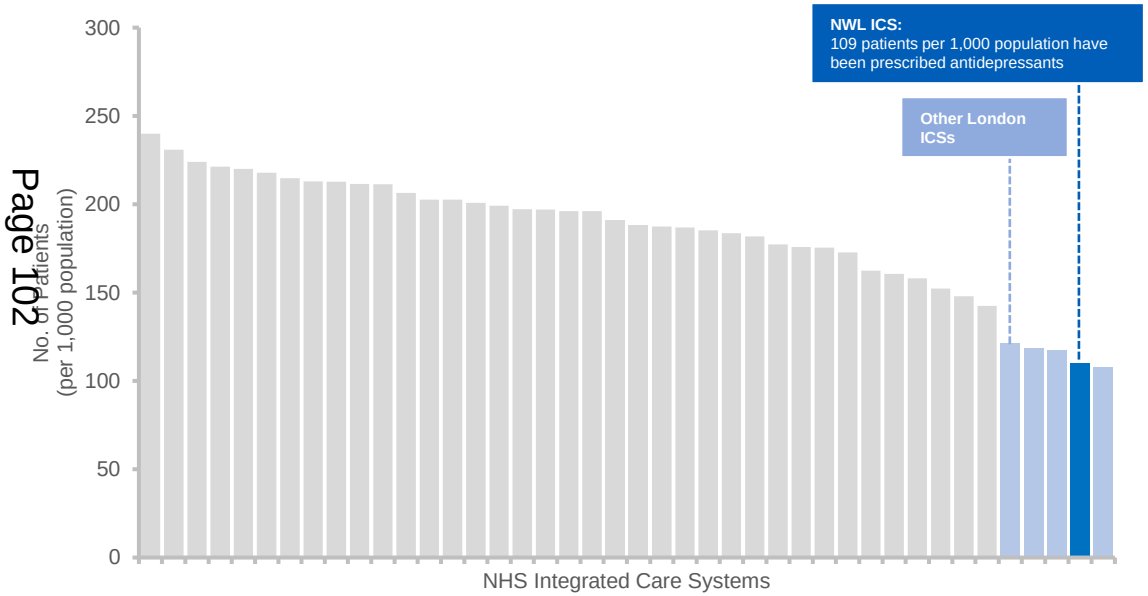



NHS North West London

# North West London has one of the lowest levels of antidepressant prescribing in the country, though this has grown 14% since the pandemic

## No. of patients prescribed antidepressants

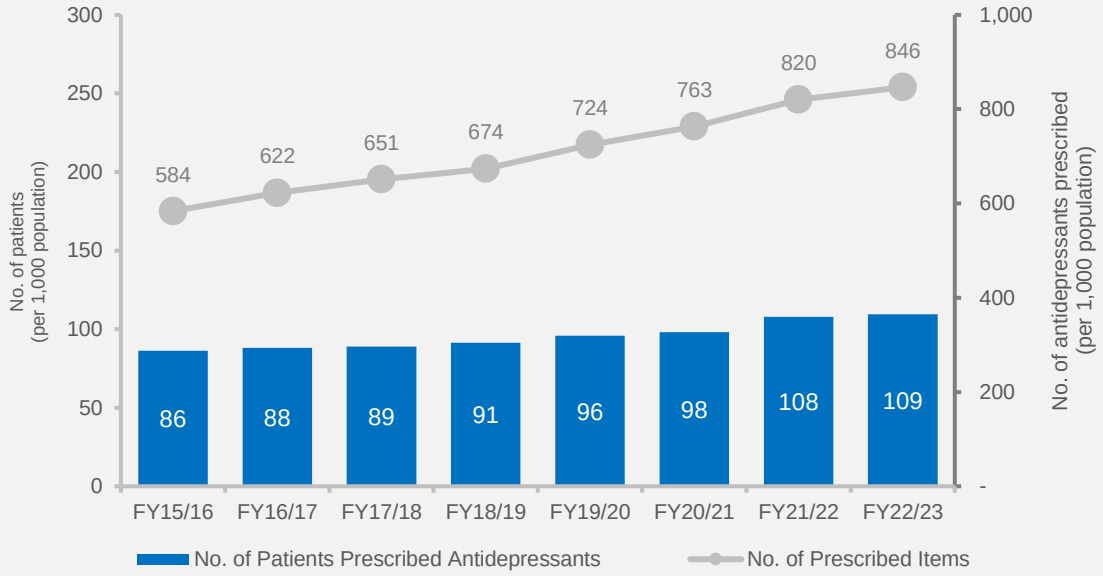
per 1,000 population: FY22/23




- **North West London ICB** has the **2nd lowest** level of antidepressant prescribing.
- **This is in line with other London ICBs**, which together have significantly lower levels of antidepressant prescribing than other England ICBs.
- **The national median is 190 patients per 1,000 population** being prescribed antidepressants – **72% higher than NWL.**
- North East and North Cumbria (NENC) ICB has the highest rate of antidepressant prescribing, with 240 patients per 1,000 population being prescribed antidepressants.

## No. of patients and no. of antidepressants prescribed

per 1,000 population: FY16 – FY23




- North West London ICB's level of antidepressant prescribing has **grown 3% year-on-year** over the **past 8 years,** with **total growth of 27%.**
- The level of antidepressant prescribing has **grown 14% since the COVID-19 pandemic.**
- The no. of antidepressants prescribed has grown at a higher rate – **4.8% year-on-year**, with **total growth of 45%,** suggesting patients with depression are taking more antidepressants than previous levels.

**Source:** NHS BSA Medicines Used in Mental Health Dataset (2015/16 – 2022/23)

# Appendix 2 – workforce priorities



NHS
North West London

# Mental Health Strategy: Workforce priorities 2024-2026

| WF priority | Initiative | Outcomes |
|---|---|---|
| **Recruitment and retention** | • Recruitment to the top five hard to fill, high impact roles that are a core driver for temporary staffing usage:<br>1. Mental Heath nurses<br>2. Psychiatrists<br>3. Occupational therapists<br>4. Psychologists; and<br>5. Social workers | Meet the collective target:<br>• Vacancy rate of 10% or below |
| | • Increase retention of current staff by making our organisations better places to work through the implementation of the exemplar initiatives within the People Promise themes | • Voluntary Turnover Rate at 12% or below |
| | • Recruit refugees, care leavers, volunteers (including service users) into employment each year through Care leavers, refugee and volunteers schemes | • Agreed number each year each year |
| **Equality and diversity** | • Diversify senior leadership and improving experience of black and minority ethnic staff | • Achieve ICS model employer goal of 50% by 2025 |
| | • Agree collective and organisational action to implement the medium term interventions that will embed equality, equity, social and racial justice within our organisations | • Sustained improvement against all 9 indicators of the Workforce Race Equality Standard and the Annual Staff Survey |
| | • Diversify routes into employment to provide a more inclusive pipeline of staff into roles into our allied health, psychological professions and support the new NWL graduate scheme | • Demographic workforce data |

# Mental Health Strategy: Workforce priorities 2024-2026

| WF priority | Initiative | Outcomes |
|---|---|---|
| **Education and training** | • Ensure that the development of a multi professional Education strategy at ICS level reflects the needs of the mental health workforce | • Education Strategy with Mental health delivery Plan |
| | • Allocate places to NW London Graduate Leadership scheme with rotations across all organisations | • Annual cohort of graduates agreed |
| | • Expand number of apprenticeships and use this route to widen access and diversify entry into professional registered roles | • Increase by apprenticeship from xx to yy |
| | • Review clinical placement capacity to support expansion of apprenticeships and student training numbers | • Additional capacity identified in each provider |
| | • Deliver the Oliver McGowan Mandatory Training via the training academies across all organisations as well as continuing a focus on cultural competency and trauma informed practices | • 30% of staff completing the training each year |
| **Workforce transformation and productivity** | • Promote, monitor and track new role development focusing on RNDAs, Psychology CAP roles, advance practice and scope feasibility of physician associate roles | • Track increase in number from 2023 baseline |
| | • Workforce transformation to redesign new ways of working required to support community based models of care through Integrated Neighbourhood Teams | • tba |
| | • Support teams and services to make productivity improvements, ensuring skill sets such as QI are developed to support this | • tba |
| | • Ensure that all the rules for providers on agency expenditure, collectively known as the ‘agency rules’ are enforced and put in measures to reduce reliance on the use of agency staff | • Comply with a ceiling for total system agency expenditure |

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| | |
|---|---|
| Brent<br>NHS<br>North West London | **Brent Health and Wellbeing Board**<br>23 July 2024 |
| | **Report from the Director of Public Health** |
| | **Lead Cabinet Member for Community Health and Wellbeing** |

# Joint Health and Wellbeing Strategy: Refresh to Tackle Health Inequalities

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | Non-Key Decision |
| **Open or Part/Fully Exempt:** (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | One: Joint Health and Wellbeing Strategy Refresh |
| **Background Papers:** | None |
| **Contact Officer(s):** | Dr Melanie Smith<br>Director of Public Health<br>Melanie.Smith@brent.gov.uk<br><br>Agnieszka Spruds<br>Strategy Lead – Policy<br>Agnieszka.Spruds@brent.gov.uk |

## 1.0 Executive Summary

1.1 The Brent Health and Wellbeing Board (BHWB) approved the Joint Health and Wellbeing Strategy in March 2022. In January 2024, the BHWB reaffirmed their commitment to the initially established priorities and, since most of the initial objectives have been achieved or become standard practice, approved the proposal to refresh the strategy. All partners collaborated to propose new commitments, continuing to focus on addressing health inequalities. This document has been prepared to present these new proposed commitments to the BHWB for approval.

## 2.0 Recommendations

The Health and Wellbeing Board is requested to:

2.1 Review and provide feedback on the proposed commitments which refresh the Joint Health and Wellbeing Strategy.

2.2 Endorse the commitments to ensure alignment and support across all relevant departments and stakeholders.

2.3 Approve the Strategy refresh for publication.

## 3.0 Background

### 3.1 Contribution to Borough Plan Priorities & Strategic Context

3.1.1 This report relates to Borough Plan Priority – Healthy Lives.

3.1.2 Every Health and Wellbeing Board is required to produce a Joint Health and Wellbeing Strategy (HWS) which reflects local health needs and to which all partners should have regard.

3.1.3 The global pandemic exposed and highlighted health inequalities, prompting Brent to redefine its approach to developing a new Joint Health and Wellbeing Strategy. The current strategy represents a shift from previously health and care-focused objectives to a broader focus on the social determinants of health, adopting a more community-centred approach.

3.1.4 In January 2024, the Health and Wellbeing Board reaffirmed their commitment to the five priorities and accepted the proposal to refresh the current Health and Wellbeing Strategy. It was noted that the first set of commitments had been narrative-based, which was appropriate at the time and mostly delivered, but there was no quantitative measure of their impact. Following this meeting, officers worked with the ICP Executive Groups, Brent Children's Trust, and Council Departmental Leadership teams to provide commitments for the refreshed strategy. It was emphasised that the new commitments must have clear key performance indicators (KPIs), a solid baseline for measurement, and a clear focus on addressing health inequalities.

## 4.0 Proposed Commitments

4.1 The points below give an overview of the proposed refreshed commitments, divided by the strategy theme they fall under. The full list of commitments, along with their leads, measurement, and a brief narrative on how they address health inequalities, can be found in Appendix 1: Joint Health and Wellbeing Strategy Refresh. These commitments include brand new projects as well as ongoing activities that were not previously included in the main strategy. Capturing this work is essential not only for measuring its health impact but also for receiving the Health and Wellbeing Board's approval and spotlight as this visibility may allow some of these activities to be expanded and further benefit the community.

### 4.2 <u>Healthy Lives</u>

**“I am able to make the healthy choice and live in a healthy way, for myself and the people I care for”**

The new commitments under "Healthy Lives" focus on improving access to healthy food, promoting health and wellbeing through community events, and addressing health inequalities. This includes developing a food strategy, providing diabetes peer support, tackling period poverty, promoting mental health awareness, and implementing initiatives to support vulnerable residents. Efforts are also directed towards improving tobacco cessation support and delivering urgent community care in partnership with local services:

- Co-produce Brent’s first food strategy to improve access to healthy, affordable food.
- Deliver health and wellbeing community events with health checks and health promotion.
- Distribute community grants addressing children's health and development projects.
- Address inequities in access to NHS services through targeted communication activities
- Provide Diabetes peer support and digital inclusion programmes.
- Tackle period poverty with the Period Dignity Brent initiative.
- Address tooth decay in children.
- Increase uptake of Healthy Start Vouchers and vitamins.
- Implement the Brent Health Matters CYP team to address health inequalities in children and young people.
- Improve school pupils' mental health with evidence-based interventions.
- Provide tailored resources to our most vulnerable residents through increasing the accessibility of the Community Hubs.
- Address tobacco-related inequalities via the Smokefree initiative.
- Partner with the London Ambulance Service to deliver urgent community care.
- Appoint two Admiral Nurses for dementia care and support.

## 4.3 Healthy Places

**“Near me there are safe, clean places where I, and people I care for, can go to relax, exercise for free, meet with like-minded people, and where we can grow our own food”**

Key commitments under the “Healthy Places” priority include organising social events to address social isolation, developing sports and activity programmes, improving housing quality, and improving community spaces like Ealing Road Library garden. The refresh also focuses on tackling air pollution, promoting active travel, supporting youth organisations, and providing comprehensive climate action guidance in schools:

- Organise regular social events for Ukrainian guests.

- Work with partners to create the Sport England Place Based Expansion programme and Football Foundation Playzones initiative.
- Develop accessible activities in community spaces and parks, such as walks, Our Parks, and outdoor gym support.
- Improve housing quality in Brent through private sector licensing and adaptations for disabled residents.
- Develop Ealing Road Library garden for community use, leisure and wellbeing.
- Review and refresh climate community engagement, encouraging local green action through Together Towards Zero grants.
- Increase sign-ups to the Healthier Catering Commitment.
- Implement The Music Mile: Mental Health Support Programme to improve mental health and revitalise Kilburn as an inclusive music destination.
- Tackle air pollution by recruiting Air Quality Champions, analysing areas with poor air quality, and providing practical advice on reducing exposure.
- Engage with school children about air quality through interactive maps and educational events.
- Increase active travel participation by creating safe environments for walking, cycling, and other active transportation, as per the Active Travel Implementation Plan.
- Equip all Brent schools with the Climate Action Guide and Plan Template, support them through webinars and Climate Champions Network meetings, provide Carbon Literacy Training, and participate in the "Our Schools Our World" programme.
- Distribute the SCIL Youth Provision Grant for improvements to premises used by youth organisations, enhancing facilities and activities for young people.
- Continue providing early multi-agency intervention and support through Family Wellbeing Centres (FWCs), offering holistic services including employment training and housing assistance, and continuously analysing data to meet family needs.

### 4.4 Staying Healthy

**“I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it.”**

The "Staying Healthy" theme centres on educating and empowering residents to maintain their physical and mental health. This includes providing multilingual mental health services, promoting cancer screening, delivering healthy eating education, and raising mental health awareness. Additionally, there are commitments to improve library services for those with dementia, introduce social prescribing, support informal carers, and reduce hospital admissions through disease education and immediate care pathways:

- Provide mental health services in Ukrainian, Russian, and English for Ukrainian guests and hosts.

- Promote bowel cancer screening in high-risk communities with multilingual awareness presentations and communications.
- Deliver targeted hypertension education in Black communities.
- Conduct healthy eating education and awareness sessions via the Health Educator contract.
- Improve mental health awareness in Brent through co-produced community engagement sessions.
- Assist residents in registering with a Brent GP.
- Provide mental health outreach and raise awareness in neighbourhoods through events and workshops; recruit mental health Community Connectors.
- Improve library service accessibility for Brent residents living with dementia.
- Pilot the introduction of social prescribing in Adult Social Care (ASC).
- Implement the Brent Carers' Strategy to improve information, advice, and guidance for informal carers.
- Develop a Prevention Strategy and implementation plan based on the Care Act principles of preventing, delaying, and reducing the need for care.
- Reduce emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) patients through education and self-management support.
- Reduce hospital admissions via the 'Step-Up Pathway' by providing immediate care accessible directly from community health services or A&E.

### 4.5 Healthy ways of working

**"The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic."**

Commitments under the "Healthy ways of working" theme include providing work opportunities through community programmes, improving partnership working to support holistic health needs, and creating employment pathways for individuals. The refresh also aims to support individuals with mental health conditions in securing employment with assistance from partner organisations:

- Provide work opportunities through the Community Champions and Health Educators programmes for local communities.
- Improve partnership working via the new Community Wellbeing Service to help those with health needs access holistic support, addressing the cost of living.
- Create pathways to employment for individuals referred by GPs, social prescribers, self-referrals, and local employment services, integrating diverse referral pathways for comprehensive support.

- Support individuals with mental health conditions in securing employment with assistance from Twinings, Shaw Trust, the Department for Work and Pensions (DWP), and Brent Works.

**4.6 <u>Understanding, listening and improving</u>**

**"I, and those I care for, can have our say and contribute better to the way services are run; BHWB data are good quality and give a good picture of health inequalities"**

Key commitments include embedding coproduction in Adult Social Care, improving localised approaches to community priorities, working with service user groups to incorporate their voices in service design, and collecting diverse information to inform health improvements.

- Develop and embed coproduction with residents in Adult Social Care (ASC), ensuring services are accessible and culturally appropriate.
- Increase understanding of Brent communities and implement more localised approaches to address their priorities.
- Continue working with service user groups, such as B3, to further embed the voices of service users in the design and delivery of treatment and recovery services.
- Collect information from a range of groups and individuals in Brent to understand and improve health through the JSNA.

## 5.0 Financial Considerations

5.1 None at this stage.

## 6.0 Legal Considerations

6.1 There are no direct legal considerations arising from the contents of the report.

## 7.0 Equality, Diversity & Inclusion (EDI) Considerations

7.1 In developing new 2024/25 commitments against the five themes, health inequalities are explicitly considered.

## 8.0 Climate Change and Environmental Considerations

8.1 In developing new 2024/25 commitments against the five themes, the potential to act to mitigate climate change has been explicitly considered, particularly through commitments aimed at improving air quality or encouraging residents to engage in active travel.

## 9.0 Human Resources/Property Considerations (if appropriate)

9.1 None at this stage.

## 10.0 Communication Considerations

10.1 None at this stage.

***Report sign off:***

***Dr Melanie Smith***
Director of Public Health

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# Brent Joint Health and Wellbeing Strategy Refresh: Tackling Health Inequalities

Brent

healthwatch Brent

NHS North West London

NHS Central and North West London NHS Foundation Trust

NHS Central London Community Healthcare NHS Trust

NHS London North West University Healthcare NHS Trust

Brent ICP Integrated Care Partnership

# Contents

# Brent Joint Health and Wellbeing Strategy

**A Health and Wellbeing Strategy is a plan designed to improve the health and wellbeing of the local population. It identifies key health priorities and outlines the necessary actions to address them. Health and Wellbeing Boards have a statutory duty to produce this strategy, ensuring that the community's health and wellbeing needs are effectively met.**

The global pandemic exposed and highlighted health inequalities, prompting Brent to redefine its approach in developing a new Joint Health and Wellbeing Strategy. The current strategy represents a shift from previous health and care-focused objectives to a broader focus on the social determinants of health while adopting a more community-centred approach.

Brent's Joint Health and Wellbeing Strategy was developed in partnership with residents, health organisations, and voluntary sector organisations.

This collaborative effort established five main themes within the strategy:

- **Healthy Lives**: I am able to make the healthy choice and live in a healthy way, for myself and the people I care for.
- **Healthy Places**: Near me there are safe, clean places where I, and people I care for, can go to relax, exercise for free, meet with like-minded people, and where we can grow our own food.
- **Staying Healthy**: I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it.
- **Understanding, Listening and Improving**: I, and those I care for, can have our say and contribute better to the way services are run; BHWB data are good quality and give a good picture of health inequalities.
- **Healthy Ways of Working**: The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic.

In January 2024, the Health and Wellbeing Board reaffirmed their commitment to these established priorities. Since most of the initial objectives have been achieved or become standard practice, all partners collaborated to propose the new commitments, which continue to be focused on addressing health inequalities. The refreshed commitments feature stronger key performance indicators (KPIs) to measure the progress effectively and continue to focus on addressing health inequalities in Brent.

# About Brent

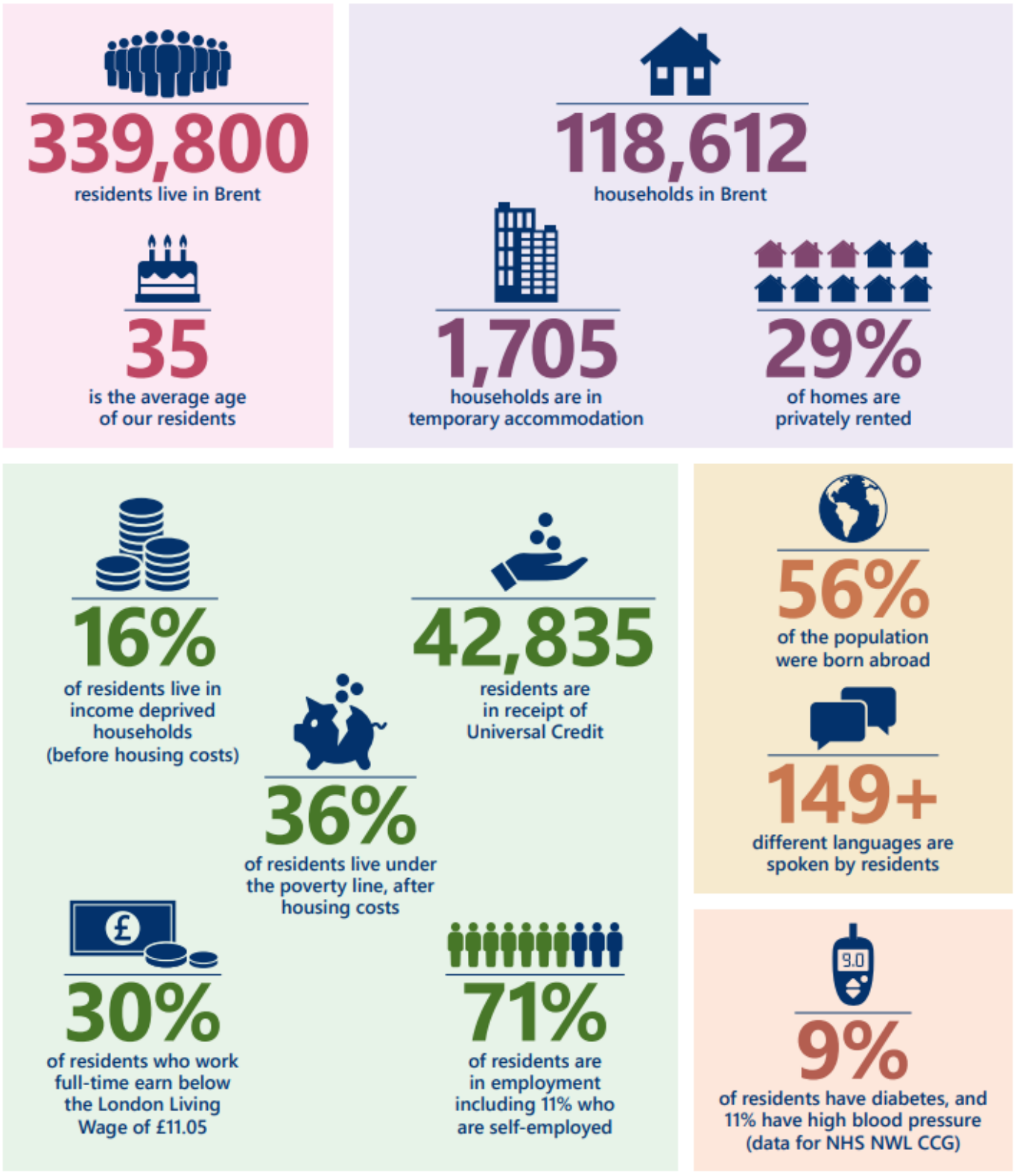
**Brent is situated in North West London. It covers an area of 4,325 hectares, making it London's fifteenth largest borough; about 22% of this is green space. It is also the capital's seventh most populous borough, with a population of 339,800. Brent is also ethnically diverse with almost two thirds of the population (64%) from Black, Asian and minority ethnic groups, the third highest in London. A further 19% of residents are from White minority groups and the remaining 16% of residents are White British, the second lowest rate in London[1].**

Brent has a young population; the median age is 35, five years below the average for England (40); 21% of local people are under the age of 18. It is one of the most diverse boroughs in London – 56% of the local population were born abroad, the largest proportion of any local authority area. We are also ethnically diverse, with 34% Asian, 35% White, 17% Black, and 13% Mixed and other ethnic groups.

The largest single group is the Indian population who comprise 17% of residents. The borough has the third largest Hindu population in England and Wales, and the tenth largest Muslim population (as a percentage of the population). Over 149 languages are spoken in the borough; 34% of residents do not have English as their main language – the second highest proportion in London.

[1] Source: Brent Open Data

# Key facts[2]

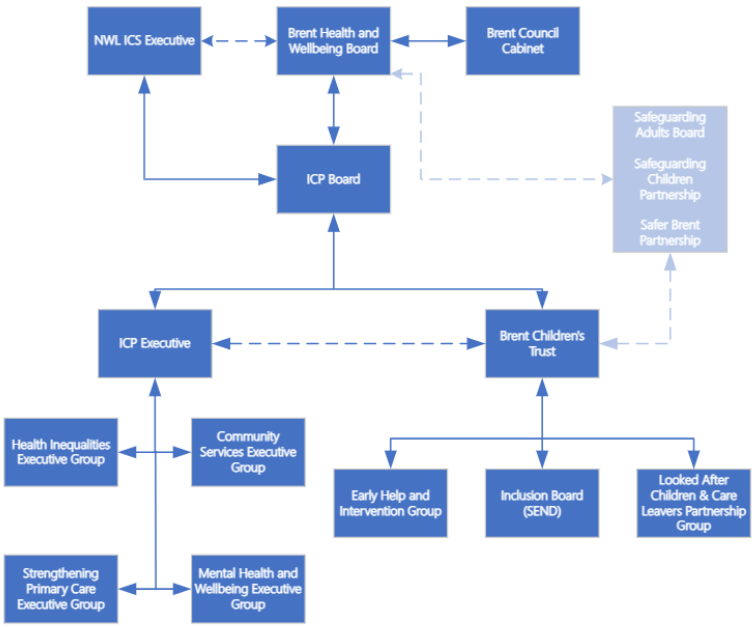



[2] Data source: trustforlondon.org.uk

# Who is responsible for delivering the Joint Health and Wellbeing Strategy?

## The Health and Wellbeing Board is responsible for delivering the Joint Health and Wellbeing Strategy (JHWS).

Health and Wellbeing Boards (HWBs) are a statutory forum where political, clinical, professional and community leaders come together to improve the health and wellbeing of their local population. Health and Wellbeing Boards have a statutory duty to produce a Joint Health and Wellbeing Strategy (JHWS) for their local population, as set out in the Health and Social Care Act 2021. All Board members must have regard for the JHWS in the delivery of their health and wellbeing services and responsibilities.




The Brent Health and Wellbeing Board (BHWB) is made up of key partners, with representatives from:

- Brent Council (including Councillors, Public Health, Adult Social Care, and Children and Young People)
- NHS Brent Integrated Care Partnership Executive Committee
    - North West London Integrated Care Board (NWL ICB)
    - Central and North West London Mental Health Trust (CNWL)
    - Central London Community Health Care (CLCH)
    - London North West University Healthcare (LNWUH)
- Nursing and residential care
- Healthwatch Brent

As well as its statutory role, the BHWB ensures system leadership across commissioners and providers working in Brent. The Joint Health and Wellbeing Strategy (JHWS) outlines the key priorities for the BHWB. Much of the delivery of the strategy sits with the Integrated Care Partnership (ICP) and Brent Children's Trust (BCT).

# What are health and wellbeing inequalities?

**Health inequalities are ultimately differences in the status of people's health, that can be related to a range of different issues that impact on the opportunities they have to lead healthy, well lives.** These can include:

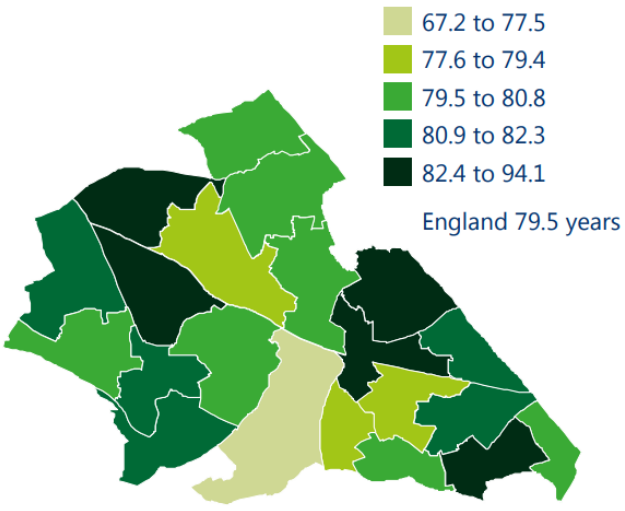
- If someone has any health conditions
- If people are able to access treatment when they need it
- The quality of the care and treatment when it is needed
- Behaviours including drinking alcohol and smoking
- Wider socio and economic determinants of health, for example where someone lives, their housing situation, the nature of their job

Often these inequalities can be experienced by different groups of people for example:

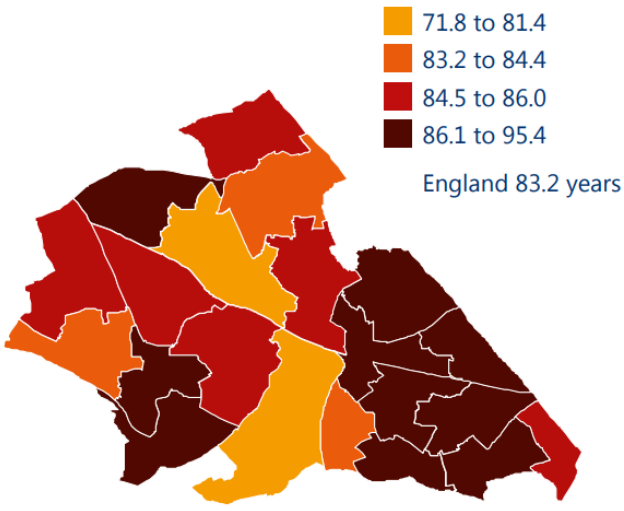
- Those living in more deprived areas and other socio-economic factors, for example those on lower incomes
- Younger and older people, those from black and minority ethnic communities and those living with a disability
- Socially excluded groups such as people experiencing homelessness

People will experience different and/or multiple combinations of these factors, and this will impact on the health inequalities they experience. A simple way of understanding the impacts of these factors is looking at the inequalities in life expectancy. Life expectancy for males at birth in Brent 2018-2020[3] is 80.4 years, female at birth is 85 years. These are lower than most of our neighbouring boroughs. There are differences in life expectancy within Brent too, as shown in the following two maps.

**Male life expectancy at birth (Brent 2016-2020)**




**Female life expectancy at birth (Brent 2016-2020)**






[3] This is the latest available life expectancy data for Brent; no more recent data has been published as of July 2024.

# New and Refreshed Commitments

The table below illustrates the new commitments for the Health and Wellbeing Strategy. These commitments include brand new projects as well as ongoing activities that were not previously included in the main strategy. Capturing this work is essential not only for measuring its health impact but also for receiving the Health and Wellbeing Board's approval and spotlight. This visibility may allow some of these activities to be expanded and further benefit the community.

| 1 | **Healthy Lives**<br>I am able to make the healthy choice and live in a healthy way, for myself and the people I care for | | | | | |
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| | **New commitment** | **How will the new commitment address health inequalities?** | **KPI** | **Baseline** | **Frequency of measurement** | **Lead** |
| 1.1 | We will coproduce Brent's first food strategy in collaboration with community groups and other local organisations. This strategy will improve access to healthy, affordable food for all residents with a focus on food education and sustainability. | By improving access to nutritious food and improving understanding through education, we aim to bridge health gaps and foster equality in health and wellbeing across our communities. | The number of organisations involved in coproducing the strategy.<br><br>Additional KPIs might be considered once the strategy is developed. | Currently, there is no formal food strategy in place for Brent. So far, we have engaged with 37 local organisations during the Visioning Workshop, who have contributed to developing the provisional scope of the strategy. | Annually | Public Health |
| 1.2 | We will deliver health and wellbeing community events throughout the Borough, | We monitor how we are reaching our more deprived | Carry out at least 40 community events per | Public Health and Brent Health Matters currently organise and | Quarterly | Public Health |

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| | including health checks and health promotion. | communities and track the ethnicity of those taking up our offer. Some of our events will have a specific focus, such as those aimed at factory workers or particular faith settings. Additionally, we will coproduce community events to ensure they meet the needs of our diverse population. We will also provide targeted interventions at a community level, focusing on conditions such as CVD, diabetes, and mental health. | month across five localities in Brent. | carry out health and wellbeing events throughout the borough. On average, they hold around 35 events per month, focusing on general health promotion, immunisation, and specific conditions like CVD, diabetes, cancer, and mental health issues. | | |
| 1.3 | We will distribute a minimum of £250,000 in community grants to support projects aimed at improving the health, wellbeing, and development of children and young people. | All grant recipients will identify specific groups of children and young people who currently face health inequalities. By targeting these vulnerable | The number of community organisations supported. | The number of community organisations who were supported last year is: 46 | 6 monthly | Brent Health Matters |

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| | | populations, we aim to reduce health disparities and contribute to more equitable health outcomes within our community. | | | | |
| 1.4 | We will address inequities in access to NHS services through targeted communication activities. | By promoting access to NHS services through social media and flyers, we aim to reach people who currently do not access NHS services in a timely manner. This approach will help raise awareness and provide information to underserved populations, thereby reducing barriers to healthcare and addressing health inequalities. | Promote communications for at least three NHS services through social media and flyers, ensuring a reach of at least 6,000 people per month. | Work has started in collaboration with NHS colleagues. We have promoted the COVID spring booster campaign, the Pharmacy First campaign, and childhood immunisations (MMR), reaching approximately 36,000 people through social media and distributing 500 flyers. | Quarterly | Brent Health Matters |
| 1.5 | We will provide Diabetes peer support and Digital inclusion programmes. | These initiatives aim to provide crucial support and resources to underserved populations, | Deliver at least six Healthy Educators programmes in the community, targeting BAME, emerging communities and | In 2023, we delivered five digital inclusion programmes, each consisting of six sessions, with 48 | Quarterly | Brent Health Matters |

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| | | improving their health outcomes and access to digital health information. | deprived neighbourhoods. | people graduating from the course.<br><br>Additionally, we provided three diabetes peer support programmes, also with six sessions each, which 33 people completed. | | |
| 1.6 | We will tackle period poverty through the rollout of Period Dignity Brent initiative, ensuring that residents have access to free, eco-friendly period products in publicly accessible council buildings across Brent and addressing stigmas and taboos that surrounds menstrual health. | Period Dignity Brent addresses health inequalities by ensuring accessible menstrual products for all, including disadvantaged groups such as asylum seekers, refugees, homeless people, or food bank users, by targeting distribution where we have identified the greatest need, in that way promoting period dignity and improving menstrual health outcomes. | This commitment will be measured by the number of sites providing the Period Dignity offer. We will track whether the offer is available at all the sites we initially targeted. | Currently there are six council buildings that can provide free period products. We have identified a further 10 locations to expand the offer. | Progress will be checked monthly | Public Health<br><br>Communications, Insight and Innovation |

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| 1.7 | We will tackle tooth decay in children in Brent by delivering the mobile dental assessment and intervention programme (oral health bus) directly to primary schools with high rates of overweight and obesity. | We will target areas with high obesity rates, focusing on children living in the most deprived areas (deciles 1-3). | The number of oral health outreach events delivered at primary school: the target is 20.<br><br>The number of children provided with dental assessments and interventions. | Last year the oral health bus visited 17 locations in close proximity to primary schools.<br><br>627 children from these locations were assessed last year. | Annually | Public Health |
| 1.8 | Further increase the uptake of Healthy Start Vouchers and vitamins | We will target all mothers, especially those from deprived areas, to ensure they have access to dental care and education. This focus will help reduce tooth decay in children by addressing the root causes and providing necessary resources and support to those most in need. | Increase the uptake of the Healthy Card Scheme among eligible Brent families by up to 5%.<br><br>Up to 80% uptake of vitamin drops by residents from Family Wellbeing Centres and up to 30% uptake of pregnancy vitamins by residents in Family Wellbeing Centres. | Currently, the uptake of Healthy Start Card scheme among eligible families is 57% in Brent and the uptake of the healthy start vitamins among Brent families was not being reported. | Quarterly | Public Health |
| 1.9 | We will implement the BHM CYP team to tackle Health Inequalities in children and young people. | Our initial focus will be on increasing uptake of immunisation, improving asthma care and increasing awareness for | Total number of vaccinations given by the team.<br><br>Number of children who received asthma reviews and | This is a new initiative, so the baseline is 0. | Annually | Public Health<br><br>Brent Health Matters |

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| | | mental health conditions. By targeting these areas, we aim to reduce health disparities among children and young people, particularly in underserved communities. | management plans as a result of the team's outreach efforts. | | | |
| 1.10 | We will improve the mental health of school pupils through evidence-based interventions. Our skilled mental health practitioners liaise with teachers to identify children experiencing distress, increased absences, or social isolation. | By integrating mental health practitioners into schools and focusing on early, evidence-based interventions, we aim to provide equitable mental health support to all children, thereby reducing health disparities and promoting overall well-being. | The number of referrals.<br><br>Percentage of referrals that progressed to interventions. | From September 2023 to March 2024, we received 98 referrals, of which 83 (approximately 85%) progressed to interventions. | Annually | Mental Health and Wellbeing Executive Group |
| 1.11 | We will continue providing tailored and accessible resources to most vulnerable residents through Community Hubs. | All Hub staff have received basic neurodiversity training, improving their flexible approach and enabling better | The percentage of enquiries resolved at point of contact.<br><br>The number of residents accessing Community Hubs. | The percentage of enquiries at the Community Hubs resolved at point of contact was 82% at the end of Q4 2023/24. | Quarterly | Resident Services |

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| | | support for residents with additional needs. This will improve residents' well-being and may reduce disparities between them and those without additional support needs. | | The number of residents accessing Community Hubs was 5,510 in Q4. | | |
| 1.12 | We will address tobacco related inequalities in Brent via the government smokefree initiative. We will ensure our most vulnerable tobacco users such as pregnant smokers and smokers in drug & alcohol services are given the opportunity to quit. | By identifying areas of need, and engaging with underserved communities, such as the newly arrived communities and Paan consumers, to address barriers and co-produce a stop tobacco service that is accessible and culturally appropriate. | Number of organisations/ individuals (i.e. community champions) that engage with the initiative.<br><br>Stop tobacco service activity as measured by number of referrals, those setting a Quit Date, or those that have Quit successfully using the programme. | We currently run a public health specialist stop tobacco service, with varying referral pathways into communities/ partner organisations.<br><br>In 2022/23, 33 smokers joined the stop tobacco service, 45% of these managed to quit. | Monthly internally.<br><br>Quarterly, with formal quarterly returns to the Department of Health | Public Health |
| 1.13 | In partnership with the London Ambulance Service, the Brent Rapid Response team will deploy clinicians alongside senior paramedics to provide urgent | This service addresses health inequalities by providing quicker response times for Category 3, 4, and 5 | The number of A&E attendances prevented by this pathway. | This project is in the pilot phase. Currently, the pathway prevents approximately 30 A&E attendances every month. | Monthly | Brent Integrated Care & Delivery Team, NWL ICB |

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| | community care. This initiative aims to prevent avoidable hospital admissions and alleviate pressure on emergency services by managing Category 3, 4, and 5 patients directly in the community. | patients, who typically wait longer for care. In Brent, where chronic conditions like diabetes and hypertension are common, timely and multidisciplinary care is crucial. The collaboration between BRR and LAS ensures these patients receive holistic and individualised treatment, improving health outcomes and reducing disparities. | The number of residents benefiting from this pathway. | Data collected from the last six months suggests 5-6 patients a day benefit from this service. | | CLCH – Brent Rapid Response Team |
| 1.14 | We will appoint two Admiral Nurses to provide emotional care and support for families and patients at the pre-diagnosis stage or those already diagnosed with dementia. These nurses will offer skills and techniques to help families stay connected, manage fear and distress, advise on financial benefits and available support services, and ensure that | This commitment will tackle health inequalities by ensuring families and patients affected by dementia receive specialised, personalised support. Admiral Nurses will provide essential skills and techniques to manage emotional | Each admiral nurse to have a minimum of 15 patients per case load of which at least 46% should have a BAME background.<br><br>75% of patients to remain at home rather than being admitted to a care home within a 12 month period. | These are new posts, so no baseline yet. | Quarterly | Integrated Care & Delivery Team, NWL ICB |

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| | both carers and patients receive the best possible additional care. | and practical challenges, reducing stress and improving quality of life. By advising on financial benefits and support services, they will help families access necessary resources, ensuring equitable care for all, regardless of socioeconomic status. | Reduction in GP visits commencing Admiral Nurse involvement.<br><br>Reduction in Hospital admissions commencing Admiral Nurse involvement.<br><br>85% of patients/carers/families to feel less isolated and feel that they can cope better following the support of the admiral nurse. | | | |
| **2** | **Healthy Places**<br>Near me there are safe, clean places where I, and people I care for, can go to relax, exercise for free, meet with like-minded people, and where we can grow our own food | | | | | |
| | **New commitment** | **How will the new commitment address health inequalities?** | **KPI** | **Baseline** | **Frequency of measurement** | **Lead** |
| 2.1 | We will organise regular social events for Ukrainian guests. | This will be twofold; it will ensure Ukrainians will be able to meet other Ukrainians who are in the same situation as them, maintaining | Number of social events available for Ukrainians (commissioned by the council) | At least one social event a month on average | Quarterly | Communities and Partnerships |

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| | | good mental health. The health inequality addressed is that the Ukrainian community, which could potentially be marginalised, is not marginalised. | | | | |
| 2.2 | We will work with partners to create Sport England Place Based Expansion programme and Football Foundation Playzones initiative | We will focus on residents in agreed locations (Stonebridge, Church End and Roundwood).<br>By conducting consultations and data collection to identify community needs and gaps in provision, we aim to create inclusive spaces that promote physical activity and community engagement.<br>This will address health inequalities by providing equitable access to sports and recreational facilities. | • Amount of funding secured from Sport England<br>• Number of community steering group established.<br>• Numbers of people engaged in new activities.<br>• Numbers of people new to Physical Activity. | Currently, there is no coordinated programme in the targeted locations (Stonebridge, Church End, and Roundwood). Initial consultations and community needs assessments are pending, and no funding has been secured yet. | Annually | Public Health<br><br>London Sport Community Organisations |

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| 2.3 | We will develop the programme of accessible activities in community spaces and parks, working with community organisations, for example walks programme, Our Parks, support to use outdoor gyms. | We will target residents, particularly those from priority groups such as children and young people, individuals with long-term health conditions, and inactive populations. By providing accessible activities, we aim to improve physical health, foster community engagement, and reduce health disparities among these groups. | • Number of programmes offered.<br>• Number of participants.<br>• Number of referrals made from health professionals. | Public Health currently operates an activity programme in parks. There is an ongoing need to increase participation and engagement, particularly among priority groups identified. | Annually | Public Health |
| 2.4 | We will improve the quality of housing in Brent across the private sector though borough wide licensing of the private rental section and an adaptations programme that makes sure that disabled residents live in homes that meet their needs. | Poor quality PRS housing is a significant contributor to health inequalities as is housing which is unsuited to residents with disabilities. | Number of properties licensed; the target is 12,000.<br><br>Amount spent on adaptations. | In 2023/24, 9,500 properties were licensed.<br><br>In 2023/24, we have allocated £8.1m on adaptations. | Annually | Housing Services |
| 2.5 | We will develop Ealing Road library garden for | A lack of access to green space | Outdoor Programming: Number | Current number of events from Spring | Annually | Resident Services |

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| | community use and leisure, programming, plant growth, support health and wellbeing. | contributes to health inequalities. | of Family Learning/Adult Events – 12 | 2024: 3 Family Learning/Adult events, with 32 adults and 51 children participating. | | |
| 2.6 | We will review and refresh our approach to climate community engagement and encourage local green action through our Together Towards Zero grants. | Grants are allocated boroughwide to address all key themes in the climate strategy but applications from seldom heard groups and those particularly impacted by the adverse effects of climate change are particularly encouraged. | Number of community grants, target: minimum of 15. | In 2023/24 we allocated 23 grants. | Annually | Communities and Partnerships |
| 2.7 | We will further increase sign up to the Healthier Catering Commitment. | This initiative aims to promote healthier eating habits, particularly benefiting residents in deprived areas where access to healthy food options is limited. | • Number of businesses signed up to the Healthy Catering Commitment<br>• Aim for 20 new sign-ups in 2024<br>• Additional 10 new sign-ups each subsequent year | Current number of businesses signed up: 0 | Annually | Public Health |

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| 2.8 | We will work with partners from Kilburn State of Mind, Brent Council, networks, and volunteers to implement The Music Mile: Mental Health Support Programme, which aims to improve the mental health and wellbeing of residents from underserved groups and to revitalise Kilburn as a music destination. | This commitment will address health inequalities by focusing, but not limiting to, residents from Black, African, and Caribbean backgrounds. It will engage delivery partners who are musicians with prior experience in mental health support and will reach local residents attending the festival, thereby promoting mental health and wellbeing within underserved groups. | Number of individuals receiving music lessons and performance training: Target 20-30 participants.<br><br>Number of semi-professional musicians who previously accessed mental health support delivering the lessons: Target 10 musicians.<br><br>Number of local residents attending the festival, particularly those struggling with mental health issues and isolation: Audience target will be determined based on venue capacity. | This is a new project, so the baseline is 0. | Annually | Resident Services |
| 2.9 | We will tackle air pollution in Brent by recruiting Air Quality Champions to improve local understanding of air quality issues and provide practical advice on reducing exposure to air pollution. | Cleaner air benefits everyone, especially people living in areas with high pollution levels, which are often linked to lower income. This helps reduce health | Number of Air Quality Champions recruited.<br><br>Number of vulnerable or disadvantaged individuals reached and supported by the Air Quality Champions | No Air Quality Champions have been recruited yet, so the baseline is 0. | Quarterly | Public Health |

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| | | differences among different communities. | The number of people involved in Air Quality projects that attend the associated workshops. | | | |
| 2.10 | We will engage with school children to educate them and raise their awareness about air quality issues through interactive maps showing high and low pollution routes within a 5–10-minute walking radius of schools, and by organising educational air quality events. | By educating children about air quality and providing them with practical tools, we help protect their health, particularly those who are most vulnerable. This initiative promotes equal access to important health information, helping to reduce the disparity in health outcomes among different communities. | We will collect data through a survey to measure the number of children who have changed their travel habits to use lower pollution routes to school.<br><br>The number of educational events organised related to air quality and pollution awareness. | We are currently supporting schools to submit their travel plan for this academic year and will use this years' data as the baseline. The data will be available by the end of July. | Quarterly | Public Realm |
| 2.11 | We will increase participation in active travel by creating safe environments where people can confidently walk, cycle, and use other forms of active transportation. | Active travel, such as walking and cycling, boosts physical activity, which reduces the risk of chronic diseases. It also improves | We aim to reduce traffic levels to 994 million vehicle kilometres by 2027 by having fewer vehicles on Brent's roads or | The targets were set pre-pandemic with Brent's baseline traffic at 1,098 million vehicle kilometres annually. | Annually | Inclusive Regeneration and Employment |

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| | Through the implementation of the Active Travel Implementation Plan, we aim to promote these activities to improve public health, reduce traffic congestion, and lower environmental impact. | mental health by lowering stress and anxiety, particularly benefiting underserved communities with limited access to recreational facilities. Reducing car use cuts pollution and traffic, creating a healthier environment and lowering transportation costs for low-income families, allowing more resources for other needs. | vehicles travelling shorter distances.<br><br>We aim to increase the proportion of residents engaging in at least 20 minutes of active travel to 41% by 2026/27. | The proportion of Brent residents doing at least 20 minutes of active travel a day is 31% as of 2022/23 data. | | |
| 2.12 | We will equip Brent schools with the Climate Action Guide and Plan Template, support them through regular webinars and Climate Champions Network meetings, and provide Carbon Literacy Training. Additionally, we will participate in the "Our Schools Our World" programme to improve sustainability education and | By integrating sustainability into the curriculum and school activities, we foster a sense of environmental stewardship and provide equal opportunities for students to engage in green careers. Additionally, schools in disadvantaged | The number of schools actively using the Climate Action Guide and Plan Template.<br><br>The attendance at the regular climate action webinars.<br><br>The number of sustainability leads trained through the | There are approximately 10 schools that use the guide.<br><br>There were two webinars organised so far with the attendance of 13.<br><br>This is a new programme, so the baseline is 0. | Quarterly | Communities and Partnerships |

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| | initiatives, ensuring every school has a trained sustainability lead to drive effective climate action. | areas will receive targeted support, helping to bridge the gap in environmental education and empowering all students to contribute to a sustainable future. | "Our Schools Our World" programme.<br><br>The number of schools that have successfully created and implemented a climate action plan. | This is a new project, so the baseline is 0. | | |
| 2.13 | We will distribute the SCIL Youth Provision Grant to fund structural changes and improvements to premises used by youth organisations, enabling better access and increasing facilities and activities for young people in the London Borough of Brent. | We are especially targeting highly deprived areas to tackle health inequalities and ensure that young people have access to a range of facilities and places where they feel safe and at ease. | The number of successful applications. | 19 EOI's have been submitted out of which 12 have been progressed to application stage. | Annually | Early Help and Social Care |
| 2.14 | We will continue providing early multi-agency intervention and support through our Family Wellbeing Centres (FWC). By working with partners, we offer services including health, education, and wellbeing, taking a holistic approach to family needs. We will continuously analyse | By analysing data and collecting feedback from families, we ensure our FWCs offer services tailored to Brent's families' needs. This approach aims to equip FWCs with the ability to address issues | The number of families supported by FWCs. | In 2023/24 a total of 18,113 families accessed FWCs. | Please provide | Early Help and Social Care |

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| | data from families to ensure our services meet their needs, preventing escalation to more specialist services. | before they become serious problems, which may prevent health disparities. Continuously analysing family data allows us to respond dynamically, ensuring services remain effective and relevant. Tailoring FWC offer based on family feedback reduces the risk of health inequalities. | | | | |
| **3** | **Staying Healthy**<br>I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it. | | | | | |
| | **New commitment** | **How will the new commitment address health inequalities?** | **KPI** | **Baseline** | **Frequency of measurement** | **Lead** |
| 3.1 | We will provide mental health services in Ukrainian, Russian, and English for Ukrainian guests and all hosts. | This will ensure that residents who are affected by the war in Ukraine either as Ukrainians or hosts who are providing a home for Ukrainian guests have access | Commission providers to provide:<br>• face-to-face mental health support<br>• 24/7 virtual mental health support | We have mental health provision for hosts, and face-to-face for guests. We are in the process of commissioning 24/7 virtual mental health support for guests. | Quarterly | Communities and Partnerships |

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| | | to suitable mental health services in their own language (Ukrainians only). | | | | |
| 3.2 | We will promote bowel cancer screening services in communities high at risk through awareness presentations and communications in different languages. | This commitment will focus on communities with high risk of developing cancer such as people living in deprived areas, Pakistani, Black African, Black other ethnicities, and people with Severe Mental Illness (SMI). | Deliver 10 engagement events with target communities. | Delivered 9 bowel cancer screening awareness presentations to communities between December 2023 and April 2024.<br><br>Working with the bowel cancer screening service at St Marks Hospital to arrange ordering of test kits for eligible people. | Quarterly | Brent Health Matters |
| 3.3 | We will deliver targeted work on hypertension in black communities. | We will focus on Black communities and individuals, aiming to reduce health disparities related to hypertension. | Support at least 100 patients with hypertension who haven't had a recorded blood pressure measurement in last 18 months. | Recorded blood pressure of 237 hypertensive patients and updated this on their GP records in 2023/24 | Quarterly | Brent Health Matters |
| 3.4 | We will deliver education and awareness sessions on healthy eating to local | People who don't normally access health care services such as those from | Deliver at least 50 health education and awareness sessions via our Health educator | Provided case management support to 66 people with or at risk of developing | Quarterly | Brent Health Matters |

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| | communities via our Health Educator contract. | BAME and emerging communities, as well as residents from deprived neighbourhoods. This initiative aims to reduce health disparities by providing essential health education and promoting healthy eating habits. | contract, targeting BAME communities.<br><br>Successfully support at least 50 people with or at risk of developing Diabetes (or other conditions) to achieve their lifestyle/healthy eating goals. | Diabetes in the last year (April 2023-2024). | | |
| 3.5 | We will improve mental health awareness in Brent through coproduction of community engagement sessions | We will target people with common mental health conditions, aiming to reduce disparities by providing essential mental health education and support. | Deliver at least 50 Mental Health awareness sessions.<br><br>Co-produce at least 50% of sessions. | Mental Health team within Brent Health Matters delivered 20 workshops for communities in 2023/24. | Quarterly | Brent Health Matters |
| 3.6 | We will assist residents to register with a Brent GP. | . This initiative aims to reduce health disparities by connecting residents with essential health and care services. | Aim to assist at least 150 residents in registering with a GP or accessing health services. | Public Health and Brent Health Matters supported 114 to register with GP last year. | Quarterly | Brent Health Matters |

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| 3.7 | We will provide mental health outreach and raise awareness in our most impacted neighbourhoods through events and workshops. Additionally, we will recruit mental health Community Connectors to educate and empower these communities. | We have identified three areas in the borough with the highest number of A&E admissions due to mental health crises, with the vast majority of these admissions being from Black and Asian communities. This illustrates significant health inequalities in these areas, which we aim to address through targeted approach. | Reduced number of A&E admissions from people in mental health crisis and decreased percentage of approaches from Black and Asian communities.<br><br>The number of mental health awareness events and workshops organised.<br><br>Number of people engaged through awareness events and workshops and proportion of attendees from Black and Asian communities. | In 2023/24, 176 people presented to A&E with a mental health crisis, with 85% of these admissions being from Black and Asian communities.<br><br>In 2023/24, we organised 129 events and 114 workshops and training sessions.<br><br>In 2023/24, we engaged with 5,326 people. | Annually | Mental Health and Wellbeing Executive Group<br><br>Brent Health Inequalities Team (CNWL)<br><br>Brent Health Matters |
| 3.8 | We will improve the accessibility and appropriateness of the library service for Brent residents living with dementia. | This commitment addresses health inequalities by ensuring Brent residents with dementia have better access to tailored library services. Improved publicity, home | Increase the number of homes receiving deliveries to 15.<br><br>Provide 6-8 boxes of dementia-friendly items, each containing 35 items, to homes. | Current delivery: 10 Homes.<br><br>Current stock: 15 items.<br><br>This will be our first time applying for the | Annually | Resident Services |

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| | | delivery, dementia-friendly materials, and accessible cultural venues ensure these residents can engage with library resources. Additionally, seeking funding for specialised programmes supports their cognitive and social needs, promoting overall wellbeing and inclusion. | Successfully apply for and receive designation status for Brent Libraries under the Arts Council England Designation Scheme.<br><br>Submit a successful Arts Council England (ACE) funding application by March 2025 (only one ACE application can be submitted at a time). | ACE Designation Scheme and funding. | | |
| 9 | Pilot the introduction of social prescribing into ASC. | The pilot will help to support people who are on the cusp of adult social care and have been referred to Brent Customer Services. Referrals come from other services such as the social prescribers in the primary care networks and other such as self-referrals to adult social care. Referrals include | Activity data and outcomes data:<br><br>Number of referrals<br><br>Types of referral/support requested<br><br>Number of allocations to social prescriber coordinators<br><br>Cases opened and cases closed | No current baseline. | Quarterly via the Oversight Board. | Adult Social Care |

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| | | groups from all communities many of whom will be experiencing health inequality. | Average length of intervention<br><br>Outcomes<br><br>Survey data – service user experience | | | |
| 3.11 | We will improve the information, advice, and guidance accessed by informal carers by implementing the Brent Carers' Strategy, which was co-produced with them. | Becoming a carer often has a negative impact, especially on young people. It affects their work, education, and mental health. Carers' wellbeing often deteriorates as soon as they take on caregiving responsibilities. Any additional support given to them could positively impact their wellbeing and reduce health inequalities between carers and those without such responsibilities. | The number of carers accessing services and resources.<br><br>The number of young identified through the Early Help Assessment and Child and Family Assessment.<br><br>The number of young carers being identified by their schools or health services. | Approximately 35 new young carers referrals to Brent Carers Centre.<br><br>924 adult carers accessed services and resources in the financial year 2023/24.<br><br>Approximately 50 young carers identified through the combined Early Help Assessment and Child and Family Assessment.<br><br>Approximately 60 young carers identified via schools. | Please provide | Adult Social Care<br><br>Early Help and Social Care |

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| 3.12 | Develop a Prevention strategy and implementation plan based on the Care Act principles of preventing, delaying and reducing the need for care | The strategy and delivery plan is underpinned by the principle of reducing health inequalities. Part of the delivery plan will involve data analysis, scrutinising cohorts who we know to be at risk of developing or exacerbating health conditions and developing interventions which will reach them earlier. | As part of the plan a set of outcome measures will be developed. These are likely to include but not limited to;<br><br>Increased uptake of support measures for carers<br><br>Decreased number of people accessing social care services for the first time through a hospital admission<br><br>Increasing number of people accessing Reablement services<br><br>Increasing number of people accessing information and advice through the Brent website | Current there is no strategy or plan which brings together preventative interventions across health and social care. | Monthly via Transformation Board | Adult Social Care |
| 3.13 | We will reduce emergency hospital admissions for patients with Chronic Obstructive Pulmonary Disease (COPD) through delivering disease education, | A disproportionate burden of COPD occurs in people of low socioeconomic status due to differences in health | 5% reduction in unplanned admission from the previous year. | The number of NEL from Nov 2022 (M8) to October 2023: 347 | Quarterly | Brent Integrated Care & Delivery Team, NWL ICB |

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| | support self-management and techniques to manage their condition independently at home. | behaviour such as tobacco smoking, social and physical environment which play leading roles in lung disease development and is also associated with worse COPD outcomes.<br>An effective intervention is to target and educate this cohort of patients. | | | | |
| 2.14 | We will reduce hospital admissions through the 'Step-Up Pathway', a service that utilises a dedicated bed to provide immediate care, accessible directly from community health services or via the A&E. | This approach reduces the need for hospital admissions. By optimising the use of hospital resources, the pathway improves access to healthcare for everyone, including the most at-risk populations, therefore reducing health disparities. | The number of residents receiving care within two hours. | This is a new project, so the baseline is 0. | Monthly | Brent Integrated Care & Delivery Team, NWL ICB |

| 4 | Healthy ways of working<br>The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic. | | | | | |
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| | **New commitment** | **How will the new commitment address health inequalities?** | **KPI** | **Baseline** | **Frequency of measurement** | **Lead** |
| 4.1 | We will provide work opportunities via our community champions and Health educators programme for local communities | We will target people who are unemployed from local communities, providing them with employment opportunities and training. This initiative aims to reduce economic disparities and improve health outcomes by engaging community members in meaningful work. | Number of new work opportunities provided to residents in Brent. | Local recruitment is prioritised within BHM with 14 Health Educators and 41 Community Champions recruited in 2023. This included two new Health Educators. | Yearly | Brent Health Matters |
| 4.2 | We will improve partnership working through the new Community Wellbeing Service to enable those with health needs to access the holistic support offer addressing the cost of living. | The Community Wellbeing service will be accessible to residents with physical and mental health needs through referral | Number of referrals from health and public health professionals to the new service. | This is a new service so no baseline. | Quarterly | Communications, Insight and Innovation |

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| | | routes with key partners. | | | | |
| 4.3 | We aim to provide pathways to employment for individuals referred by GPs, social prescribers, self-referrals, and local employment services. By integrating these diverse referral pathways, we can ensure comprehensive support for those in need. Through this initiative, we aim to support individuals with mental health conditions in securing employment, with assistance from Twinings, Shaw Trust, the Department for Work and Pensions (DWP), and Brent Works | We aim to address health inequalities by providing employment opportunities to those with mental health challenges. Through this initiative, we can help reduce economic disparities, thereby improving overall health and well-being. Employment is a critical factor in improving mental health outcomes, and by supporting individuals in gaining employment, we help enhance their financial stability, social inclusion, and overall quality of life. | We aim to assist 160 people in gaining employment. | Our current baseline is 149 people with mental health supported into employment. | Quarterly | Inclusive Regeneration and Employment |

| 5 | Understanding, listening and improving<br>I, and those I care for, can have our say and contribute better to the way services are run; BHWB data are good quality and give a good picture of health inequalities | | | | | |
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| | **New commitment** | **How will the new commitment address health inequalities?** | **KPI** | **Baseline** | **Frequency of measurement** | **Lead** |
| 5.1 | We will develop and embed coproduction with residents in ASC and ensure services are accessible and culturally appropriate. | The Co-production Champions will work across a spectrum of services and community groups to engage individuals and partners in the coproduction and codesign of adult social care services. Working closely with Public Health colleagues we will identify groups who are less well served by Adult Social care e.g. Gypsy and Roma communities and develop engagement strategies and plans that are appropriate. | Activity data on engagements:<br><br>Number of people engaged.<br><br>Number of referrals to Brent Customer Services/Adult Social Care<br><br>Number of recorded service users on Mosaic from specific groups | In Adult Social Care's recent self-assessment, we identified the following:<br>'We are also very aware that there may be groups we are under-serving. For example, over the past year, there were no service users who were identified as Roma, Gypsy and Traveller or with an LGBTQIA+ identity. This is not in line with what we know about the population composition within Brent and could reflect accessibility, disclosure and recording challenges. | Quarterly | Adult Social Care |

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| | | We will review our system and practice around recording demographic groups to better reflect the communities in Brent (where we are able to make changes). | | We recognise we have further work in this area to identify and engage with groups where there may be unmet need. | | |
| 5.2 | We will establish a programme of ward-level data insight sessions with elected members, including continued development of ward profiles to inform ongoing discussions between councillors and officers.[4] | Councillors will have a greater understanding around their residents, which will inform the strategic discussions and policy making process. This includes identifying trends across different wards, which often might be health or wellbeing related. | The number of sessions delivered | We have delivered four sessions in Spring 2024. | Annually | Communications, Insight and Innovation |
| 5.3 | We will continue working with service user groups, such as B3, to further embed the voices of service users in the design and delivery of | This commitment directly addresses health inequalities by ensuring that the design and delivery of treatment and | The number of individuals who have successfully completed the recovery champion course and are available to support | By the end of the financial year 2023/24, there were 46 recovery champions who had successfully completed the course. | Quarterly | Public Health |

[4] Pilot sessions and next steps are pending evaluation.

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| | treatment and recovery services. | recovery services are informed by those who use them, particularly those from marginalised groups. | and guide others through their recovery journey.<br><br>The number of new attendees to BSAFE sessions. | In the financial year 2023/24, there were 99 new attendees at BSAFE sessions. | | |
| 5.4 | We will collect information with a range of groups and individuals in Brent and use this to understand and improve health. | This will include conversations with community groups and individuals who have everyday experience of health challenges. We will focus on topics that affect groups that currently have poorer health or are less well served by public health initiatives. We will take a community researcher approach where possible so that local people are involved in the planning, delivery and learning from the research. | Include people with lived experience in 100% bespoke health needs assessments over the next year.<br><br>Take a participatory research approach in at least one evidence and insight project over the next year.<br><br>Prioritise including representatives from at least two new community groups. | Where appropriate in terms of methodology, we have incorporated resident's view in 4 out of 6 (66%) bespoke needs assessments in the previous year.<br><br>We currently engage with communities that have some established connect with public health. We aim to hear from more people in different communities within Brent. | Annually<br><br>Through each new project research design (at scoping phase) as well as at the end of each project to establish learning from participant recruitment phase. | Public Health |

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| Brent<br>NHS<br>North West London | **Brent Health and Wellbeing Board**<br>23 July 2024 |
| | **Report from the Corporate Director Community Health and Wellbeing** |
| | **Cabinet Member for Community Health and Wellbeing - Councillor Neil Nerva** |

# Brent Carer's Strategy 2024-2027

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| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | Non-Key |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | Appendix 1 – Brent Carers' Strategy 2024-2027<br>Appendix 2 – Supporting Informal Carers |
| **Background Papers:** | None |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Sitabile Pswarayi<br>Head of Service, Project Implementation<br>sitabile.pswarayi@brent.gov.uk<br><br>Lynette Gbedze<br>Service Manager, Direct Services<br>lynette.gbedze@brent.gov.uk |

## 1.0 Executive Summary

1.1 The report sets out the council's responsibilities to carers, provides demographic information on carers in the borough, and carers supported by Adult Social Care. The report also includes information on the engagement work that has taken place to inform and develop the Carer's strategy for unpaid carers and an overview of the draft implementation plan.

## 2.0 Recommendation(s)

2.1 Health and Wellbeing Board Members are asked to review and comment on the proposed work to improve support for Carers in the Borough and:

- Support the development and implementation of the Carers Strategy 2024 – 2027
- Sign-off a final version of the Brent Carers Strategy 2024 – 2027
- Review and comment on the proposed implementation plan of the Brent Carers Strategy

## 3.1 Detail

3.1.1 Unpaid carers play an essential role in keeping vulnerable residents independent in our communities, often providing support that delays, or prevents admissions to hospitals, or more expensive and restrictive forms of care. As such, supporting people in their caring roles is a high priority not just for Adult and Children's Social Care, but for all the partners within the Integrated Care Partnership.

### 3.2 Contribution to Borough Plan Priorities & Strategic Context

3.2.1 Amongst other stakeholders, carers were consulted as part of the development process of the Borough Plan (2023-2027). This report relates to Priority 5 of the borough plan - A Healthier Brent (Desired Outcome 1: Tackling Health Inequalities) Informal carers are twice as likely to suffer from poor health compared to the general population. Carers who provide more hours of care a week have poorer health.

3.2.2 The Brent Carers Strategy aims:

- To set out a local offer for carers in Brent that includes all the different forms of support across health and social care available to carers in one place, as well as details of how each one can be accessed.
- Continually listen to the challenges that carers tell us they are facing and aim to develop services and resources that will make real, long-lasting differences in their lives.
- Clarify the various elements of our respite offer. This will also include reviewing the respite and short break requests, ensuring that this service responds to carers in a timely manner while supporting their needs.

### 3.3 Background

3.3.1 The 2021 census estimates that in England and Wales, 5 million people aged five and over provide unpaid care to family members, friends, neighbours, or others in need. Unpaid care is often an expression of unconditional love and respect for the person supported, and as such, it is priceless and difficult to quantify. To raise awareness of the importance of unpaid carers in society, it is essential to assign a monetary value to the care that unpaid carers provide. Carers UK estimates that unpaid care is a cost avoidance to the health and social care system, equivalent to £162 billion year.

3.3.2 The work of unpaid carers is vital in ensuring the sustainability of the Health and Social Care system. For unpaid carers to be adequately supported, the totality of the Health and Social Care system and the wider community and voluntary sector must come together behind this purpose. As such, the new Brent Carers Strategy 2023-27 for unpaid carers is not solely the Adult Social Care commitment but a true partnership approach in recognition of the need for this to be delivered as a system and community-wide approach to supporting those who provide unpaid care.

### 3.4 Who is Caring in Brent?

3.4.1 The 2021 census confirmed that there are 22,845 unpaid carers in Brent. Between the 2011 and 2021 census, there was a significant decrease in the proportion of unpaid carers in the population, but a higher proportion of those who provide care are providing a greater level of care. This may reflect a change to the wording of the question in the 2021 Census but may also reflect an impact of the coronavirus pandemic on people's circumstances or behaviours, such as household mixing rules.

3.4.2 Our carer population is ageing, particularly those providing 50+ hours of care each week. Unpaid carers have an older age profile than the general population and are

older than in the 2011 census population. 45% of carers 65+ provide 50 or more hours of care a week.

3.4.3 Full details of the Census data can be found in the draft carer's strategy, in Appendix 1.

3.4.4 The above captures only identified carers. There are significant numbers of hidden carers in the borough who are not accessing support services. A key priority within the strategy is to support increased identification of carers by universal services and targeted services. For example, one outcome of successful implementation of the strategy will be increased identification of young carers by health providers and schools.

**3.5 Development of the Carers Strategy**

3.5.1 The Brent Carers Strategy has been informed by and takes into consideration legislative and policy framework. Policies which outline Brent Council's legal requirements and vision to see all carers recognised include:

a) The Care Act 2014, under which local authorities have a duty to provide preventative support services to carers, with a focus on well-being and an emphasis on the needs of Carers through carers' assessments.

b) The Care Act and the Children and Families Act - should work together to assess and meet the holistic needs of the family to prevent or reduce inappropriate or excessive care for young carers.

c) The Equality Act 2010 - states that no individuals should be discriminated against in service provision, employment, or education because of any of the protected characteristics under the Act. Carers cannot face discrimination based on their association with or support of a disabled person.

d) The NHS Long Term Plan 2019 – recognises that many carers are older people living with complex and multiple long-term conditions. It outlines how the NHS will work with Carers to improve recognition and strengthen support services to address the individual health needs of carers.

e) Carers Act 1995 – states that the right to a carers assessment also applies to carers of disabled children.

f) Health and Care Act 2022 – provides details of the requirements to consult carers and involve carers in hospital discharges.

3.5.2 The term "carer" is defined in the Care Act 2014. The Brent Carers Strategy recognises carers in a far broader sense. Too narrow a definition risks people not getting the recognition and support they need. A carer is anyone who provides any care or support to an individual, such as a relative, partner, friend, or neighbour, who needs assistance in their day-to-day life and cannot manage without help. Carers do this without payment, and they are not under a contractual obligation to provide care.

3.5.3 The engagement programme for the new Brent Carers Strategy 2024-2027 began in November 2022 and consisted of officers hosting a series of events and attending existing carers groups and forums to undertake focus groups and interviews with both unpaid carers, and relevant professionals.

3.5.4 Although some of the conversations were challenging, they were necessary. Carers highlighted the requirement for services to do more to support and appreciate carers in Brent. Those conversations were essential in developing a shared vision of how services can improve.

3.5.5 Feedback from engagement with carers was very consistent in terms of the challenges that carers felt needed to be addressed most urgently:

- Information is hard to find - both health and care information for the cared-for person, and wider support for carers such as GP appointments, benefits and so on
- Services are fragmented – creating frustration in continually repeating requests or information.
- Carers don't feel valued or listened to by some Health and Social Care professionals.
- There isn't enough support for well-being - there is demand for more and varied respite and more personalised opportunities for self-care.

3.5.6 Throughout the development of this strategy, we have kept the values of the Brent Integrated Care Partnership (ICP) in mind; putting the resident at the heart of its development, working in partnership, and really listening to our community of people who care, to understand what matters to them, and what will have the biggest impact for them, whilst also considering the sustainability of the health and care system. This strategy takes its roots in what carers have told us they want, rather than the vision of what has been set out by the Health and Care system.

3.5.7 Collectively, we agreed that we want Brent to be a place for people who provide unpaid care are:

- Seen and heard when accessing services
- Supported as individuals, with more opportunities to be themselves
- Valued for the care they provide.

3.5.8 A collection of actions, grouped within six key themes, were developed with carers to address these challenges, and to address the significant gap between the number of carers known to the health and care system, and the number of residents providing unpaid care according to census data.

3.5.9 Co-produced to reflect the voices of the carers we spoke with; we have identified 6 key commitments we intend to implement in the next 3 years.

1. Access to information
2. Partnership working
3. Supporting wellbeing
4. Carer awareness
5. Reaching into communities
6. Supporting young carers at the start of their caring journey

**3.6 Carers Strategy Implementation**

3.6.1 We are currently developing a Carers Strategy Implementation plan to ensure that the strategy is effectively executed, and the commitments made to carers and young carers are delivered. An overarching principle of the Strategy will be adopting the No Wrong Doors Memorandum of Understanding designed to improve joint working between adult and children's social care services, integrated care boards and other key organisations in respect of identification and support for young carers and their

families. It covers a range of areas such as identification, whole-family approaches to support and transitions from children to adult services.

3.6.2 As there are around 30 activities identified in the strategy, a prioritisation exercise has also taken place involving engagement with carers via the attendance of a listening event and the publication of a survey, to solicit their views on what activities included in the strategy should be prioritised.

3.6.3 This plan will include key milestones, actions, and resources required for each of the activities, as well as associated timelines. It will also incorporate project management tools such as a risk register and will ensure accountability by indicating how the impact associated with each activity will be evaluated.

### 3.7 Carers Support Services

3.7.1 Brent Adult Social Care commission a Carers Support Service through a contract with Brent Carers Centre. Work on the specification for the newly commissioned service ran alongside the engagement of the new Brent Carers Strategy. Based on feedback from carers, outcome measures were included in the carer's contract to ensure the new Carers Service can meet the needs of Brent's informal carers and address the key issues highlighted in the Carers Strategy.

3.7.2 Brent Carers Centre provide support to 7199 local informal carers.
Services include the following:

**Adult Carers**

- Advice and information
- Benefits advice, form filling and money matters
- Carer Assessments (assistance in completing the carers assessment)
- Education and training workshops
- Peer Support Groups & Activities
- Respite (sitting service / short Breaks / befriending and PA support)
- Quarterly Carers Forum
- Emergency planning
- Carers counselling

**Young Carers**

- Early Help Assessments
- Information, advice and signposting
- Advocacy and representation
- Young Carers support group and forums
- Trips and activities

### 3.8 Review and Monitoring of the Carers Strategy and Implementation Plan

3.8.1 The Brent Carers Strategic Board reports to the Health and Well-being Board. It includes membership from Brent Council Adult Social Care, Public Health, Children and Young People Services, Integrated Care Partnership, CNWL Mental Health Trust, the voluntary sector, the independent sector, and, most importantly, service users and Carers.

3.8.2 The Carers Strategic Board will oversee the implementation of the actions in the Carers strategy, measuring meaningful outcomes and monitoring impact. The Board

will review the Carer's strategy to ensure it responds to changing circumstances and remains relevant to the needs of local carers.

## 4.0 Stakeholder and ward member consultation and engagement

4.1 Brent Council Officers organised two carers celebration events at the Brent Civic Centre in November 2022 and June 2023, where we invited the entire carer community in Brent, including providers and unpaid carers. We were able to hear the views and experiences of participants, which helped to shape the development and implementation of the Carers Strategy.

4.2 In addition to the above events, officers set aside specific engagement with young carers in the Granville community centre in August 2022 and young carer's social activity events in March 2024.

4.3 Engagement has been undertaken with a wide range of partners in the development and implementation of the Carers strategy and gaining commitment to the proposed actions.

This has included:

- Regular updates and drafts to the carers board
- Regular updates to the Lead Members for Community Health and Wellbeing, Children and Young People and Schools
- Presentations to the Integrated Care Partnership (ICP) Executive
- Report and presentation to the Community Wellbeing Scrutiny Commitee
- Attendance at Mental Health workstream meetings, and the CP partnership forum
- A Senior Managers Group (SMG session) to gain Council-wide input.
- Meetings with relevant service leads from across our provider partners.

## 5.0 Financial Considerations

5.1 Adult Social Care commissions an all-ages Carers Support provider on behalf of both Adults and Children's services. Recommissioning of the service was aligned to the strategy development work, to ensure that the contract specification was able to specifically address the challenges being raised.

5.2 Three unpaid carers were part of the evaluation panel in May 2023, and the contract was issued to Brent Carers Centre in July 2023. The contract is let on a 2+1+1 term, with an annual value of £224,000 per year, so up to £896,000 over the duration of the contract if it is extended for the maximum term.

5.3 While the commissioned provider will lead on many of the initiatives outlined within the strategy, given the importance of unpaid carers to the health and care system, and the complexity of working across multiple organisations, it is proposed that a "Carers Resources Officer" post is created on a time-limited basis that will support the work of partnership forum, and make a step-change in the provision of accurate information to carers from across the wide range of stakeholders and services.

5.4 Carers UK estimates that the cost avoidance to the health and social care system from unpaid carers is £162 billion, so is arguably an area in which care, health and well-being collectively cannot afford not to invest.

## 6.0 Legal Considerations

6.1 The Care Act 2014 is regarded as major legislation focusing on increasing the rights of carers. It puts carers on an equal footing with the individual they care for, with statutory entitlements to assessment and support in their own right.
There is a clear focus on promoting carers' well-being and considering the impact caring has on all aspects of their lives.

6.2 The Care Act places "well-being at the heart of care and support". Councils must promote the principle of well-being in carrying out assessments and providing support services to carers.

6.3 Under the Care Act, Local Authorities have a statutory duty to carry out a Carers Assessment, if they believe a carer may require support, or if a carer requests one. Unpaid Carers have a legal right to access services to support them in their caring role where the assessment identifies needs, and the carer meets the conditions of eligibility set out in the Care Act.

6.4 This strategy does not seek to discharge the statutory duties of the local authority. What it hopes to do, is improve unpaid carers' access to universal support services, and improve their overall experience when accessing health and social care services for their loved one. The Council must meet its statutory duties as set out in the Care Act 2014.

## 7.0 Equality, Diversity & Inclusion (EDI) Considerations

7.1 Census 2022 data shows us that the burden of providing unpaid care falls disproportionately on more deprived communities (insert stats). Given that provision of unpaid care is known to place additional pressure on household finances, and the health of the carer themselves, this will exacerbate existing health inequalities within our communities.

7.2 Brent Council will build on our statutory duty to carers and will endeavour to routinely identify carers when they access services, assess impact on carers of any policy or service change, and monitor equality of access as we would for other groups who are known to experience inequalities.

7.3 The Carers Strategy promotes an integrated approach across the Care Health and Well-being Directorate to advance equality of opportunity to health services and reduce inequalities through accessible health care that achieves outcomes in an integrated way.

7.4 In the development and implementation of the Carers Strategy, officers had "due regard" to the provisions of the Equality Act: to eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act, to advance equality of opportunity and foster good relations.

7.5 A high proportion of carers face health inequalities. Carers' health is known to be worse than that of non-carers due to the pressures of the role and is compounded by many factors, including providing more than 50 hours of care each week. Carers UK reports that caring has been announced as being a social determinant of health recently by Public Health England. Feeling lonely or isolated is a common experience for carers, as a direct result of their caring role. The impact of isolation on health is wide-reaching, including increased risks of death, cognitive decline, dementia, coronary heart disease and stroke.

7.6 The Carers strategy does not disproportionately affect people with a protected characteristic under the Equality Act. Research also identifies that carers from ethnic

minorities are more likely to have concerns about services not meeting their needs (Carers UK, 2024), the strategy aims to remove or minimise the disadvantages suffered by all unpaid Carers in Brent.

## 8.0 Climate Change and Environmental Considerations

8.1 These proposals have no direct impact on the Council's environmental objectives and climate emergency strategy.

## 9.0 Human Resources/Property Considerations (if appropriate)

9.1 This report does not relate to any HR or property related issues.

## 10.0 Communication Considerations

10.1 A comprehensive Community Engagement and Communications Plan supported carers engagement events, carers week celebration events and Carers Strategy Launch.

10.2 Carers Week is an annual campaign to raise awareness of caring for others, highlight the challenges unpaid carers face and recognise the contribution they make to families and communities throughout the UK. It also helps people who don't think of themselves as having caring responsibilities to identify as carers and access much-needed support.

10.3 The purpose of this community engagement and communications plan is to:

- Raise awareness and provide information on caring.
- Celebrate carers and highlight different services.
- Launch the carer's strategy to the community.

10.4 The key audience groups we seek to reach and engage with include the following:

- Residents
- Key community organisations/groups/partners, inclusive of emerging communities
- Internal staff
- Young carers
- Formers carers
- Parent carers
- Adult carers
- Sandwich carers – those with caring responsibilities for different generations
- Media
- Universal and specialist services

10.5 The engagement methods will include the following:

- Drop flyers across hubs, libraries, family wellbeing centres, schools and community centres across each Brent Connects area
- Engage with Carers organisations.
- Share information with ethnic minority groups
- Multimedia campaign; website, Twitter, Facebook and Instagram
- Share information internally and engage with Brent's internal forums
- Video to be created and circulated highlighting information on carers' experiences.

***Report sign off:***

***Rachel Crossley***
Corporate Director of Community Health and Wellbeing

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# Brent Carers' Strategy 2024–2027

# Foreword

# Foreword

Before providing the details of this carers' strategy, it is vital that we express our gratitude to Brent's 22,000 unpaid adult and young carers. We have the utmost respect for the work that you do to support those in need, and the borough could not be what it is today without your dedication.

This strategy document aims to raise the profile, recognition and understanding of the invaluable work that all types of carers do, whilst also recognising the struggles they face and how we can support them better.

We hope to make the lives of carers easier, through listening and responding to their needs, so that they can continue to deliver crucial support.

We recognise that we need to work more closely with communities and partners to reach carers we don't know about, so that we can support their wellbeing and help them to navigate the complexities of the health and care system. We endeavour to do this through the commitments explored in this strategy.

We would also like to thank those who have been involved in the development of this strategy, and once again extend our appreciation to Brent's carers who go above and beyond to help others. We believe that through the implementation of this strategy, we can achieve real and long-lasting change for carers.



**Cllr Neil Nerva**
Cabinet Member,
Chair:
Health and Wellbeing
Board

**Dr Mohammad Haidar**
Brent Medical Director and
ICP Clinical Lead,
Vice Chair:
Heath and Wellbeing
Board

# Reflections from our Carers Board members

We prioritised taking the time to meet and listen to our Carers of all ages. The stories we heard gave us a good foundation to form our commitments, and so it would only be right to include some of their stories in this strategy.

It was really important to us when developing this strategy that we heard from a wide variety of people who care for others in Brent, and we're pleased that carers have been involved in every step of the journey to develop this document. As a result, we believe this document really represents what carers have told us is important and will make a difference. We hope that this document is the start of a journey that gets us to a place where anyone who cares for others can feel seen, valued and supported.

# Carers stories

**Stephan, aged 14**

*"I've been caring for my mum for 8 years. My day-to-day role involves helping my mum with whatever she needs. In the morning, this could be making her breakfast or making her a hot water bottle. After my school day, I continue caring for her by helping her with her evening routine. I believe Brent Council could help carers by checking in with them more often – my family can't always handle mum's health problems, so it would be good if we could get more support. To all the young carers out there, I want you to know that there's always someone you can talk to, someone to help you. You're not on your own."*



**Aisha – Brent Carers Centre Member**

*"Being a carer has been extremely challenging for me as the person I care for, my father, is fiercely independent, challenging, strong willed and stubborn.*

*Brent Carers Centre have been extremely efficient, proactive, empathetic, understanding, and supportive. My support officer Jenice, from Brent Carers Centre, has supported me in various ways with my issues. Solutions were provided to ease my stress, as well as weekly counselling sessions to uplift and motivate me. Undoubtedly, the support has been my safe haven.*

*Moving forwards, I would like to see the council provide additional housing supports for those who are cared for. To use the example of my father, who likes his independence and so does not want to go into assisted living, it would be good if I could have some support and advice as to how to get the best possible outcome for him."*

# Carers stories

**Adult carer, Brent Carers Centre member**

*"My caring role is very demanding, since I am a carer to both my husband, who has mental health issues, chronic depression and dementia, and my son who is autistic, has a learning disability and a personality disorder.*

*It's hard since there are four adults living in two bed temporary accommodation, as well as a large problem with mould. I have to sleep on a mattress on the kitchen floor.*

*Brent's ASC coordinator has provided me with support and helped me to arrange my husband to go to day care 4 days a week. This has made a massive difference for me, since now I can have breaks and have time to attend my doctor's appointments. The council also arranged the delivery of a shower stool, which has made the showering process a lot easier for my husband.*

*Although the support from the council has been good, I still don't feel as though I have enough of a break, or time to myself. I hope these change moving forward."*

# Vision/ Executive summary

# Vision/ Executive summary

Throughout the development of this strategy, we have kept the values of the Brent Integrated Care Partnership (ICP) in mind; putting the resident at the heart of its development, working in partnership, and really listening to our community of people who care to understand what matters to them, and what will have the biggest impact for them, whilst also considering  the sustainability of the health and care system. This strategy takes its roots in what carers have told us they want, rather than the vision of what has been set out by the Health and Care system.

The strategy has been crafted following **over 150 conversations** with dedicated individuals that care for others in Brent. The directions of these conversations were influenced by a group of carers responsible for co-producing this strategy, and so they were vital in giving us direction in terms of the type of questions we asked, the people we spoke to, providing analysis of the information we gathered and forming the commitments we endeavour to make.

Although some of the conversations were hard, they were necessary given that they highlighted the requirement for Health and Social Care services to do more to support and appreciate carers in Brent. Those conversations helped us to develop a shared vision. Collectively, we agreed that we want Brent to be a place for people who provide unpaid care are:

- **Seen and heard when accessing services**
- **Supported as individuals, with more opportunities to be themselves**
- **Valued for the care they provide**

This strategy will play a key role in ensuring that the ambitions set out in Brent's Health and Wellbeing strategy, Adult Social Care Vision and Borough plan are fulfilled.

# Our six key commitments

Based on this vision, we have crafted **6 key commitments**, which we intend to implement in the next 3 years.

Brent's commitments are based around the following themes:

- Access to information
- Partnership working
- Supporting wellbeing
- Carer awareness
- Reaching into communities
- Supporting young carers at the start of their caring journey

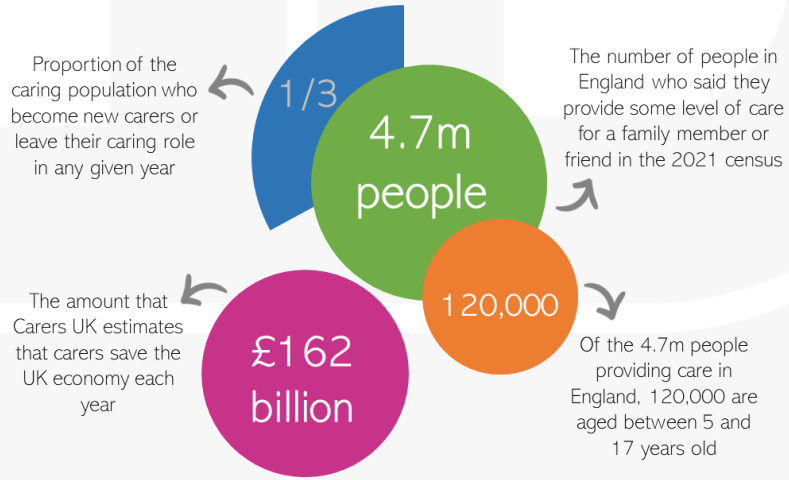
# People who care: An overview

A “carer” is defined as anyone of any age who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction, and who cannot cope without their support. The care they give is unpaid.

Most of us will provide care and support for a loved one at a given stage in our lives, but the length and intensity of that experience will vary greatly.

On average, it will take someone two years to recognise that they are a carer, and even after this period of time not everyone will identify with this label. Instead, they see the support they provide as a display of their love for the individual they care for, and as a core aspect of the relationship with their loved one.
For some, it is okay that they do not identify as a carer as they may not need anything more than access to universal services and their existing support network. For others, however, the caring role can have a significant impact on their employment, finances, relationships and their own health and wellbeing. Therefore, it is crucial that we capture the needs of those who may not identify with the term “carer”, but still require that extra support. The role of education is key here, particularly for young carers you may not be aware of the support available to them or the role they are playing.

Carers are so deserving of this support given that they often take on large amounts of responsibility in order for their loved one to be able to maintain a degree of independence, whether that be due to a long or short-term illness. Carers are so important that if they were all to stop working, Carers UK estimates it would cost England & Wales an extra £162 billion annually (that’s £444 million per day) to cover the costs, meaning the Health and Social Care system would simply collapse. This is just one of the numerous figures that demonstrate how vital carers are to keeping society afloat.



# Adult Carers: the facts

Brent census data collected in the last decade also highlights some interesting statistics regarding carers:


Although this data demonstrates a decrease in the number of unpaid carers between 2011 and 2021, it shows that those who are providing care are providing a greater level of care.

The council also carried out a Survey of Adult Carers in 2021, which further confirmed that impact that caring has:

**54%** said caring has caused financial difficulties

**60%** said they struggled to look after themselves

Within the last 12 months **22%** said caring had caused them to develop their own health condition

Within the last 12 months **58%** said caring responsibilities have caused them to feel stressed

Within the last 12 months **38%** said caring responsibilities have caused them to feel depressed

Surveys such as this also reveal that the burden of care does not fall equally on the respective genders:


10.3% of women have caring responsibilities in comparison to 7.6% of men.

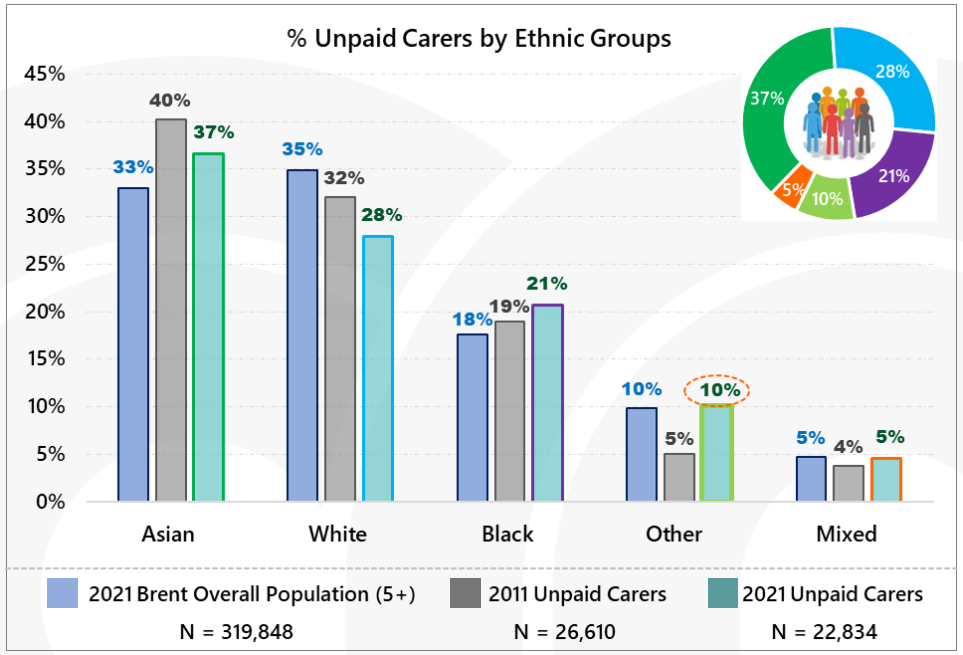
Brent

# Adult Carers: the facts

The theme of inequality prevails with the following statistics:

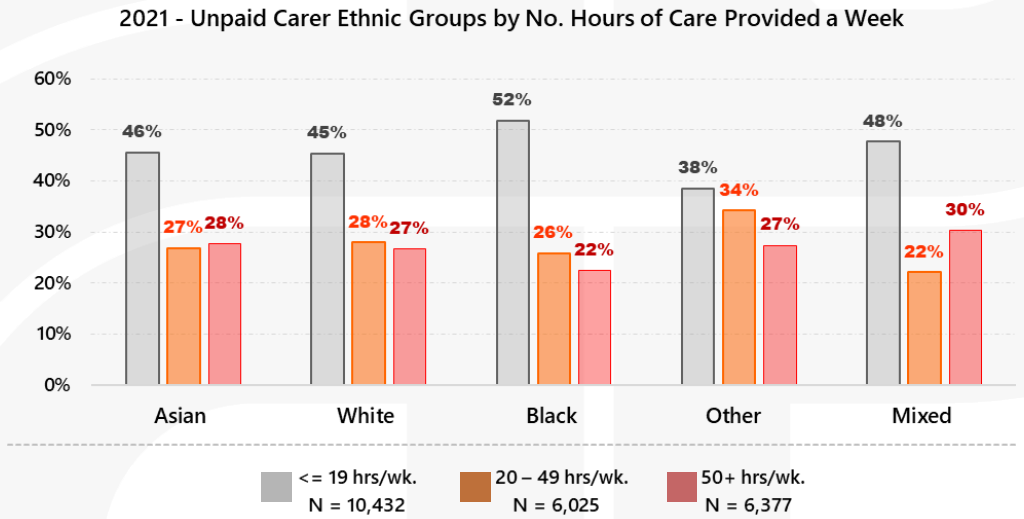
There is a higher proportion of people providing unpaid care in the most deprived communities (10.1%)…

…than there are in the least deprived (8.1%)




Moreover, given the nature of the role, people who care will undoubtedly face additional financial and health inequalities when compared with the rest of the population.

Brent carers are not equally distributed across the ethnic groups, with black carers being over-represented, and on the rise.

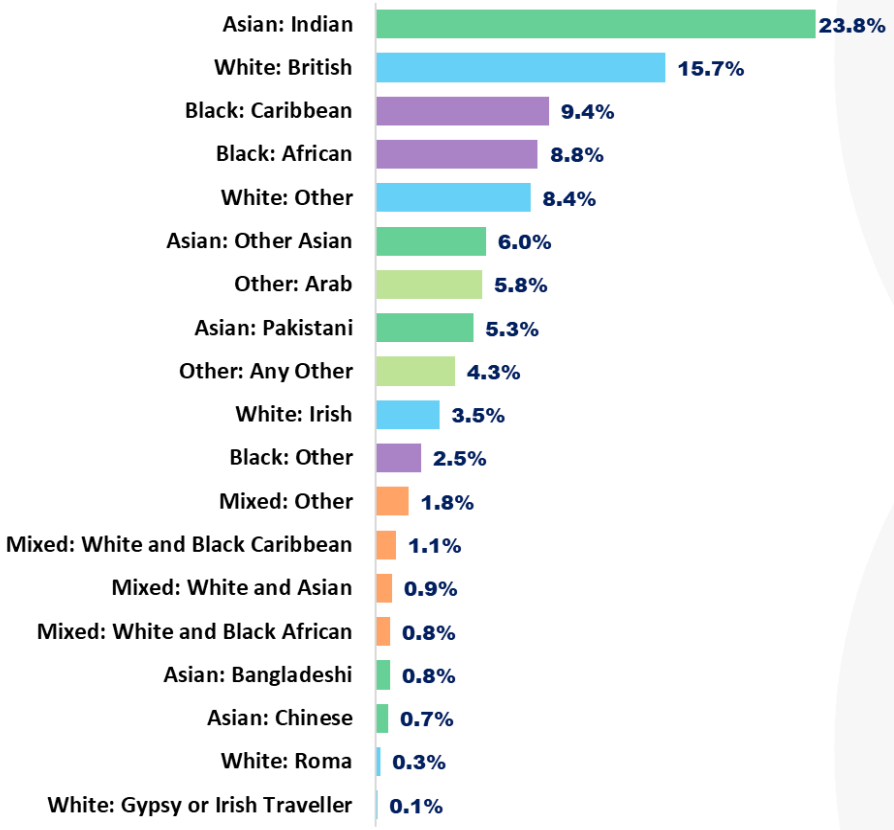



Brent

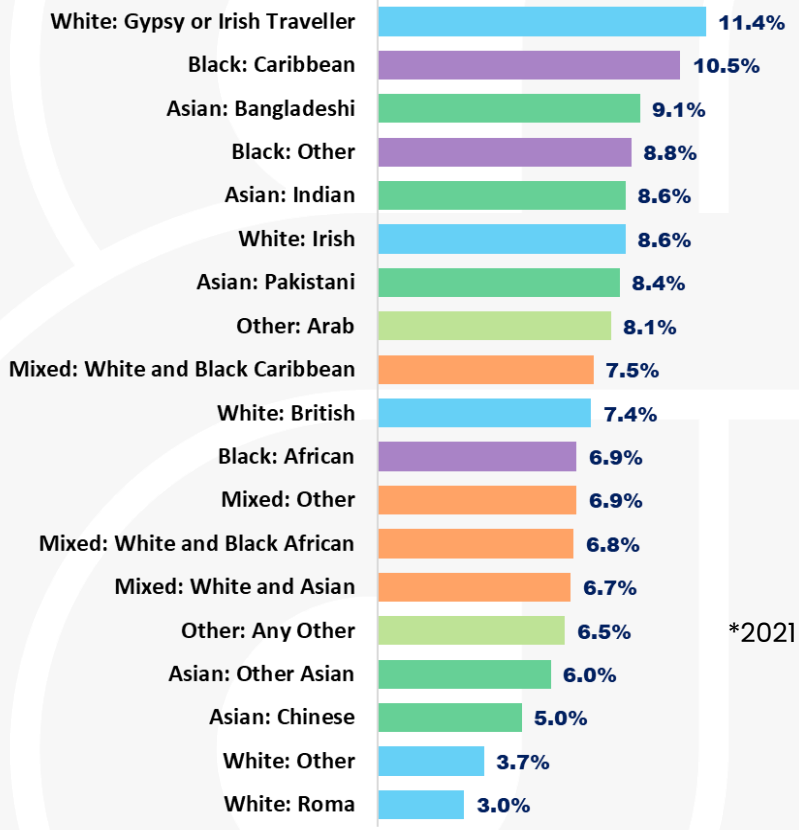
# Adult Carers: the facts

- Indian residents, who are Brent's largest ethnic group (19.6% of the general population) make up almost 1 out of 4 unpaid carers (24%)
- 11.4% of all Gypsy/Irish Travellers in Brent are unpaid carers
- The lowest proportions of ethnic subgroups, who are unpaid carers, are Roma (3.0%) and Other White (3.7%) and those groups also generally have low 65+ age compositions (2% and 5% respectively) in Brent.

Composition of Unpaid Carers by Ethnic Sub Groups*




Proportion of Brent's Ethnic Sub Groups who are unpaid carers*




*2021 Census data

# Young Carers

# Young Carers: the facts

We must also recognise the equally vital role that young carers play in Brent. There are 120,000 young carers across England without whom, the adult care system would undoubtedly crumble.

A young carer is someone who "cares for a friend or family member who, due to illness, disability, a mental health problem or an addiction, cannot cope without their support"

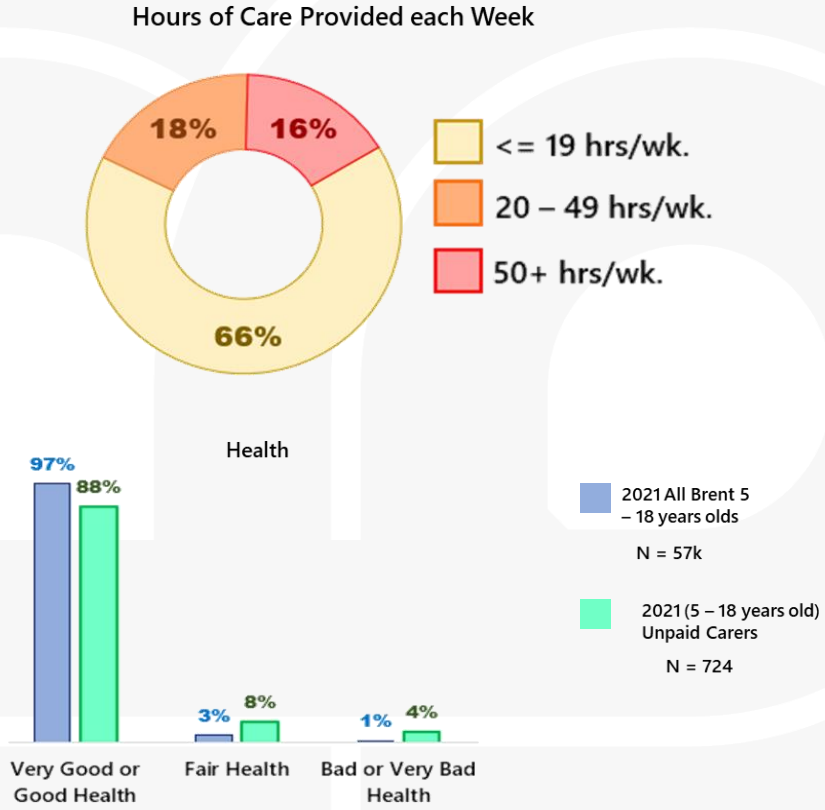
A young carer's day to day responsibilities could include tasks such as:

- Cooking, housework and shopping
- Physical care, such as helping someone out of bed
- Emotional support, such as talking to someone who is distressed
- Personal care, such as helping someone get dressed
- Helping to give medicine

According to the census young carers in Brent are even more likely to come from deprived backgrounds than adults. They are also 9% less likely to have very good or good health when compared with their peers.

Despite there likely being thousands of young cares in Brent, fewer than 100 carers were identified in the Schools census in 2023.

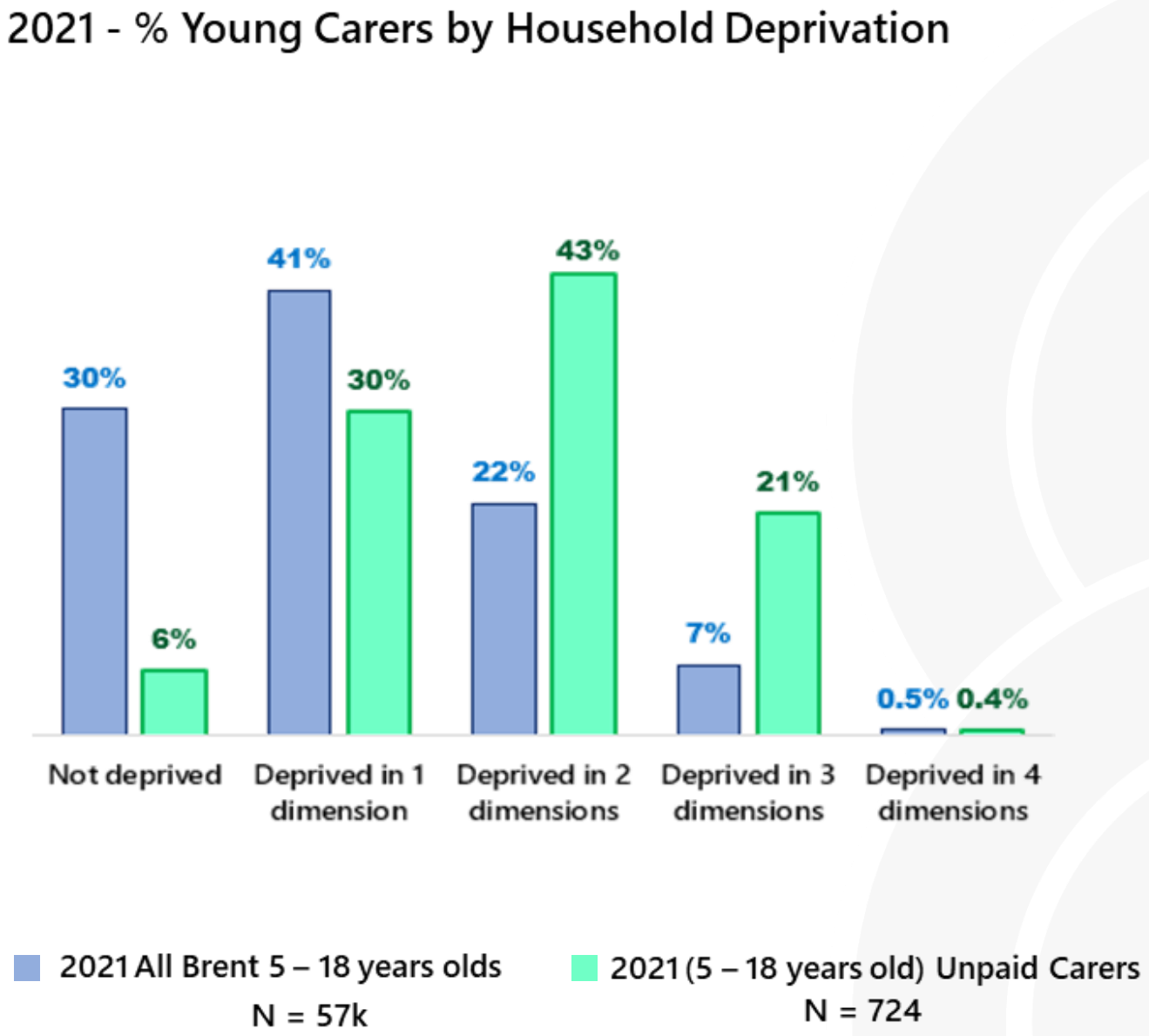
Although young carers typically take on fewer hours of caring per week than adult carers, statistics demonstrate that this role takes a toll on the health of young carers.




The gap between the population and carers who say they have good health is 9% for both adult and young carers.

Adults are more likely to say their health is fair or bad, but the gap between the general population and carers is much bigger for young people – 5% and 3% compared to only 1% for adults

# Young Carers: the facts




Young carers are also even more likely to come from deprived backgrounds, in comparison to their peers who are not carers. The dimensions represented in the bar chart cover four key areas of deprivation: Employment, education, health and disability, and household overcrowding.

# Our commitment to a “No wrong doors” approach in Brent:

# ‘No wrong doors’

‘No wrong doors’ is an approach that Brent intends to commit to and implement in the coming years.

The principle underpinning this nationwide memorandum of understanding is that there should be “no wrong doors” for young carers and their families. Young carers should be identified, assessed and supported regardless of which service is accessed in the first place.

It is necessary given that there is evidence to suggest that the caring role has a negative impact of caring responsibilities on mental health, education and life opportunities for young carers

- 1 in 3 ‘always’ or ‘usually’ struggle to balance caring with education
- Young carers are significantly more likely to report severe psychological distress, self-harm, and make attempts on their own life
- Young Adult Carers are 38% less likely to achieve a university degree, and significantly less likely to enter employment.

# What has been achieved so far for carers in Brent?



# What has been achieved so far?

Although we acknowledge that there is still a lot of progress to be made in terms of our identification of and support for carers, it is important to recognise and celebrate the numerous achievements that have been made in recent years with regards to carers.

In 2022-2023 we identified 454 new carers and were able to support them on a range of issues from providing them with carers needs assessments (218 were completed), advising them on things like finances and benefits, linking them in with other services, and providing them with respite opportunities. We also continue to provide a range of activities for carers including cinema trips, guided relaxation, coffee mornings, and days out at places like Kew Gardens.



**Brent's Young Carers report 2022-23 identified the following key successes:**

- 104 young carers were identified in this year
- Young Carers contacts at sessions in Family Wellbeing Centre's have doubled
- Young carers continued to receive support from a range of multi-agency professionals, particularly regarding issues such as social isolation
- Processes have been implemented to ensure young carers identified in Child and Family Assessments are made aware of the Brent Gateway Support offer.

Moreover, as part of the ongoing contract arrangements, there is a regular programme of support and activities for young carers. Some favourites include movie nights, defensive driving courses and arts-based activities.

# National policies and legislation underpinning this strategy

# National policies and legislation underpinning this strategy

This strategy has been informed by and takes into consideration a number of strategic and legal factors. Some policies which outline Brent's legal requirements and vision to see all carers recognised include:

- **Care Act 2014** – Councils must identify and provide carers with information, undertake carers assessments and provide preventative support. If statutory carers eligibility is met, support must be provided.
- **Children Act 1989** – Councils must identify and provide information to young carers and parent carers, undertake needs assessments and parent carer assessments, as well as preventative support. (Note – the Care Act 2014 and Children Act 1989 include requirements for NHS bodies to cooperate with local authorities, in relation to their responsibilities to carers and young carers.)
- **Children and Families Act (2014)** – Gives young carers and parent carers in England a right to an assessment of their own needs.
- **Carers Act 1995** – States that the right to a carers assessment also applies to carers of disabled children.
- **Health and Care Act 2022** – Provides details of the requirements to consult carers and involve carers in hospital discharges.



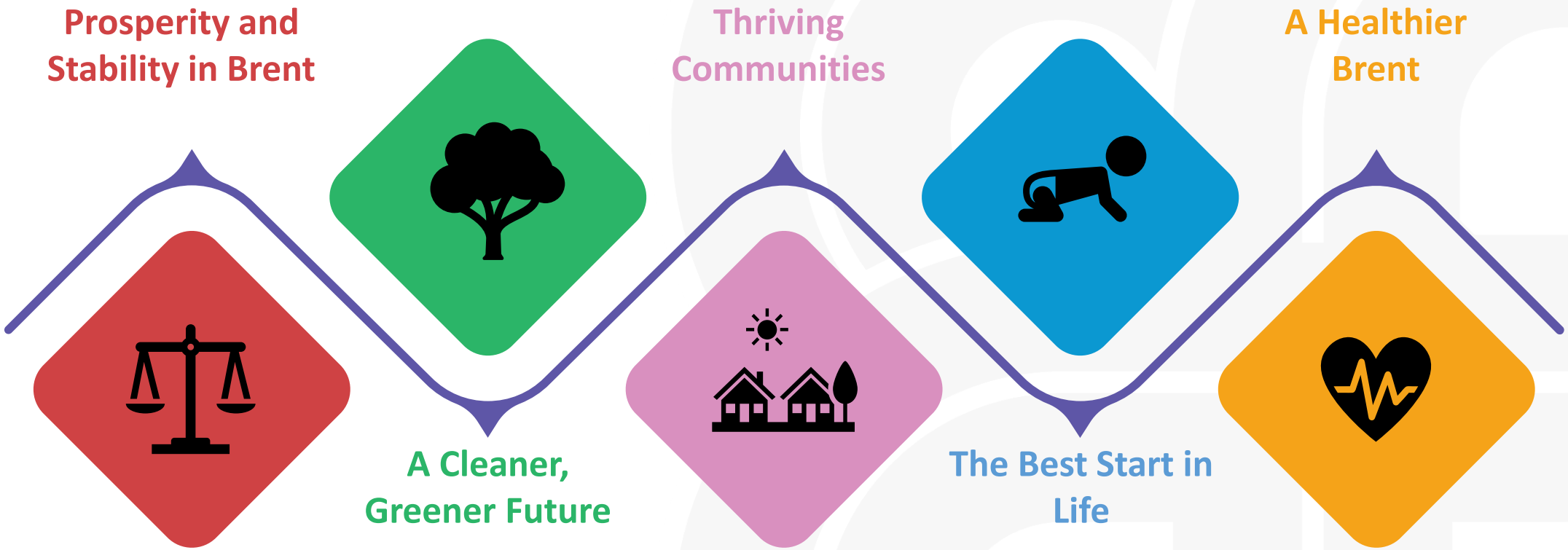
We have also written this strategy with the principles of 'Think Local Act Personal' (TLAP) in mind – This is a national partnership of more than 50 organisations, all of which are committed to 'transforming health and care through personalisation and community-based support'

Based on the philosophy of TLAP, we have generated some statements which reflect what "we" as a council will do to support carers, as well as some "I" statements, which will reflect how carers should feel following the implementation of this strategy. These statements were coproduced with carers and can be found woven into our commitments laid out in this document.

# Brent's local plans and policies:

# Brent's local plans and policies

Amongst other stakeholders, carers were consulted during the creation process of the Borough Plan (2023-2027). This document outlines Brent council's ambitions for Brent in the coming years. The 5 priorities are:



# Brent's local plans and policies

The Brent Health and Wellbeing strategy also directly references caring in its five priorities that will support efforts to reduce health inequalities and wider determinants of health inequalities:

1. Healthy Lives – I am able to make healthy choices and live in a healthy way, for myself and the people I care for.

2. Healthy Places – Near me there are safe, clean places where I, and people I care for, can go to relax, exercise for free, meet with like-minded people, and where we can grow our own food.

3. Staying Healthy - I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it.

4. Understanding, Listening, and Improving – I, and those I care for, can have our say and contribute better to the way services are run; Brent Health and Wellbeing Board data are good quality and give a good picture of health inequalities.

5. Healthy Ways of Working – The health, care, and wellbeing force will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic.

# What we do for people who care:

# What we do for people who care:

Our previous engagement work led to the provision of services which reflect the needs and wants of carers.

**Brent Adult Social Care currently provides:**

- Working with multiple stakeholders to identify carers, ensuring that as many are aware of the support that is available to them and that all of their details are up to date on the database.
- Brent Carers' Centre is commissioned to provide direct support to our carers, with their mission being to "ensure that unpaid carers are recognised, valued and supported to live rather than just exist" Their role involves carrying out carers' assessments, advocating for carers across a range of services, and offering wellbeing support such as leisure activities, support groups and (retail) discounts. Brent Carers' Centre also provides tailored support for end of life and loss of loved ones.
- Carers can access Carers' booklets which has been co-written with Primary care to provide the most up to date health information for carers.
- Brent Council will provide respite where an assessment identifies need for it.
- Brent Customer Access provides support for carers to access/ apply for benefits and understand the eligibility criteria.
- Recognition that, for those who are both council employees and carers, the role will place additional strain on these employees when they are 'working from home'. In order to mitigate this, employees are encouraged to take advantage of Brent's flexible working policy, including compressed hours or employment breaks.

# What we do for people who care:

Our London partners, London Northwest Healthcare University Hospital (LNWUH), Central and Northwest London Community Healthcare Trust (CNWL), and Central London Community Healthcare Trust (CLCH) have also adapted their service and enhanced their offer to carers.

**LNWUH currently provides:**

- Discounted parking and canteen offers at hospital sites for those with a carers card
- 'Conversation cafes', where carers can chat with community partners and councillors and council staff about any barriers they may be facing
- Paid carers' leave for their employees who are carers & recognition that the role will place additional strain on these employees when they are 'working from home'
- Carers' voices are regularly heard in the steering group for patient involvement strategy for the LNWH

**CNWL currently provides:**

- CNWL Recovery & Wellbeing College specifically mention carers in their info about who can attend
- Check in & Chat service for Carers of CNWL patients
- Resource Guides
- Implemented the six standards within the triangle of care in both inpatient and community services. The triangle of care is a therapeutic alliance between carers, service users and health professionals. It aims to promote safety and recovery and to sustain mental wellbeing by supporting carers.
- Host support groups for carers
- Implemented 'DIALOG+' , a therapeutic model that measures and seeks to improve quality of life, and is based upon open dialog and so has helped to build family connection and improve communication and relationships between patients and their carers
- Developed consent/confidentiality training for their staff, to ensure carers are understood and treated with respect.
- Paid carers' leave for their employees who are carers & recognition that the role will place additional strain on these employees when they are 'working from home'

# What we do for people who care:

**CLCH currently provides:**

- An online collaborative resource free and available to all staff, patients and carers signposting to borough-specific support
- Direct signposting to carer assessments and registration
- Trust-wide awareness campaign emphasising the importance of identifying carers at the earliest opportunity
- Links to existing carers passport/emergency card schemes in each borough to reduce the number of times a carer must disclose
- Parents and Carers staff network – a platform for those with caring duties to have a voice on new policies (e.g., flexible working policy) and activities at the Trust
- Prioritised access to volunteering and work experience placements for young carers and outreach via our looked after children's teams and local careers hubs

# What we do for people who care:

In addition to universal services, unpaid carers have the right to an assessment if the local authority or the carer themself feels as though they need support.

The assessment focuses on aspects of wellbeing that are important to the individual carer. This could include factors such as maintaining a habitable home environment, engaging in work, training, education or volunteering, and developing and maintaining family or other relationships.

Unpaid carers are legally entitled to support services to aid them in their caring role. **This support is granted once the assessment identifies the carer's needs, and the following three eligibility criteria points are met:**

The carer's need for support arises because they are providing necessary care to an adult.

1. As a result of their caring responsibilities, the carer's physical or mental health is, or is at risk of deteriorating, or the carer is unable to achieve any one of the outcomes listed in the Care Act.
2. As a result of being unable to achieve these outcomes, there is or there is likely to be, a significant impact on the carer's wellbeing.

If Brent has decided that the carer has eligible needs, they must consider what they can do to meet these specific needs.

**Despite the existence of these support services from us and our partners, some issues and challenges have been flagged on the back of these developments:**

- There remains a need to balance safeguarding with the needs of carers.
- Persisting issues surrounding people not necessarily being aware of their role as a carer, meaning they reach crisis point before they have been reached by us or have accessed support.

**To mitigate these issues, we could:**

- Do more to increase the visibility and awareness of caring as an integral part of many people's lives – this would involve a campaign drive with images and soundbites, promoted widely across the borough e.g. in GPs, Brent council buildings.
- More training for professionals, in order to improve assessments, ensure checklists are being used etc.
- Making sure information is easy to find, so that carers do not have to fight to find it.

# The experiences of people who care:

# The experiences of people who care

A consistent theme of the conversations we had was the pride that carers feel to be able to provide care for their loved ones and spoke of the strong bond it creates.

The carers we engaged with were also eager to make it clear that they feel tired, but by the same token are eager to avoid the health and social care system stepping in to take over.

Unfortunately, they feel they have to fight in order to have their voices heard, to have the right support in place for their loved ones, and to find the information they need. These relentless challenges add to the existing exhaustive nature of balancing the role of being a carer, whilst juggling all the other aspects and responsibilities of their life. This means that the first sacrifice they often make is self-care, which is worrisome given that this can lead to a deterioration in their physical and mental health.

In the 150+ conversations we had with carers, a recurring issue that presented itself was the problems they faced in obtaining the information they needed to care effectively for their loved ones. Similarly, they also struggled to seek the support they needed for themselves in their caring role.

Many also spoke candidly about the strain placed on them due to the responsibility of their caring role, which puts extra pressure on their work and relationships. This led to calls for more frequent and different types of respite being made available to them.

They also spoke about the frustration felt when they are excluded from conversations and decisions surrounding their loved one's care, and the lack of recognition and acknowledgement they receive from some health and care professionals.

**Their feedback has been summarised into four main themes:**

Information is hard to find

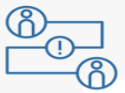
*"I got bounced around for months before finally finding the right support"*

Carers don't feel listened to

*"Key workers don't understand [his] needs. I am labelled as difficult and anxious."*

There isn't enough support for carer's wellbeing

*"No time to look after yourself. To do things others take for granted like a cup of coffee with friends."*



Services are fragmented

*"The services aren't joined up. You have to keep repeating your story."*

# Commitments:

# Commitments

Following this engagement work, we have identified 6 key commitments, which we believe will help to improve the lives of carers and young carers in Brent. The commitments reflect the voices of the numerous carers we spoke with, and therefore aptly illustrate what carers and young carers need and want. In the section below we explore the commitments in detail.

The commitments we have made as a place are:

- Access to information
- Partnership working
- Supporting wellbeing
- Carer awareness
- Reaching into communities
- Supporting young carers at the start of their caring journey

# Commitment One: Access to information

# Commitment One: Access to information

This commitment reflects an issue that we had to address given that in the 2021-22 survey of adult carers, 26% of respondents said that they found information very difficult to find. This figure is higher than the London average of 19%, and also higher than the figure from the 2018-19 Brent survey of 21%. Even when people can get advice, 14% of residents told us that the advice wasn't helpful, which is considerably higher than the London average of 7%.

Carers also told us about the inconsistency of advice and knowledge they were provided with depending on who they spoke with. They also voiced understandable frustration towards the process of being referred to multiple organisations and people before finally being able to obtain the right support. This exasperation led to them being strong advocates for the creation of a single, central resource that outlines the full range of support that is available.



**To achieve this we will:**

- Create a single carers resource, that brings together information from health, social care and Brent's communities in one place, which will be communicated in a variety of formats so that it is accessible to all.
- Promote how and where information can be accessed in a wide range of health settings, such as community buildings, libraries, and places of worship.
- Support the maintenance of carer hubs, including young carer hubs spread broadly across Brent.
- Hire a carers engagement officer within the Brent council's Adult Social Care team, who will be responsible for coordinating the resources available to carers and strengthen the community-based offer for them.

**How will we know that we are fulfilling these commitments?**

- Our Carers' hub and universal information, advice and guidance will be accessed by carers from a wide range of backgrounds.
- Every public building and community space will have a poster that promotes the carers resource.
- Carers will tell us that information is easier to find and more helpful.
- Carers can get information and advice about their health and how they can be as well as possible physically, mentally and emotionally.

# Commitment One: Access to information

*We provide information and advice about health, social care and housing which is tailored to a person's situation without limiting their options and choices.*

*Think Local Act Personal 'we' statement*

*I can get information and advice about my health and how I can be as well as possible- physically, mentally and emotionally*

*Think Local Act Personal 'I' statement*

# Commitment Two: Partnership working

# Commitment Two: Partnership working

This commitment focuses on the difficulties that carers face when trying to get a sense of all the different services that are available. Professionals across the health and care system also echoed this sentiment, telling us that there is a lot of support and resources available, but no-one seems to have a clear picture of what is available. Different organisations hold different pieces of the puzzle, and we will only be able to deliver holistic support if we bring all those pieces together.

Similarly, many expressed frustrations towards the lack of communication amongst the different parts of the system, saying that they often don't communicate with each other. The result of this is that those who care often have to repeat their story as they move from service to service. Therefore, we must learn to work in a multi-disciplinary way, so that information is shared appropriately. In turn, it should make the move between organisations more seamless for our carers, thus easing the burden on them.

This partnership working must also extend to carers. They voiced irritation towards the fact that we do not utilise the insight they have in terms of delivering care to their loved one, and in the delivery of services more broadly.

For that reason, we commit to improving partnership working across all of health and social care, and the voluntary sector. Services will also become less fragmented through the improvement of information sharing, whilst ensuring that carers are fully involved in shaping and enhancing services.



**To achieve this we will:**

- Create a Carers partnership forum, attended by all the organisations who support people who care. Therefore, this will bring together community organisations, health, and social care to share information, access training and opportunities, and work together in new ways to improve services.
- Explore the creation of a "consent passport". With the consent of the individual who is being cared for, this document would allow carers to be involved in conversations regarding their loved one's care, without having to repeatedly justify their right to do so.
- Host quarterly care forums, alongside Brent's health partners, to enable the voices of all carers to be heard.
- Build on the co-production of this strategy to put carers at the heart of service delivery, such as monitoring our new carers contract, and overseeing the delivery of this strategy.

# Commitment Two: Partnership working

**How will we know that we are fulfilling this commitment?**

- Our Carers partnership forum will have appropriate and representative membership and meet at least four times a year.
- The four carers forums that will be held each year will be in partnership with health providers wherever possible

Carers will have an equal footing on our strategy delivery group and contract monitoring group.



> *I can keep in touch and meet up with people who are important to me, including family, friends and people who share my interests, identity and culture*

*Think Local Act Personal 'I' statement*

# Commitment Three: Supporting Wellbeing

# Commitment Three: Supporting Wellbeing

This commitment addresses one of the biggest strains of being a carer: the toll it takes on an individual's physical and mental health. The time commitment of providing care can make it difficult to balance this role with work and family commitments, making it near impossible to prioritise their own health appointments and care.

A staggering 60% of carers who responded to the 2021-22 survey of adult carers said that they struggle to look after themselves well enough. Moreover, 33% of respondents said that they didn't "do anything that they value or enjoy" with their time. Although some said they are able to draw strength and support from peer support, they equally voiced that it took them months or even years to find. They also stated the necessity for more accessible respite in more varied forms.

**To achieve this we will:**

1. Create a local offer for carers in Brent, that sets out all the different forms of support that is available to carers in one place, as well as details of how each one can be accessed.
2. Continually listen to the challenges that carers tell us they are facing and aim to develop services and resources that will make real, long-lasting differences to their lives.
3. Clarify the various elements of our respite offer. This will also include a review of the respite and short break requests, ensuring that this service responds to carers in a timely manner, whilst supporting their needs.
4. Use the new Carers' hub to deliver a range of support services and wellbeing therapies
5. Develop tailored support to help unpaid carers through transition periods in their caring role, such as the death of their loved one, or the transition to adulthood.
6. Carers, and organisations that support Carers are encouraged to participate in a range of training delivered by the Public Health Team. including the two day 'Mental Health First Aid' Training and the 1 hour Dementia Friends Information Session.
7. Work with Brent Health Matters to offer a 'one stop shop' for health in communities.
8. Develop an improved 'carers card', that enables registered carers to access a wider range of benefits and enhancements which would improve their wellbeing.
9. Utilise the council's position in the local economy/ community to bring in benefits for carers. This will include policies such as social value clauses on contracts and negotiating benefits from businesses.

# Commitment Three: Supporting Wellbeing

**How will we know that we are fulfilling this commitment?**

- Feedback from carers and users of services and resources will reflect that we are making positive differences to their lives.
- Carers will feel supported at all stages of their caring journey, knowing where to go for advice or support.
- Carers will be provided with coordinated care and support. Everyone works well together, as well as with the carers directly.
- Our new Carers' hubs will be in place and will be accessed by carers that are representative of all of our communities.
- The new and improved carers card will enable access to a wider range of services and benefits.

# Commitment Four: Carer awareness

# Commitment Four: Carer awareness

Many carers in Brent feel as though their voices are not being heard when it comes to the care of their loved one. In fact, 15% of adult carers who took part in the adult carers survey in 2021 said that they never felt involved or consulted in discussions about the care and support of their loved one.

They spoke of being excluded from assessments and hospital discharges, of feeling that their input was invalid, and of not being given necessary information with regards to their caring role. Some also told us that they had been labelled as anxious by health professionals for asking questions or raising concerns to health and social care professionals. They also referred to the shame they had felt after losing their temper with some staff after continual "micro-hassles" when trying to get things done. Every conversation with people who care, and partner organisations alike, came back to the same thread: people who care want to be heard and understood.

Our aim is to work towards all public services and communities recognising the importance and value of carers, acknowledging the work that they do, whilst giving carers awareness of who they could talk to if needed.

Wherever possible, we want services and professionals to be empowered so that they can be flexible to meet the needs of individuals. To us, this would look like "bending the rules" to get the right outcome for the individual. This could be in the form of longer appointments, more flexible times, or going the extra mile to make accessing a service easier.

**Therefore, we are committing to the creation of a culture in which carers are respected and recognised across the Health and Social Care system. We will celebrate and appreciate people who care, upholding their rights, and give make them feel seen and heard when accessing any services for themselves or their loved one.**

# Commitment Four: Carer awareness

**To achieve this we will:**

- Develop a carer awareness course, based upon the principles of our Making Every Contact Count (MECC) approach, that can be delivered to community groups, all front-line roles within the council and health and partner organisations.
- Improve our training offer for health and social care staff, which will set standards for adult and young carer assessments, implement the triangle of care, and make best use of tools such as the Carers Trust hospital discharge toolkit.

**How will we know that we are fulfilling this commitment?**

- Carer awareness training will be delivered to all front line council services, and available to NHS partner organisations and wide variety of community organisations.
- Carers will tell us they feel involved and consulted in conversations about care and support for their loved one.
- Carer awareness sessions are held throughout the year in Brent schools.



> *We see people as individuals with unique strengths, abilities, aspirations and requirements and value people's unique backgrounds and cultures*

*Think Local Act Personal 'we' statement*

> *I have considerate support delivered by competent people*

*Think Local Act Personal 'I' statement*

# Commitment Five: Reaching into communities

# Commitment Five: Reaching into communities

There are many people in Brent who we have not identified as being a carer. This means they may be missing out on vital universal support and information that could help them in their caring role.

Although not everyone will want, need or be eligible for support from social care services and/or other services, it is important that we do outreach work to make them aware of what they may be entitled to.

The census revealed that as of 2021, 22,800 people in Brent were providing care for others in Brent. Just 9,112 of these are known to their GP. 503 Adult Carers and 104 young carers were identified and supported by Brent's commissioned services, Brent Gateway Partnership, in 2022-23. Only 182 adult carers and 56 young carers had a statutory assessment in that year.

Statutory services cannot reach everyone, so we must ensure that we are promoting information in all our communities, and with all our partners. This means that it will reach all people who care, wherever they are, making them aware of the formal support available.

Nationally, 1/3 of carers start or stop caring in any given year, so it is vital that we reach into communities continuously.

**Therefore, we will work with communities, health partners and commissioned providers to ensure we reach everyone who has a caring role.**

# Commitment Five: Reaching into communities

**We will achieve this by:**

- Changing the language, we use to make it more recognisable, encouraging people who care to seek information and advice at the earliest possible stage in their caring journey.
- Using our local offer to be clear about the benefits of being identified as a carer, to encourage people to come forward and utilise the services available to them.
- Developing a comprehensive communications campaign, that includes proactive provision of information in places carers will be able to access it, such as alongside certain benefits, or when collecting prescriptions for another person etc.
- Working with schools to improve identification of young carers and make sure they are linked in with services.
- Building better connections with community faith groups and raise awareness to disseminate information and identify carers.
- Improving access to local authority carers assessments.
- Building on the success of events such as the Health and Social Care Awards to develop more opportunities to celebrate carers and reduce stigma.
- Brent Council will build on our statutory duty to carers and will endeavour to routinely identify carers when they access services, assess impact on carers of any policy or service change, and monitor equality of access as we would for other groups who are known to experience inequalities.
- The Council and Health Partners will adopt a leadership role in setting a standard for recognising carers in the workplace; building a supportive staff network to raise their profile, and ensuring our policies reflect our commitment to flexibility and support for carers' wellbeing at work.

**How will we know that we are fulfilling this commitment?**

- Our Carers partnership forum will include a wide range of community and faith groups, who will disseminate information into their communities.
- The number of carers registered on health and social care systems increases year on year and is representative of all Brent communities.

# Commitment Six: Supporting young carers at the start of their caring journey

# Commitment Six: Supporting young carers at the start of their caring journey

The impact of providing care on young carers is significant. According to the census young carers in Brent are even more likely to come from deprived backgrounds than adults. They are also 9% less likely to have very good or good health when compared with their peers. Despite there likely being thousands of young cares in Brent, fewer than 100 carers were identified in the Schools census in 2023.

**Therefore, we will work more closely with schools and GP surgeries to identify and support more young carers at the start of their caring journey.**



**We will achieve this by:**

- Increasing engagement with the existing awareness programme to ensure that professionals across all agencies are confident to identify and refer young carers
- Target the programme particularly at teachers and healthcare professionals
- Establish communication channels and set up regular meetings so that information can be shared, and young carers identified quickly
- Developing a communications campaign and raising awareness amongst students at schools about the role of young carers and the support available to them

**How will we know that we are fulfilling this commitment?**

- We will see an increase in young carers undertaking a carers needs assessment
- We will repeat the Young Carers survey and see an increase in the number of young carers being identified by their teachers or GPs
- We will gather feedback from participants to understand the effectiveness of the awareness programme and associated training
- We will gain feedback from Young Carers to ensure their views continue to shape the support offer available to them

# Our future pathway for people who care

# Our future pathway for people who care

## Information

- Carers are given the practical information they need in order to carry out their caring role, such as information about the person they are caring for's condition, medication, and care plan, when to expect follow up, and who to contact if there is a problem
- Carers are told where they can find the universal carers resource, and they will be referred to universal services.

Note – some carers will not require an assessment and additional support. They are able to live well and independently in the community, utilising the rich array of universal services available to them in Brent.

## Identification

- Carers are identified at the earliest possible stage of their role.
- Carers' details are consistently recorded on the identifier's system.
- Where necessary, we will share the individual's carer status with relevant services that they or the person they are caring for access.

## Universal support services (can be accessed by anyone)

- Priority GP appointments
- Advice about benefits/ financial support
- Access to peer support and wellbeing activities
- Access to community respite
- Access to training and employment support

## Involvement

- Carers work in partnership with health and care workers. Their input and knowledge is valued and they are appropriately involved in discussions regarding the person they care for's care.

## Assessment

- Carers are informed of their right to a statutory Carers Assessment, to assess their own needs.
- Assessments are carried out in a timely manner and at time convenient to the carer.

## Support and review

- In addition to universal services, carers that meet the statutory criteria will have their own care and support plan, which will include respite if needed.
- All carers are offered an annual review.

# How this strategy will be monitored:

# How this strategy will be monitored

The Carers Partnership Forum will become an important part of the delivery mechanism for this strategy; bringing different parts of the health and care system together in a more comprehensive manner to deliver the collective improvements in the experience of unpaid carers.

We will also create a Carers Strategy monitoring group, with carers being directly involved in this, who will review our progress towards the goals set out in this document and hold us accountable for its delivery. This group will also play a key role in monitoring carers' services across the partnership. This will involve ensuring that the voices of carers and their lived experience in accessing services has a direct influence on contract monitoring and is used to continually improve services.

A Carers Engagement Officer will be recruited to support both of these initiatives, as well as delivering against the commitments of the strategy more broadly.

We will ensure that regular updates are provided at Carers forums, and will develop a short annual report, summarising our performance, achievements, challenges, and joint solutions, which will be given to the Health and Wellbeing Board, and made publicly available.

# Glossary:

# Glossary

- “The 'Making Every Contact Count' (MECC) approach encourages us all to have very brief conversations about health and wellbeing issues as part of the everyday contact we have with other people, and if appropriate, let them know where they can get further information or support.”
- “An Integrated Care Partnership (ICP) is a statutory committee jointly convened by Local Authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.”
- “Adult social care covers a wide range of activities to help people who are older or living with disability or physical or mental illness live independently and stay well and safe.”
- A Carer’s assessment determines whether an individual is classed as a carer or not, and assesses what the council can do to support them if so.
- “The triangle of care is a partnership between professionals, the person being cared for, and their carers. It sets out how they should work together to support recovery, promote safety and maintain wellbeing.”
- CNWL – refers to the collection of services provided by the Central and North West London Trust, covering community, sexual health, mental health, health & justice and addiction services.
- London North West University Healthcare – Refers to the three Nort West London hospitals (Central Middlesex, Ealing and Northwick Park) that serve more than one million people. LNWH is also responsible for running sexual health services across Brent, Ealing, Harrow and Hillingdon. [ADD CLCH ROLE]

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# **Supporting Informal Carers**
# Brent Carers Strategy 2024 - 2027



Brent

# Today

- Recap the journey so far
- Explore the content of the strategy in more detail
- The six commitments  (inc. 'No Wrong Doors' MoU)
- Next Steps
- Discussion



Brent

# The Vision

Throughout the development of this strategy, we have kept the values of the Brent Integrated Care Partnership (ICP) in mind; putting the resident at the heart of its development, working in partnership, and really listening to our community of people who care to understand what matters to them, and what will have the biggest impact for them, whilst also considering the sustainability of the health and care system. This strategy takes its roots in what carers have told us they want, rather than the vision of what has been set out by the Health and Care system.

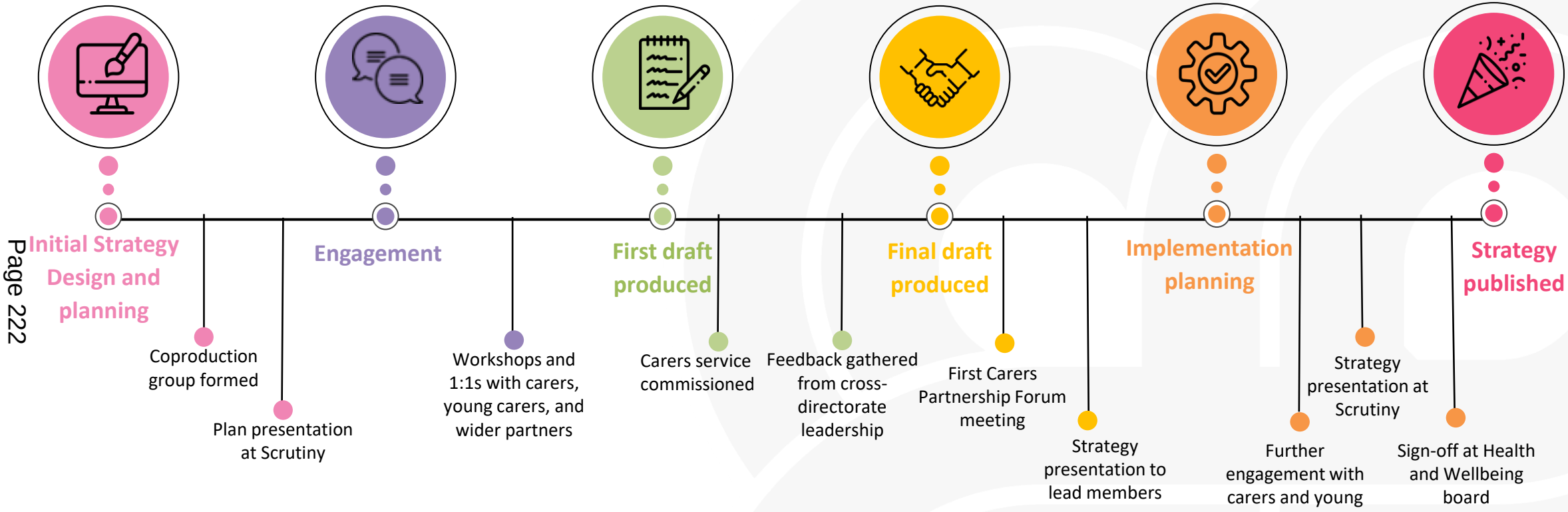
Although some of the conversations were hard, they were necessary given that they highlighted the requirement for Health and Social Care services to do more to support and appreciate carers in Brent. Those conversations helped us to develop a shared vision. Collectively, we agreed that we want Brent to be a place where  people who provide unpaid care are:



- **Seen and heard when accessing services**
- **Supported as individuals, with more opportunities to be themselves**
- **Valued for the care they provide**

Brent

# The journey so far






Brent

# 'No Wrong Doors'

- **'No wrong doors'** is a memorandum that Brent Council intends to commit to and implement in the coming years.
- The principle underpinning this nationwide memorandum of understanding is that there should be **"no wrong doors"** for young carers and their families. Young carers should be identified, assessed and supported regardless of which service is accessed in the first place.
- It is necessary given that there is evidence to suggest that the caring role has a negative impact of caring responsibilities on mental health, education and life opportunities for young carers
    - 1 in 3 'always' or 'usually' struggle to balance caring with education
    - Young carers are significantly more likely to report severe psychological distress, self-harm, and make attempts on their own life
    - Young Adult Carers are 38% less likely to achieve a university degree, and significantly less likely to enter employment.



Brent

# Our six key commitments

Based on the vision in the strategy, we have crafted **6 key commitments**, which we intend to implement in the next 3 years.

Brent Council's commitments are based around the following themes:

- Access to information
- Partnership working
- Supporting wellbeing
- Carer awareness
- Reaching into communities
- Supporting young carers at the start of their caring journey



Brent

# Our six key commitments

## Access to information

- **Create a single carers resource**, that brings together information from health, social care and Brent's communities in one place.
- **Promote how and where information can be accessed** in a wide range of health settings, such as community buildings, libraries, and places of worship.
- **Maintain "Carers Hubs"**
- **Hire a carers engagement officer** within the council's Adult Social Care team

## Partnership working

- **Create a Carers partnership forum**, attended by all the organisations who support people who care.
- **Explore the creation of a "consent passport"**.
- **Host quarterly care forums,** alongside Brent's health partners, to enable the voices of all carers to be heard.
- **Build on the co-production of this strategy** to put carers at the heart of service delivery, such as monitoring our new carers contract, and overseeing the delivery of this strategy

## Supporting wellbeing

- **Create a local offer for carers in Brent**
- **Continually listen to the challenges that carers tell us they are facing** and aim to develop services and resources that will make real, long-lasting differences to their lives.
- **Clarify the various elements of our respite offer.**
- Use the new Carers' hub to **deliver a range of support services and wellbeing therapies**
- **Develop tailored support to help unpaid carers** through transition periods in their caring role
- We will continue to provide **Mental Health First Aid Training**
- **Develop an improved 'carers card'**
- Work with Brent Health Matters to offer a **'one stop shop'** for health in communities
- **Utilise the council's position in the local economy/community to bring in benefits for carers.**

# Our six key commitments

## Carer awareness

- **The development of a carer awareness course**, based upon the principles of our Making Every Contact Count (MECC) approach, that can be delivered by our commissioned provider to community groups, all front-line roles within the council and health and partner organisations.
- **Improve our training offer for health and social care staff**, which will set standards for adult and young carer assessments, implement the triangle of care, and make best use of tools such as the Carers Trust hospital discharge toolkit



## Reaching into communities

- **Changing the language, we** use to make caring more recognisable
- **Using our local offer** to be clear about the benefits of being identified as a carer
- **Developing a comprehensive communications campaign.**
- **Building better connections with community faith groups**
- **Improving access to local authority carers assessments.**
- **Develop more opportunities to celebrate carers** and reduce stigma.
- Brent Council will build on our statutory duty to carers and will endeavour to routinely identify carers when they access services, assess impact on carers of any policy or service change, and monitor equality of access as we would for other groups who are known to experience inequalities.
- The Council will adopt a leadership role in **setting a standard for recognising carers in the workplace.**

## Supporting young carers at the start of their caring journey

- **Developing an awareness programme** to educate teachers, school staff, and healthcare professionals about how to identify young carers
- **Adapt our training offer and roll it out amongst teachers**
- **Establish communication channels and set up regular meetings** so that information can be shared, and young carers identified quickly
- **Developing a comms campaign** and raising awareness amongst students at schools about the role of young carers and the support available to them

Brent

# Implementation: granular planning

Here is an example of content from the more detailed implementation plan including timelines:

| | Access to information | | | | | 01/04/2024 | 01/05/2024 | 01/06/2024 | 01/07/2024 | 01/08/2024 | 01/09/2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ref** | **Activity** | **Owner** | **Start** | **End** | **Status** | **April** | **May** | **June** | **July** | **August** | **September** |
| **1** | **Create a single carers resource** | | 01/04/2024 | 13/09/2024 | On track | | | | | | |
| 1.01 | Review the carers resource created by Hasmita and update if necessary | | 01/04/2024 | 31/05/2024 | Completed | | | | | | |
| 1.02 | Review available online platforms to publish the resource | | 01/05/2024 | 31/05/2024 | On track | | | | | | |
| 1.03 | Publish online on various platforms, including the Brent council website | | 01/05/2024 | 30/06/2024 | On track | | | | | | |
| 1.04 | Print copies and use as an ongoing engagement tool | | 01/07/2024 | 30/09/2024 | Not started | | | | | | |
| 1.05 | Identify opportunities to host the resource, e.g. in Brent Carers Centre, GP surgeries, Brent Council buildings, libraries, hubs | | 01/07/2024 | 30/06/2024 | On track | | | | | | |
| 1.06 | Develop a comms plan to outline how the resource will continually be promoted, Easy Readversion, Braille, Languages , sign language video | | 01/06/2024 | 31/07/2024 | Not started | | | | | | |
| 1.07 | Secure commitment from Carers Partnership Forum to promote the resource | | 01/06/2024 | 30/06/2024 | On track | | | | | | |
| 1.08 | Implement the resouce as a standing agenda item at the Carers Partnership Forum | | 01/06/2024 | 30/06/2024 | Not started | | | | | | |
| 1.09 | Agree a schedule to review and update the resource | | 01/07/2024 | 31/07/2024 | Not started | | | | | | |
| 1.1 | Attend outreach events with Brent Health Matters to increase reach into communities | | 01/07/2024 | 30/09/2024 | Not started | | | | | | |
| **2** | **Promote how and where information can be accessed** | | 01/04/2024 | 13/09/2024 | Not started | | | | | | |
| 2.01 | *See above actions for 'Create a single carers resource'* | | 01/04/2024 | 13/09/2024 | Not started | | | | | | |
| **3** | **Hire a Carers Engagement Officer** | | 01/04/2024 | 20/09/2024 | On track | | | | | | |
| 3.01 | Identify and agree budget for post | | 01/04/2024 | 30/04/2024 | Completed | | | | | | |
| 3.02 | Produce job description, agree length of contract, and get sign-off from HR | | 01/04/2024 | 30/04/2024 | Completed | | | | | | |
| 3.03 | Advertise the role, using the council website, guardian jobs and others | | 30/06/2024 | 31/07/2024 | Not started | | | | | | |
| 3.04 | Review applications and shortlist candidates | | 01/08/2024 | 15/08/2024 | Not started | | | | | | |
| 3.05 | Interview prospective candidates | | 20/08/2024 | 28/08/2024 | Not started | | | | | | |
| 3.06 | Agree hire | | 01/09/2024 | 01/09/2024 | Not started | | | | | | |
| 3.07 | Create workplan for Engagement Officer | | 01/07/2024 | 01/09/2024 | Not started | | | | | | |
| **4** | **Support maintenance of carer hubs** | | 01/04/2024 | 30/09/2024 | Not started | | | | | | |
| 4.01 | Establish location and set-up of Carers hubs | | 01/04/2024 | 31/05/2024 | Completed | | | | | | |
| 4.02 | Ensure understanding of support offered by each hub | | 01/05/2024 | 30/06/2024 | Completed | | | | | | |
| 4.03 | Establish what support is required to maintain the Carer hubs | | 01/05/2024 | 31/07/2024 | Completed | | | | | | |
| 4.04 | Create maintenance plan | | 01/04/2024 | 31/05/2024 | Completed | | | | | | |



Brent

# Next Steps:  Beyond Strategy Sign-off



**23 July 2024**

Carers strategy sign off

**Sep. 2024**

Celebration Event; Carers Strategy Launch, Mid

**July–Dec. 2024**

Carer Awareness Training; All ASC staff (ASC, CYP & Health partners, Brent Res & Non-Gov Org)

Carers strategy comms plan complete

**30 Aug. 2024**

ASC pilot for carers assessment finalised

**30 Sep. 2024**

Presenting Carer Strategy to Brent Res & Orgs (Uni, Colleges, Schools)

**Aug. 2024 – Aug. 2025**

# Discussion

- Questions?



Brent

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| | |
|---|---|
| Brent<br>NHS<br>North West London | **Brent Health and Wellbeing Board**<br>23 July 2024 |
| | **Report from the Director of Brent Health Matters** |
| | **Lead Cabinet Member for Community Health and Wellbeing - Cllr Neil Nerva** |

# Brent Health Matters Annual Report 2023/24

| | |
|---|---|
| **Wards Affected:** | N/A |
| **Key or Non-Key Decision:** | Non-Key Decision |
| **Open or Part/Fully Exempt:** (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | Appendix 1 - Brent Health Matters Annual Report |
| **Background Papers:** | N/A |
| **Contact Officer(s):** (Name, Title, Contact Details) | Nipa Shah<br>Director of Brent Health Matters<br>nipa.shah@brent.gov.uk |

## 1.0 Executive Summary

1.1. An annual report has been produced to summarise the Brent Health Matters programme's approach, achievements between April 2023 and March 2024, and priorities for 2024/25. This is the first annual report produced for the programme. This is being presented to the Health and Wellbeing Board to seek approval to finalise and circulate the report to all partners.

## 2.0 Recommendation(s)

2.1 Comment on and approve the Brent Health Matters programme's annual report for 2023/24.

## 3.0 Detail

### 3.1 Contribution to Borough Plan Priorities & Strategic Context

3.1.1 The Brent Health Matters programme aligns with strategic priority 5 within the Brent Borough Plan 2023-27, which is to build a healthier Brent. One of the key outcomes being addressed through the programme is 'ensuring our health and social care services meet local needs and reduce health inequalities'. The programme also aligns with several of the Council's priorities including the Health and Wellbeing Strategy, Black Community Action Plan, Digital, and Equalities strategies.

## 3.2 Background

3.2.1 The Brent Health Matters programme was launched in September 2020 soon after the first wave of Covid, when the impact on the community had shone a light on the inequalities that historically existed in Brent. The programme was expanded to cover the entire borough following a 6-month pilot in the areas that were hardest hit by Covid, Alperton and Church End. The programme follows an iterative process which has contributed to its continuous evolution over the last three and a half years.

A Brent Health Matters newsletter is circulated to all staff and partners once a month to ensure everyone is kept up to date with the programme's progress. Following the completion of the 2023/24-year, an annual report has been produced to take stock of the programme. The report provides a brief overview of; introduction, our purpose, the programme model, achievements, and priorities for 2024/2025.

## 4.0 Stakeholder and ward member consultation and engagement

4.1 The report was developed with input from key programme partners.

4.2 The annual report was approved by the ICP Board on the 8th of July.

## 5.0 Financial Considerations

5.1 None.

## 6.0 Legal Considerations

6.1 None.

## 7.0 Equality, Diversity & Inclusion (EDI) Considerations

7.1 None.

## 8.0 Climate Change and Environmental Considerations

8.1 None.

## 9.0 Human Resources/Property Considerations (if appropriate)

9.1 None.

## 10.0 Communication Considerations

10.1 Once approved by the Health and Wellbeing Board, the annual report will be published on the Brent Health Matters webpage, and will be circulated to partners across health, care, and voluntary organisations.

***Report sign off:***

***Rachel Crossley***
Corporate Director of Community Health and Wellbeing

# Brent Health Matters Annual Report 2023/2024



July 2024

# Contents





Brent ICP
Integrated Care Partnership

# 1. Foreword

*Cllr Neil Nerva, Cabinet Member for Community Health and Wellbeing, Chair of Health and Wellbeing Board*

*Dr Mohammad Haidar, ICP Clinical Lead, Vice Chair of Health and Wellbeing Board*

*Robyn Doran, Brent ICP Director*



# Foreword

**Brent is an incredibly diverse borough with unequal health outcomes.**

**The Brent Health Matters programme is improving the health experience of residents whose access to services is limited** by knowledge, language, ability to access and time to access. It therefore acts a bridge between the community and mainstream services, enabling residents who have limited contact with these service to have health and care needs better met.

**The programme reaches residents often with unrecognised health and care needs**, which could have long-term implications if not treated on time.

**A priority for system leaders is enabling health and care services to use findings from the programme to adapt and improve mainstream services.**

**The prevention model promoted by the programme is welcomed by residents** and enables better use of valuable financial and practitioner resources. Residents value the self-help and peer supported approach promoted by the programme and enabled through its community grants programme.

**Councillor Neil Nerva –** Cabinet Member for Community Health and Wellbeing, Chair of Health and Wellbeing Board

# Foreword

**The Brent Health Matters (BHM) programme is a partnership across all stakeholders in Brent** that was setup to tackle health inequalities through community engagement and outreach. The programme launched in September 2020 soon after the first wave of Covid, when the impact on the community had shone a light on the inequalities that historically existed in Brent. BHM reports into the Health Inequalities and Vaccination Executive Group, which feeds into the Brent ICP and the Brent Borough Partnership.

**We continuously seek to understand the barriers faced by different communities and people that are seldom heard from**, and work with them to support them to meet their health and care needs. The BHM team is made up of 5 locality teams that work in each of the 5 'Brent Connects' areas, and includes staff from teams in CNWL, Brent Council, CLCH and voluntary organisations consortium led by Brent Carers Centre.



**There is a lot that we're proud of this year** including our flexible approach to working in the community in response to emergency incidents, building the community's trust in services, capacity building in the community, and our work with different stakeholders. We were finalists for an MJ, HSJ, and nominated for a parliamentary award this year.

**We want to thank our residents and community organisations that have worked with us in the last year and look forward to strengthening the working relationships in the coming year.**

**We hope you find this report interesting and helpful.**

**Dr Mohammad Haidar -** ICP Clinical Lead, Vice Chair of Health and Wellbeing Board

**Robyn Doran -** Brent ICP Director

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# 2. Overview

*An overview of the role and approach of Brent Health Matters in supporting residents; our impact in numbers; our spending; and challenges faced in 2023/2024.*



# Background to health inequalities

## Population

**339,800**
Brent population

▲9%
Increase 2011-21

Population density
**7,859**
people per km²

14th highest in England & Wales

## Language

**34%**
1 in 3 Brent residents* use a main language other than English, the 2nd highest rate in England & Wales

**8%**
of residents have poor proficiency in spoken English – the 3rd highest rate nationally

**20%** of households have no-one who uses English as their main language, the highest rate nationally

Around **90** different languages spoken in Brent.

## Life expectancy

**Variation of 9 years between different parts of Brent**

**Variation of 11.7 years between different parts of Brent**

Life Expectancy at Birth in Brent (2017 - 2019)

## Ethnicity & Country of Birth

**65%**
of residents from Black, Asian & minority ethnic groups ▲ 2nd highest rate in England & Wales

**56%**
of Brent residents born outside the UK – the highest rate in England & Wales

## Index of Multiple Deprivation (IMD)

Brent is the most deprived borough in NWL with an IMD rank of **49**, compared to the borough with the highest rank in NWL which is **199.**

## COVID-19

The underlying inequality that was present in the community has been exacerbated by Covid-19. Brent had the highest overall Covid-19 mortality rate out of all regions in England from March to June, 2020. Brent saw a rate of **216.6 deaths per 100,000 people**, in that time period.

## Diabetes

According to the diabetes QOF prevalence, in 2021/22, **8.6%** of patients were recorded on practice registers as having diabetes. This is higher in comparison to the England average at 7.3%.

## Mental Health

According to the Mental Health QOF prevalence, in 2021/22, **1.15%** of patients were recorded on practice registers as having a mental health diagnosis. This is higher in comparison to the England average at 0.95%.

## Cardiovascular Disease

In 2021, Brent's mortality rate from all cardiovascular disease (for all ages) was **267.2 deaths per 100,000 people.** This is higher than the England average at 230.4 deaths per 100,000 people in that time period.



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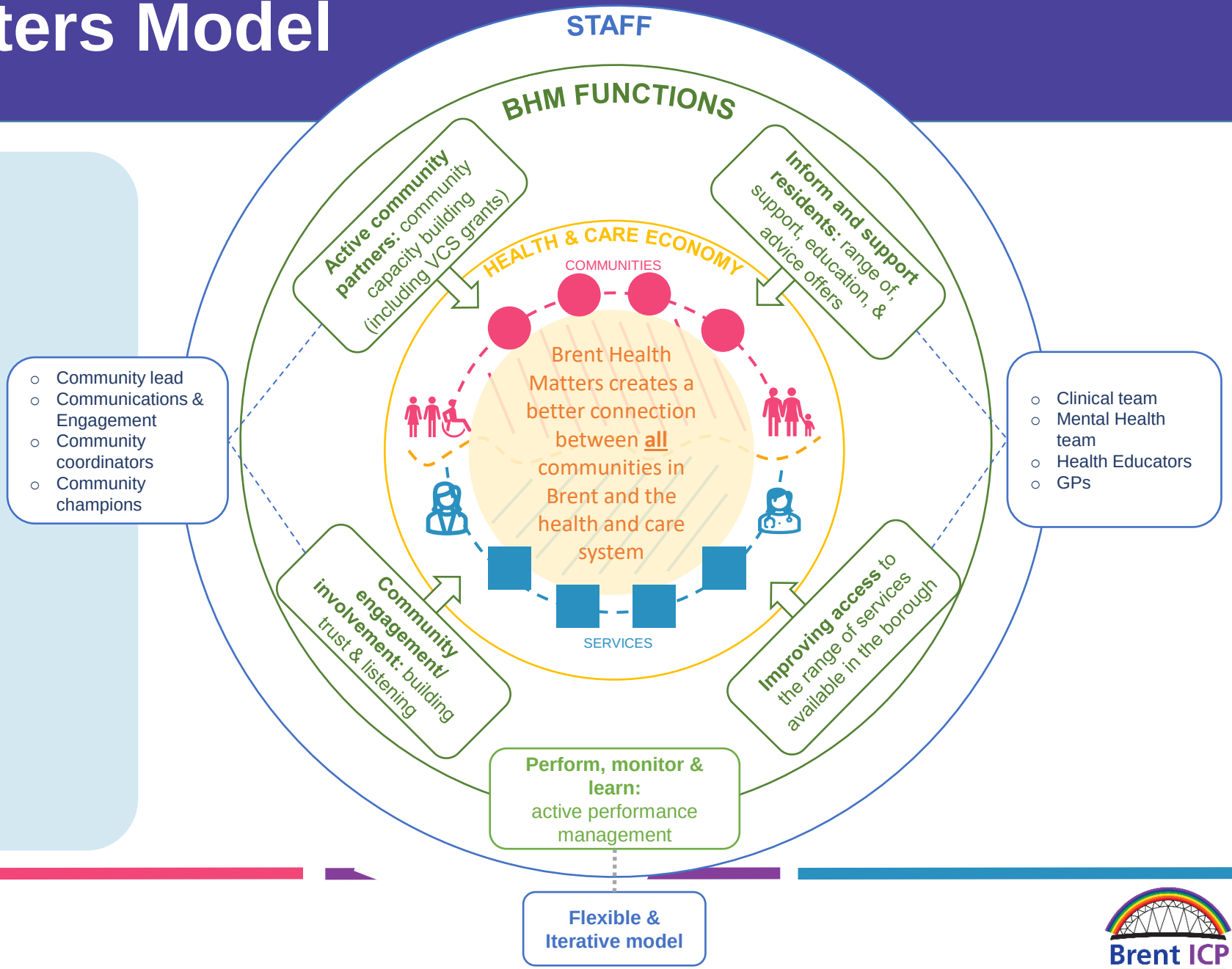
# Brent Health Matters Model

- **Brent Health Matters is both a model to tackle inequalities and a team supporting that model.**
- The model recognises that very often the way in which we provide health and care services and engage with our residents, does not make it easy for people to access the care they need, or encourage the behaviours that would support healthier happier lives.
- Brent Health Matters is a partnership across all stakeholders in Brent setup in 2020 to understand the barriers faced by some communities and people who are seldom heard from and support them to improve the management of long-term conditions and quality of life.



# Brent Health Matters workstreams

**Brent Health Matters works to tackle health inequalities in Brent.**

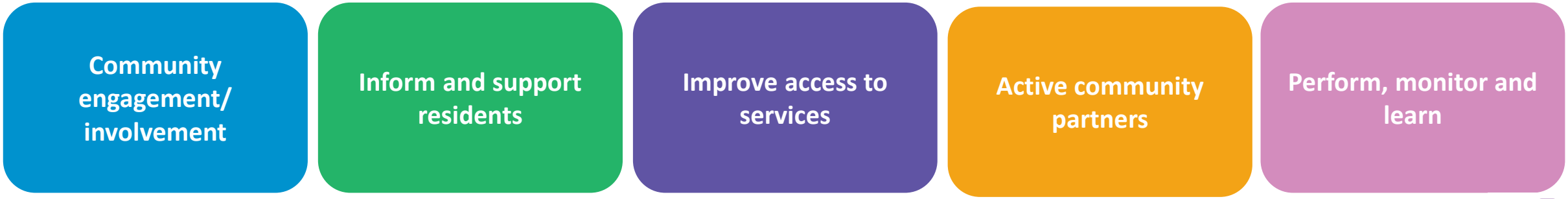
**We work with residents and local organisations from diverse communities** who don't normally access health and care services**.** For example, specific BAME communities, homeless people, emerging communities, people with disabilities; people with mental health issues; deprived areas; and night shift workers. **Demand for our services is growing** – largely because we have increased our visibility and presence in the community.

**Our approach seeks to understand residents' needs and challenges around health and care, and to work with them to improve their health and wellbeing.** Support offered via Brent Health Matters includes developing localised action plans with communities, health checks and mental health support in the community, health education and awareness (on Diabetes, Bowel Cancer screening and Hypertension), supporting people to register with a GP, Diabetes digital inclusion classes, Diabetes peer support groups, and linking the community with Council and NHS services.



**We learn as we deliver and adapt our approach.** We've started running smaller events and activities in target areas which has increased uptake of our offer in specific communities. We're providing more 1-to-1 support to our community grants recipients.

**Brent Health Matters plays an integral part in realising the Council and Brent ICP's ambitions to build a healthier Brent.**

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# Brent Health Matters: the community approach

## We build and maintain networks of community contacts focussing on untapped communities

**Our community engagement staff and volunteer Community Champions are recruited locally and reflect the diverse populations in Brent.** They work with community organisations, residents and groups to co-produce and co-deliver local actions plans in each of the 5 Brent Connect areas (Wembley, Kingsbury & Kenton, Kilburn, Willesden, and Harlesden). We currently have 40 volunteer Community Champions supporting the work of BHM.

**We acknowledge the time it takes to build the community's trust** in statutory services, which is why we gradually build relationships with people, often progressing from informing to consulting, involving, co-creating and empowering levels of interaction. The table below highlights the levels of participation we achieved in 2023/24.



| | Brent Connect area | | | | | |
|---|---|---|---|---|---|---|
| Level of interaction with organisations and groups | Harlesden | Kilburn | Kingsbury & Kenton | Wembley | Willesden | Total |
| Informing | 53 | 46 | 63 | 46 | 23 | 231 |
| Consulting | 9 | 8 | 17 | 12 | 15 | 61 |
| Involving | 10 | 8 | 9 | 7 | 11 | 45 |
| Co-creating | 3 | 3 | 1 | 11 | 12 | 30 |
| Empowering | 16 | 10 | 12 | 13 | 10 | 61 |
| Total | 91 | 75 | 102 | 89 | 71 | 428 |

**We co-produce outreach events, taking health and care into the community** at various locations including factories (day and night shifts), high streets, foodbanks, homeless shelters, places of worship, community centres, leisure centres and libraries. We held 119 events attended by 4261 people in 2023/24.

**We co-produce communication assets in different languages** to suit our diverse audiences, including translated leaflets and posters and videos and voice-notes recorded in community languages. We communicate with residents and stakeholders through a variety of channels including different social media platforms, WhatsApp groups, newsletters, videos, webpages and much more, including programmes on two local community radio stations.

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# Our relationship with VCS providers in 2023/24

## We have built and maintained relationships with local voluntary organisations

- **We linked with 428 community organisations and groups –** our locality teams have connected with new organisations to focus BHM's in-reach to untapped communities, to ensure that their voices are heard too. For example, we held consultations with organisations and their resident groups focusing on themes such as digital exclusion, cancer screening, diabetes and mental health, to co-produce action plans.

- **We awarded community grants to 27 community organisations –** the projects that were delivered addressed a range of concerns and various target groups including children with hearing impairment, people with dementia, parents and carers of children and young people with special needs, physical activity sessions, people with visual impairment, to mental health and green spaces. The support provided by Brent Health Matters to organisations in this process helps them become more sustainable to apply for other grant opportunities.

- **We learnt from providers** – there is a lot that we can learn from the community to ensure BHM and health and care services better support them. We received awareness sessions from various organisations to improve our understanding of the challenges faced by certain groups such as people with learning disabilities, and people from Somali, Iraqi and Romanian backgrounds.

- **We held quarterly community forums** – this provided an open space for organisations and residents to meet us and provide feedback about different themes such as community grants and our communications. The community's insights informed the programme's communications strategy and most recent community grants scheme.



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# Brent Health Matters: mental health approach

**The programme's mental health approach involves assertive outreach with residents and people with lived experience to improve residents' outcomes, experiences and access to mental health and emotional wellbeing services.**

**We recognise the importance of listening to and learning from the community to inform and shape services we provide or source**. The team co-produce meaningful interventions that are culturally sensitive to suit the diverse needs of the communities we work with.



**We have open and relatable conversations about mental health and emotional wellbeing with people in the community. This is tackling the stigma around mental health.**

We've held forums, information sessions, co-facilitated events, training sessions, and co-produced mental and physical health workshops, such as loneliness workshops and mental health first aid training.

We have made great progress with certain communities such as the Somali community, and have had important conversations with others such as refugees, asylum seekers, homeless people, and foodbank users.

**We engaged with more than 5,000 people to raise awareness of mental health and the support that they can access.**

We supported 2,564 individuals with their emotional wellbeing needs, signposting to relevant services that would support their needs.

Around 250 community engagement events were held in 2023/24.

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# Brent Health Matters: the clinical approach

**The programme's clinical approach supports people to re-engage with healthcare services to manage their health.**

**The clinical service follows the ethos of taking healthcare to communities**, supporting communities to improve awareness and case finding, for example identifying people with hypertension, diabetes and atrial fibrillation who aren't accessing healthcare services. The team also works with people from different ethnicities and areas of high deprivation to improve health outcomes, for example cancer screening and improving uptake of vaccinations.

**Our health checks at outreach events consists of:**

- Height, weight and Body Mass Index (BMI)
- Blood sugar level
- Blood pressure
- Atrial fibrillation
- Heart rate
- Diabetes risk assessment

These readings are communicated with patients' own GPs and documented on the same system as Brent GPs, with escalations as needed.

**Our clinical priorities have evolved over time.** The programme initially supported patients with Diabetes and Covid-19 vaccinations from GP lists. This was revised in 2023 to better target health inequalities issues in certain groups:

- Support people known to have high blood pressure from Black ethnic background who have not had any blood pressure recorded in their GP notes in the last 12 months.
- Follow-up with patients who haven't had a Severe Mental Illness (SMI) physical health check in the last year, to do home visits to understand barriers and do the check.
- Reach out to patients from GP lists who have not responded to an invite for bowel cancer screening, focussing on deprived areas, Pakistani, Black African, Black other ethnicities, and people with SMI.

In 2023/24:

- 69% of people who had health checks live in areas of high deprivation (IMD 1, 2, 3 and 4).
- We saw 79 foodbank attendees, 467 workers at factories and 76 refugees
- 27% of our health checks were provided to people from Black ethnic backgrounds.
- We provided blood pressure reviews for 148 patients known to have high blood pressure from Black ethnic backgrounds.
- We carried out physical health checks with 35 patients with SMI.
- We successfully contacted and ordered bowel cancer screening test kits for 998 patients from priority groups.



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# Brent Health Matters: Health Educator Service

**Our Health Educators play an integral role equipping residents to better prevent and manage long term health conditions, and access the range of services, support, education and advice available in Brent.**

**Our consortium of VCS providers (Brent Carers Centre, SAAFI, Community Barnet, PLIAS and Brent Mencap) deliver this service.** Like many of the programme's staff, Health Educators are recruited locally to reflect the diverse cultures and languages in Brent. This allows them to have conversations with people on streets, shops and community centres. They had conversations with 16,547 people in 2023/24 alone. They also support people to register with a GP if needed.



**Some residents were keen to get their health back on track after meeting our Health Educators,** whether that's someone with a health condition such as Diabetes or Hypertension, or someone who's at risk of developing health conditions. A personalised approach is taken with individuals to support them to achieve their healthy eating and lifestyle goals in 3 months. Health Educators have case managed 66 people in 2023/24.

**The 8-week Diabetes peer support programme** has been creating a safe space for people with or at risk of developing Diabetes to better manage their health together.

Participants complete the programme feeling equipped with information, advice, and peers that motivates them to improve their physical health and emotional wellbeing. 62 people completed the programme in 2023/24.

**The 6-week Diabetes digital inclusion programme** has been equipping people with Diabetes with the skills and confidence to manage their condition online.

Participants are supported to create an email address and ask their GPs to update their records with this information. They get registered onto the Know Diabetes website and learn how to sign up and use online resources and support groups. 65 people completed the programme in 2023/24.

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# 3. Achievements

*A summary of the programme's achievements over 2023/34, including our successes, and our areas for improvement.*



# Brent Health Matters 2023/24: in numbers

We held 119 events attended by 4,261 people and carried out 3,930 health checks.

We linked in with 428 community organisations and groups.


Identified 262 undiagnosed people with high blood pressure at events

Identified 182 people with non-diabetic hyperglycaemia

We supported 2,564 people for mental health and emotional wellbeing at events



We supported 65 digitally excluded people with Diabetes or at risk of developing Diabetes to create an email address and use the Know Diabetes platform.

Supported 239 residents to register with a Bent GP practice

Supported 51 people to access Housing, Adult Social Care and Employment services to resolve their social issues.

Supported 128 Diabetic/pre-Diabetic people to implement healthier eating and lifestyle changes to prevent or manage their condition.

Awarded grant funding to 27 community organisations to deliver health inequalities projects

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# Brent Health Matters 2023/24: our feedback

**We are always seeking feedback from the community to continually improve our approach. With this in mind, we collect feedback forms from people who have had a health check at our events, and people who complete our peer support group and digital course. We also keep an open dialogue with our stakeholders such as factories and VCS organisations, which has helped us know what to keep doing, what to stop, and what we can do differently.**

***We are proud of the positive feedback that we hear from those we serve***

**All our teams have received positive feedback from residents and service users** – their efforts have made a real impact and we are proud to recognise that…

*Feedback from the **Bakkavor Factory Abbeydale Road site Senior Executive Manager***

> *By you guys coming here, we are helping employees feel more confident about their health and are finding conditions that people were unaware of, with many employees telling me they have been referred for further support.*

*Feedback on **the Healthy Cookery Programme at Brent Mencap***

> *I'm really enjoying learning how to make healthy food, I like the environment and I like to socialise with other people.*

*Feedback for our **Diabetes Digital Course***

> *Once I joined I found it very interesting, especially Know Diabetes because it gave me a lot of ins and outs of Diabetes. I joined GP online appointments and I did in just 2 hours. I was so happy I done something.*

*Feedback from **a resident***

> *This is my first time attending a health and wellbeing event, and it was great to get all this support in one place. I learned lots and feel encouraged to take charge of my health.*

*Feedback from our **Harlesden Community Champion***

> *The talks hit every nail on the head. BHM has changed my life, giving me the power to overcome challenges, and the platform to support others in the community. There is no place like Brent.*



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# Brent Health Matters 2023/24: areas for improvement

We have identified the following areas for improvement in 2023/24 and have commissioned the King's Fund to help us address some of these:

- Our events should focus on untapped and emerging communities, as well as the communities that face the highest health inequalities.
- We need to build closer working relationships with GPs and PCNs.
- We have had limited success in incorporating the BHM model with wider health and care services to make tackling health inequalities business as usual.

We have started to develop our theory of change (Appendix A) to guide our evaluation and improvement. We need to build on this and further develop our theory of change to ensure we can demonstrate our outcomes and impact.



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# 4. Priorities

*A summary of the programme's way forward for 2024/25*



# Brent Health Matters 2024/25: moving forward

**Looking ahead, 2024/25 is likely to be another challenging yet rewarding year for Brent Health Matters. We are determined to continue working with the community to deliver a high-quality service that meets people's needs and influence the way health and care services are delivered too.**

**Priorities for 2024/25:**

- **Supporting the development of Integrated Neighbourhood Teams and the Council's Change programme which has a strong focus on community empowerment and neighbourhood working.**
- **Refreshing our clinical priorities based on current data, such as hypertension in the black community and bowel cancer screening.**
- **Launching a team to tackle health inequalities in children and young people, focussing on asthma management, mental health and immunisations.**
- **Linking with other untapped and emerging communities to hear their voices and co-produce solutions to issues they face.**
- **Continuing our community grants programme and support community organisations to deliver community grants projects. Work with community organisations to collect data to understand the impact of projects and make organisations more sustainable.**
- **Using the cultural competency framework, implement and measure changes to CNWL as a result of our improved understanding of communities and their needs.**
- **Increase BHM's programme's presence at established council spaces in the community, for example hubs and family wellbeing centres.**



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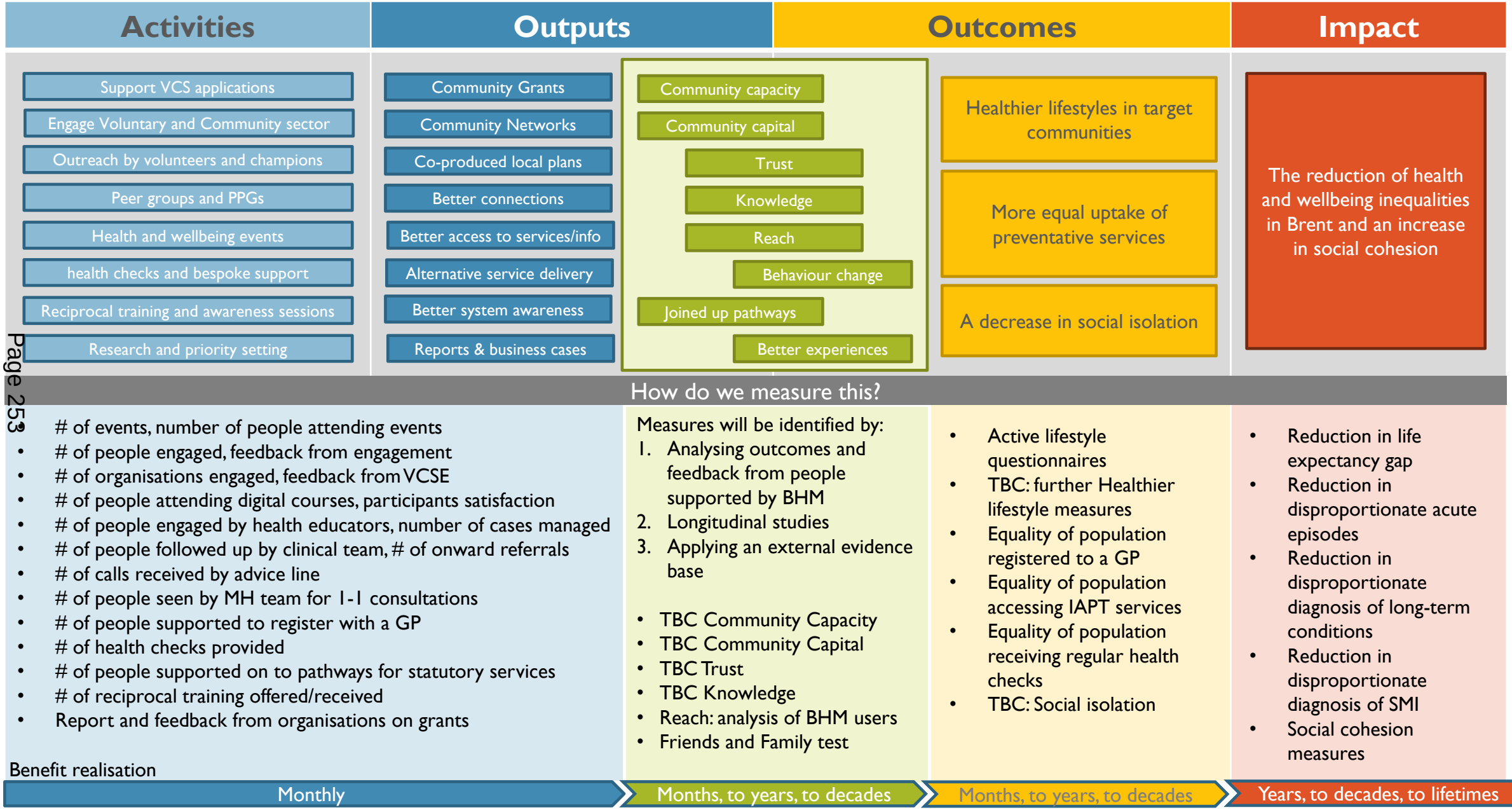
# Appendix A: Our Theory Of Change



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| | |
|---|---|
| Brent<br>NHS<br>North West London | **Brent Health and Wellbeing Board**<br>23 July 2024 |
| | **Report from the Executive Director of Strategy and Population Health** |
| | **North West London ICB** |

# North West London's Joint Forward Plan

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | Appendix 1 - Joint Forward Plan |
| **Background Papers:** | None |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Toby Lambert<br>Executive Director of Strategy and Population Health, North West London ICB. |

## 1.0 Executive Summary

1.1 North West London ICB, in common with all ICBs, is required to produce a five-year Joint Forward Plan (JFP) that shows how the ICB and its NHS partners intend to deliver services to the population of North West London in line with the strategy set by the Integrated Care Partnership. The ICB is required to produce and publish this plan on an annual basis, before 31st March each year. The deadline for submission to NHS England was changed to July 5 2024 in recognition of the delays to the planning guidance for 2024/25 and the calling of the general election.

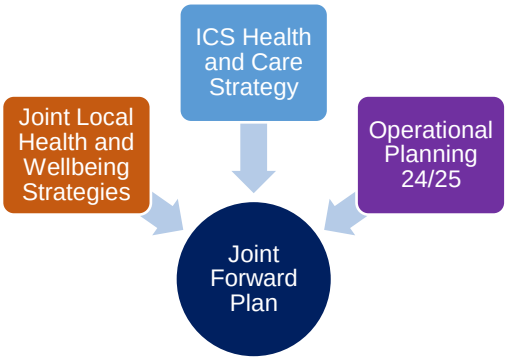
1.2 The ICB is also required to share the plan with each relevant Health and Wellbeing Board, who in turn are required to respond with their opinions as to whether the plan takes proper account of their joint health and wellbeing strategies.

1.3 NHS England guidance on the pre-election sensitivity period limited the ICB's ability to discuss the JFP before the London mayoral and assembly elections, and NHS England has specifically instructed ICBs not to discuss at any meeting in public until after the general election. This has made it impossible for HWBs to respond with their opinions, though officers from some local authorities sent comments in lieu of formal HWB feedback.

1.4 A summary of the JFP is provided at the end of this cover note and the full document is attached.

The plan contains:

- plans and outcomes across nine different priorities, decided through a prioritisation process.
- plans for the enabling work streams to support the priorities.
- borough plans setting out alignment with NWL priorities to achieve scale and separate, local priorities.




## 2.0 Recommendation(s)

2.1 Comment on the suggestions for improving the process for the next Joint Forward Plan;

2.2 Note that, while the draft Joint Forward Plan (JFP) was provided to Health and Wellbeing Boards for comment, successive pre-election sensitivity periods made formal feedback from HWBs impossible within the set deadline; and

2.3 Note that the JFP was submitted to NHS England on 5 July (the deadline set).

## 3.0 Detail

### 3.1 Summary

3.1.1 The Joint Forward Plan is a statutory document that sets out how Integrated Care Boards (ICBs) and their partner NHS trusts propose to exercise their functions in the next five years. These should be reviewed before the start of each financial year.

3.1.2 In November 2023 North West London's Integrated Care Partnership published our Health and Care Strategy for North West London. The ICP brings together our eight local authorities, the NHS and wider partners. The strategy sets out how we will improve outcomes in population health and wellbeing, prevent ill health and tackle inequalities, enhance productivity and value for money and support broader economic and social development.

3.1.3 The Joint Forward Plan takes the strategy (including the borough joint health and wellbeing strategies), the nationally set NHS operating plan[1] and agreed national and local targets and translates these into meaningful milestones and activities. It clarifies where the NHS will prioritise resources and objectives now and where we should invest in the future. It hence reflects and complements the Joint Health Wellbeing Strategies developed by each of our boroughs.

3.1.4 Our borough based partnerships and provider collaboratives will continue to have their own specific plans to improve health and wellbeing and to deliver the operating plan. However, aligning these with the Joint Forward Plan will mean that we can concentrate resources across the system in the most effective way possible.

[1] The 2024/25 priorities and operational planning guidance was published on 27 March. The JFP was developed using our best intelligence as to the likely content of the guidance.

3.1.5 Delivery will require cross-system collaboration from our providers through provider collaboratives, ICS programme teams, clinical networks, voluntary and community sector organisations (VCSEs) and borough teams. The board will receive assurance on delivery of the JFP through reports supplied to Performance Committee.

### 3.2 Context

3.2.1 North West London ICB, in common with all ICBs, is required to produce a five-year plan that shows how the ICB and its NHS partners intend to deliver the ICS strategy. The ICB is required to produce this plan each year.

3.2.2 The process of producing the Joint Forward Plan, as well as being a statutory requirement, is part of the organisational effectiveness work stream within the organisational design programme. It aims to:

- Show how the six priorities identified in the strategy translate into a work programme;
- Deliver consistent plans and priorities and improve coordination across the ICB (and thereby reduce bottlenecks resulting from conflicting priorities between different parts of the ICB and the wider ICS);
- Identify areas where working at scale across North West London to develop a shared offer and models of care that can tailored locally will enable us to go further and faster in delivering for our population;
- Be consistent with the ICB's medium term financial strategy;
- Ensure that local priorities that are not shared between North West London's borough Health and Wellbeing Strategies can continue to be progressed locally; and
- Be deliverable within the reduced capacity of the ICB.

3.2.3 Planning is taking place against a challenging backdrop – in common with the NHS across the country, our services have been under immense pressure in the last couple of years. Although NW London is one of the best performing healthcare systems, we have:

- A **financial challenge**, with a spend per head lower than average, insufficient capital to meet our estates need and a commitment to reallocate funding within NW London to services that need it most, rather than where it has been spent historically
- A **productivity challenge**, requiring a challenging 3.7% efficiency gain in addition to normal expectation of productivity improvement, so we can free up the funds to invest in better, more equitable services; and
- An **organisational challenge**, with new statutory duties and a requirement to restructure our workforce, but also new opportunities through changes to the way we work across our partnerships and our providers coming together as collaboratives to capture the benefits of scale, reduce unnecessary variation and create greater resilience.

3.2.4 This means that our focus in the initial period of the plan has to be on reducing waiting times and maximising productivity so we can provide equal access to a common set of high quality services regardless of where our residents live. During this time, we will also be testing proactive approaches that prevent, reduce or delay the onset of need, support our residents to stay

well and identify and support people at risk of or diagnosed with illness through providing best practice interventions.

3.2.5 Our aim is to be ready to roll out these programmes over time work together with our local authorities and voluntary sector partners, within the context of a resilient and productive NHS.

### 3.3 Process

3.3.1 We acknowledge that this is the first time that the ICB has attempted to prioritise and plan across its entire portfolio of work and has taken place within a very short timeframe. This first iteration of the JFP is capable of considerable improvement and subsequent JFPs will take on board lessons learnt and feedback from the first iteration to improve the process and the quality of the output each year.

3.3.2 In developing the plan, we took the following approach:

- Each programme, clinical network, borough team and collaborative submitted their **proposed work streams and plans** for the next five years, and in more detail for the earlier years.
- A **prioritisation framework** to support the leadership in selecting 5-10 shared initiatives was drawn up and taken through a working group. This covered the following domains:
    a. Alignment with the Health and Care Strategy;
    b. Contribution to health outcomes and inequalities;
    c. Alignment with national requirements, including the NHS E operating framework and the medium term financial strategy; and
    d. Delivery feasibility.
- We took **views from system leaders** on their priorities;
- A **town hall meeting** bringing together representatives across the ICS leadership was held in mid-February to discuss their plans, the initial prioritisation outcomes and what needed to be true to ensure the new priorities could be delivered well without additional asks;
- Based on feedback from the Town Hall the programmes, clinical networks, borough teams and collaboratives **resubmitted their plans, including enabling programmes assessing feasibility of delivering requirements** and we refined the priorities.

### 3.4 Summary of the Joint Forward Plan

3.4.1 The JFP contains nine priorities with corresponding activities, supported by four enabling work streams. It also includes a summary of each borough's plans.

## Priorities

| Priority | Intended outcomes | Focus in early years | Focus in later years |
|---|---|---|---|
| **PRIORITY 1:** Reduce inequalities and improve health outcomes through population health management (PHM) | • PHM based service design and investment decisions embedded in all settings including integrated neighbourhood teams.<br>• Improved value for money and better able to meet population need and tackle health inequalities. | • Deliver PHM & Health Equity Academy – upskilling staff, starting with primary care; map financial position to need.<br>• Deliver core common offer, address hesitancy. | • Intelligence Function with PHM underpinning our approach across the system for all conditions.<br>• Complementary services where common offer does not deliver for specific groups. |
| **PRIORITY 2:** Improve children and young people's mental health and community care | • Consistent core healthcare offers for children resulting in equitable outcomes for health conditions in childhood, and for reducing risks in later adulthood<br>• Local and national qualitative and quantitative evidence unders tood and shared across partners<br>• Integrated multi-professional partnership to provide seamless integrated healthcare to children | • Reduce waiting list for child and adult mental health services (CAMHS)<br>• Close gap in school nursing provision for looked after children and children with special educational needs<br>• Implement child health and family hubs<br>• Deliver children and young people speech and language therapy priority quick wins | • Transformational improvements for specific conditions with known health inequity<br>• Equity of experience of care |
| **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) with general practice at their heart | • Clarity for residents on how to get the care they need.<br>• Avoidance in hospital and care home admissions Earlier detection of people at risk of ill health, earlier diagnosis of ill health and improved quality of care for people with long term conditions | • Establish and roll out standard operating procedures for the three Fuller areas, plus elective care<br>• Extend same day access across all INTs<br>• Establish core common offer for frail / elderly | • Focus on all residents and families to have care plans who need them with high adherence and making best use of local authority and community resources<br>• Early and accurate diagnosis of disease |
| **PRIORITY 4:** Improve mental health services in the community and for people in crisis | • A reduction in unwarranted variation and equality in health outcomes, access to services and experience<br>• An increased use of analysis and insights to help inform productivity and local decision making | • Focus on productivity to reduce waiting lists waiting lists. | • Increase capacity to where needed to reduce inequalities |
| **PRIORITY 5:** Embed access to a consistent, high quality set of community services by maximizing productivity | • Reduction in waiting times for community services<br>• Increase in urgent community response for first care contacts<br>• Reduction in length of stay in community beds<br>• More clinical time with patients | • Implement consistent offer in community nursing, community beds and specialist palliative care<br>• Conduct demand and capacity modelling across system<br>• Drive increased productivity across these services. | • Implement consistent offer in neuro rehab<br>• Services in line with right demand and capacity<br>• Launch additional virtual ward pathways<br>• Identify and reduce patients experiencing inequality of access, experience and |

| | | | |
|---|---|---|---|
| | | | outcome in urgent and emergency care services |
| **PRIORITY 6:** Optimise ease of movement for patients across the system throughout their care – right care, right place | • Reduced delay for patients in hospital who are medically well enough to be discharged<br>• More patients are discharged back to their place of residence than in previous years<br>• Patients put at a reduced risk of harm by being discharged from hospital sooner | • Remove delay for medically optimised patients in hospital - implement discharge to assess or equivalent model and embed system escalations and operational support<br>• Enhance support to care homes to improve intermediate care<br>• Direct referrals to same day emergency care (SDEC) services | • Launch additional virtual ward pathways<br>• Identify and reduce patients experiencing inequality of access, experience and outcome in urgent and emergency care services |
| **PRIORITY 7:** Transform maternity care | • Reduce the inequity of pregnancy care and outcome<br>• Improved safety of services, with more support from maternity services to higher risk cases<br>• Low numbers of still births and intrapartum brain injuries | • Develop maternity strategy<br>• Achieve NHS England safe staffing standards<br>• Inreach offer for ethnic communities adversely affected by poor outcomes in maternity services | • Implement wider maternity transformation |
| **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment | • Improved early diagnosis by tackling variation in screening<br>• Faster and more efficient access to diagnosis and treatment | • Increase HPV vaccination uptake in school age children<br>• Reduce population differences in seeking help for symptoms of concern, focussing on Brent<br>• Deliver and maintain national performance requirements for faster diagnosis and treatment<br>• Target lung health checks (TLHCs) in high risk wards | • Roll out lessons on early diagnosis from Brent to wider NW London<br>• Roll out and embed approaches to early diagnosis and treatment, ensuring spread and adoption of useful technology |
| **PRIORITY 9:** Transform the way planned care works | • Elimination of waits over 52 weeks for elective care<br>• Reduction in avoidable outpatient referrals and activity<br>• More meaningful and effective communications with patients, leading to fewer missed appointments and a better patient experience<br>• Increase staff satisfaction, reduction in staff burnout | • Drive productivity in outpatients and elective care<br>• Drive efficient use of diagnostic centres<br>• Innovation of new workforce models to deliver clinics<br>• Activities to improve patient communications (NHS App, better use of language) | • Focus on care in most appropriate setting through transformation of clinical pathways, moving closer to home<br>• Embed continued wellbeing through recovery and proactive care models |

3.4.2 We know that the Joint Forward Plan is currently underpowered in a couple of areas:

- We are committed to developing an urgent and emergency care strategy - completion due in the summer). Once complete, this will enable us to strengthen priority six on flow;
- The Acute Provider Collaborative is currently working up its strategy – completion again due in the summer. A particular theme in the strategy will be elective recovery and swifter access to specialist opinion (which underpins outpatient transformation). Once complete, this plan will allow us to strengthen priority nine (planned care).

### Enabling programmes

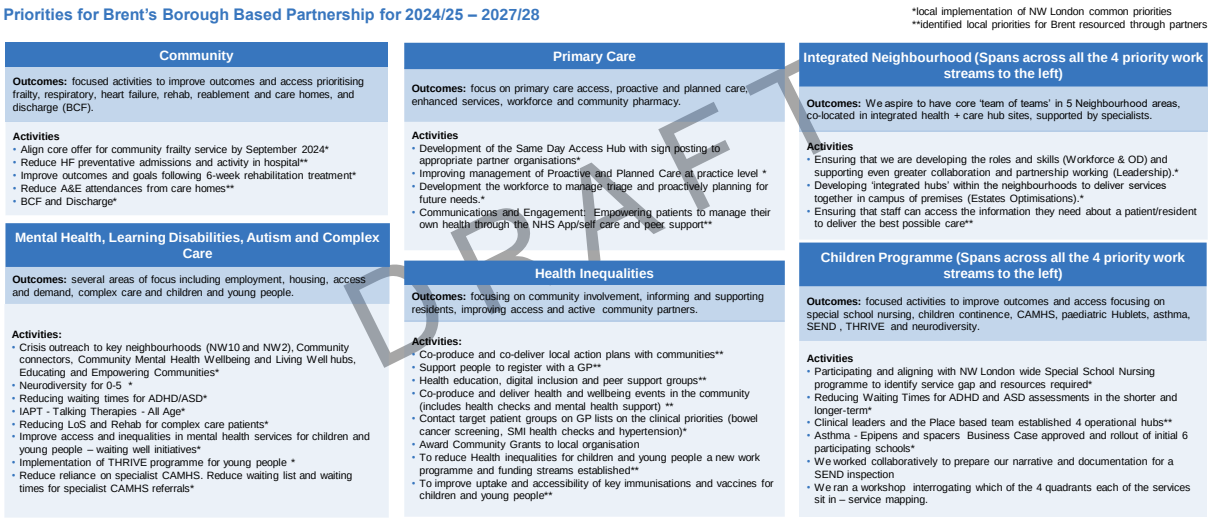
3.4.3 The priorities confirm the estates, digital and data, workforce and communication and engagement requirements to deliver the priorities, in addition to the enabling activities to deliver the wider strategy.

| Enabler | Intended outcomes | Focus in early years | Focus in later years |
|---|---|---|---|
| **Estates** | • Estate facilitates services which respond to the needs of the local population<br>• Effective and appropriate utilisation<br>• Best design for integrated working | • Immediate prioritised investments<br>• Fit for purpose estates for early INT sites | • Completion of major projects identified for integrated working<br>• Infrastructure planning and delivery |
| **Workforce** | • A safe and manageable workload<br>• Increased satisfaction from staff surveys<br>• Clear workforce model included new and fulfilling roles with productivity gain | • Expand and diversify routes into recruitment<br>• Workforce productivity and new ways of working for community nursing and mental health roles | • Workforce elements of the system wide programmes to enable new ways of working in support of new models of care |
| **Digital and data** | • Stable and secure ICT infrastructure<br>• Shared records across health and care settings and with access to citizens to help them manage their own health and care<br>• Data used intelligently to improve population health and reduce inequalities<br>• Take advantage of digital healthcare innovation. | • Migration of the Whole Systems Integrated Care dashboard to a modern cloud platform and integration into workflows<br>• Link 111, 999, VCS data to WSIC<br>• Create population health dashboards for whole sector<br>• Ongoing programme of digital enhancements | • Plan and implement the transformation required to make use of shared records |
| **Communications and engagement** | • The JFP includes an assessment of the communications and involvement work to deliver the priorities in addition to strategic activities not directly related to the priorities, such as the programme to combine resident insights with other data to improve decision-making and the campaign to simplify use of language across ICB and then wider ICS. | | |

## Borough place partnership priorities

3.4.4 The Joint Forward Plan also includes a summary of each borough based partnership's plans. The plan sets out where these align with the nine NW London priorities and can therefore be delivered at scale and where there are additional activities which may be phased differently or implemented now for specific, local reasons in agreement with their Health and Wellbeing Boards. The priorities within the Joint Forward Plan for Brent are included below (easier read version in the accompanying JFP):

**Brent**



**Priorities for Brent's Borough Based Partnership for 2024/25 – 2027/28**

*local implementation of NW London common priorities
**identified local priorities for Brent resourced through partners

**Community**

**Outcomes:** focused activities to improve outcomes and access prioritising frailty, respiratory, heart failure, rehab, reablement and care homes, and discharge (BCF).

**Activities**
- Align core offer for community frailty service by September 2024*
- Reduce HF preventative admissions and activity in hospital**
- Improve outcomes and goals following 6-week rehabilitation treatment*
- Reduce A&E attendances from care homes**
- BCF and Discharge*

**Mental Health, Learning Disabilities, Autism and Complex Care**

**Outcomes:** several areas of focus including employment, housing, access and demand, complex care and children and young people.

**Activities:**
- Crisis outreach to key neighbourhoods (NW10 and NW2), Community connectors, Community Mental Health Wellbeing and Living Well hubs, Educating and Empowering Communities*
- Neurodiversity for 0-5 *
- Reducing waiting times for ADHD/ASD*
- IAPT - Talking Therapies - All Age*
- Reducing LoS and Rehab for complex care patients*
- Improve access and inequalities in mental health services for children and young people – waiting well initiatives*
- Implementation of THRIVE programme for young people *
- Reduce reliance on specialist CAMHS. Reduce waiting list and waiting times for specialist CAMHS referrals*

**Primary Care**

**Outcomes:** focus on primary care access, proactive and planned care, enhanced services, workforce and community pharmacy.

**Activities**
- Development of the Same Day Access Hub with sign posting to appropriate partner organisations*
- Improving management of Proactive and Planned Care at practice level *
- Development the workforce to manage triage and proactively planning for future needs.*
- Communications and Engagement: Empowering patients to manage their own health through the NHS App/self care and peer support**

**Health Inequalities**

**Outcomes:** focusing on community involvement, informing and supporting residents, improving access and active community partners.

**Activities:**
- Co-produce and co-deliver local action plans with communities**
- Support people to register with a GP**
- Health education, digital inclusion and peer support groups**
- Co-produce and deliver health and wellbeing events in the community (includes health checks and mental health support) **
- Contact target patient groups on GP lists on the clinical priorities (bowel cancer screening, SMI health checks and hypertension)*
- Award Community Grants to local organisation
- To reduce Health inequalities for children and young people a new work programme and funding streams established**
- To improve uptake and accessibility of key immunisations and vaccines for children and young people**

**Integrated Neighbourhood (Spans across all the 4 priority work streams to the left)**

**Outcomes:** We aspire to have core 'team of teams' in 5 Neighbourhood areas, co-located in integrated health + care hub sites, supported by specialists.

**Activities**
- Ensuring that we are developing the roles and skills (Workforce & OD) and supporting even greater collaboration and partnership working (Leadership).*
- Developing 'integrated hubs' within the neighbourhoods to deliver services together in campus of premises (Estates Optimisations).*
- Ensuring that staff can access the information they need about a patient/resident to deliver the best possible care**

**Children Programme (Spans across all the 4 priority work streams to the left)**

**Outcomes:** focused activities to improve outcomes and access focusing on special school nursing, children continence, CAMHS, paediatric Hublets, asthma, SEND , THRIVE and neurodiversity.

**Activities**
- Participating and aligning with NW London wide Special School Nursing programme to identify service gap and resources required*
- Reducing Waiting Times for ADHD and ASD assessments in the shorter and longer-term*
- Clinical leaders and the Place based team established 4 operational hubs**
- Asthma - Epipens and spacers Business Case approved and rollout of initial 6 participating schools*
- We worked collaboratively to prepare our narrative and documentation for a SEND inspection
- We ran a workshop interrogating which of the 4 quadrants each of the services sit in – service mapping.





## 3.5 Ways of Working

3.5.1 As we have progressed the organisational restructure, staff in the ICB have expressed considerable scepticism that that the organisation will indeed adhere to a defined list of priorities when there are considerable pressures to react to further demands. To build confidence, we have used feedback from the Town Hall event to develop a set of principles:

1. **Priorities are collectively agreed upon and endorsed** - ensuring alignment across all program teams, boroughs, networks, and collaboratives, fostering understanding and endorsement of the priorities and their sequencing;
2. **Programme priorities are aligned with Borough requirements** - ensuring consistent delivery of priorities to the same standard and at the same time. This may necessitate some programs and boroughs to adjust their focus and adopt a more collaborative approach;
3. **Clear establishment and monitoring of deliverables and metrics for each priority** - with a single empowered lead overseeing each aspect;
4. **We are empowered to discontinue deprioritised work and to challenge additional tasks** - thorough scrutiny and review should be applied to any work that does not support a priority;
5. **Resource allocation is accurately aligned with priorities** - with some activities being halted and increased focus directed towards certain areas;

6. **Leadership is committed to upholding these commitments** - being prepared to push back against national and regional requests, while carefully considering the implications of any additional tasks.

### 3.6 Overseeing implementation of the JFP

3.6.1 We will use the Joint Forward Plan to track our delivery against the milestones and actions in the priority areas and report these through the ICB performance processes. The performance report already contains a section on each of the ICS' programmes. Progress against the milestones and actions in the JFP should be reported through this route. Local delivery is reported through local structures.

3.6.2 The ICB's Strategic Commissioning Committee is also establishing a cycle of strategic reviews. The committee has representation from a DASS (being agreed) and a DPH (currently H&F). The reviews should follow a clear structure – starting with the relevant goals laid out in the JFP and progress towards them.

### 3.7 Feedback from Health and Wellbeing Boards

3.7.1 Health and Wellbeing Boards HWBs were sent the draft plan on 9th April and asked to provide their commentary, and specifically respond with their opinion as to whether the plan takes proper account of each relevant joint local health and wellbeing strategy. The pre-election sensitivity period for the London elections made it impossible for the ICB to attend HWBs between late March and the 2 May 2024; the the pre-election sensitivity period for the general election made it impossible for the ICB to attend HWBs from 25 May to the 4 July. NHS England revised the deadline for the Joint Forward Plan to 5 July 2024, which was of no help in securing the view of HWBs. Written and/ or executive feedback from our boroughs was sought in lieu of consideration from HWBs.

### 3.8 Potential improvements

3.8.1 Statute requires the ICB to prepare a joint forward plan every year. The team working on the joint Forward Plan has collated the following suggestions to improve the process for next year:

- Make the link to the health and care needs of residents clearer (i.e., update North West London's shared needs assessment, drawing on JSNAs, each September);
- Start the JFP process earlier in year (September) so that:
  - The outputs can inform commissioning intentions in December;
  - Those outputs and commissioning intentions can inform NHS operational planning (rather than be developed in parallel to the operating plan);
  - Programmes and boroughs can prepare a more detailed one year plan drawing on the JFP; and
  - Engagement with health and wellbeing boards can take place from January to March, enabling a final JFP by the end of March.
- Strengthen clinical and professional contribution into the JFP process (e.g., holding a clinical advisory group summit to inform the prioritisation of the plan);

- Strengthen input from partners (e.g., local authorities, voluntary sector, etc.). While partners were invited to the town hall meeting, and many partners sit on the ICS programmes who contributed to the JFP, this may not be the most effective way of inviting input;
- Strengthen the consideration of financial, workforce and other constraints in the JFP process, for example by supporting programme, borough and corporate teams with tools that will enable them to prioritise more effectively within the available resource.

**3.9 Next steps**

3.9.1 The NHS is required to produce a five-year Joint Forward Plan before the beginning of each financial year. This provides us with the opportunity to update the plan as local and national priorities evolve. Our aim is to produce a draft by December of each year, giving Health and Wellbeing Boards to comment in January and February to allow publication by the end of March.

**3.10 Contribution to Borough Plan Priorities & Strategic Context**

3.10.1 The Joint Forward Plan builds upon the Joint Health and Wellbeing Strategies developed by each North West London's boroughs.

**4.0 Stakeholder and ward member consultation and engagement**

4.1 The JFP Plan builds on the North West London Health and Care Strategy that was developed last year. This strategy was subject to public consultation and the final iteration included feedback from residents and communities.

4.2 Continuing input from the ICB's 'What matters to you' engagement programme has been fed into the development of the JFP.

4.3 The draft of the JFP was on the website, giving residents and communities the opportunity to comment before the JFP is finalised.

**5.0 Financial Considerations**

5.1 No direct financial considerations for Brent London Borough Council.

**6.0 Legal Considerations**

6.1 Health and Wellbeing Boards have a duty to respond to the Joint Forward Plan giving their opinion on whether the plan takes proper account of their joint local health and wellbeing strategy. Unfortunately, this year's pre-election sensitivity periods have made it impossible to receive opinions from Health and Wellbeing Boards before NHS England's deadline.

**7.0 Equality, Diversity & Inclusion (EDI) Considerations**

7.1 While the initiatives outlined in the Joint Forward Plan will doubtless give rise to EDI implications, North West London addresses these considerations (though, for example, EQIAs) as we prepare for implementation.

**8.0 Climate Change and Environmental Considerations**

8.1 N/A

## 9.0 Human Resources/Property Considerations (if appropriate)

9.1 N/A

## 10.0 Communication Considerations

10.1 To outline relevant considerations in relation to any required communication strategy or campaigns.

***Report sign off:***

***Toby Lambert***
Executive Director of Strategy and Population Health

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NHS
North West London

# Joint Forward Plan for North West London

**Draft, July 2024**

# Contents

# Foreword

We are delighted to introduce our five-year Joint Forward Plan (JFP).

The plan builds on the Health and Care Strategy we published last year, which sets out how North West London's eight local authorities and the local NHS will improve outcomes in population health and wellbeing, prevent ill health and tackle inequalities, enhance productivity and value for money and support broader economic and social development.

The JFP is technically joint between North West London Integrated Care Board and our partner NHS trusts, and sets out how the local NHS will prioritise, sequence and deliver measurable improvements and outlines what we will do to deliver our strategy and when. It complements the Joint Health and Wellbeing Strategies developed by each of our boroughs.

The past few years have been incredibly challenging for everybody working in the NHS, with the COVID pandemic, rising waiting lists and industrial action. Although NW London is one of the highest performing integrated care systems in the country, these challenges have not passed us by and feedback from our residents is quite clear that we can do more.

So the focus of the next two years has to be on transforming our health and care services so that they continue to respond to the needs of our residents and communities.

For the next two years we will prioritise reducing waiting times and improving productivity to provide access to a common set of high quality services regardless of where our residents live. We will, for example, test proactive approaches that prevent, reduce or delay the onset of need; support our residents to stay well; and identify and support people at risk of, or diagnosed with, illness by providing best practice interventions.

To deliver the plan, we will continue to work with local authorities, primary care, the voluntary sector and our communities across North West London to coproduce and develop services that meet our communities' needs and that they can have confidence in. Our aim is to be ready to roll out these programmes over time, within the context of a resilient, efficient and effective NHS.

Delivering this Joint Forward Plan will require building on the shift to working as a system we saw during the pandemic. It means working across sectors to foster an environment which supports healthy behaviours and lifestyles. With the commitment, expertise and resources of our partners across our collaboratives and borough-based partnerships, we are confident that we can deliver on our ambition.





**Rob Hurd**
Chief Executive Officer, NHS North West London ICB

**Penny Dash**
Chair of NHS North West London ICB

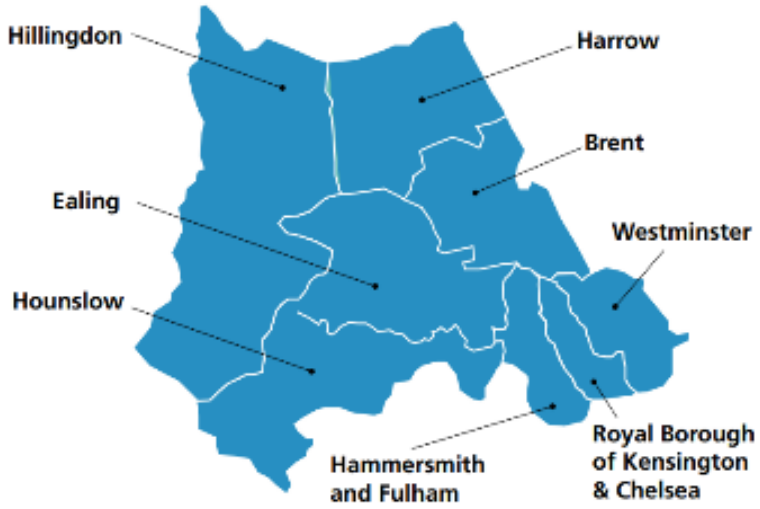
# Section 1: Introduction

# **Who we are –** our system and population

Welcome to the Joint Forward Plan for North West London. This plan sets out how the NHS will support the delivery of North West London's Health and Care Strategy, published in 2023.

North West London is one of the biggest and most complex Integrated Care Systems nationally. We have a diverse population of over two million people, who come from over 200 different ethnicities.

While in general our residents are more affluent than the national average, we also have significant clusters of multiple deprivation and concentrations of groups we struggle to hear. These include asylum seekers, travellers and members of particular ethnic groups.




## Our population is:

- **Younger than elsewhere in England.** The median age across our boroughs ranges from 35 to 39 with the median age across Integrated Care Boards in England averaging 40.
- **One of the fastest growing.** Population projections are uncertain due to the ongoing impact of factors like immigration, COVID-19 and Brexit, but an increase of over 100,000 by 2040 is predicted.
- **More diverse**, with our residents speaking well over 60 different languages. Brent, Harrow, Ealing, Hounslow and Hillingdon all have a higher share of non-white population than the London average. After 'white ethnicity' the largest ethnic population is 'Asian/Asian British'.
- **More affluent than the national average, but with pockets of significant deprivation.** Kensington and Chelsea and Westminster have the highest gross disposable income in North West London and nationally, however we also have significant clusters of residents experiencing deprivation in each of our boroughs.
- **Has a higher life expectancy** than the national average, but with a **difference in life expectancy** between our most affluent and most deprived neighbourhoods of almost two decades.
- Has **higher unemployment rates and rates of people economically inactive** than the national average, and this is higher still in our most deprived populations





**North West London by numbers**

**2.1m** resident population
**1,300** GPs
**65,000** NHS employees
**8** Boroughs
**276** care homes
**349** GP practices
**1,500** adult social care staff
**1** ambulance trust
**4** acute trusts
**1,500** voluntary organisations
**4** community and mental health trusts

# How we collaborate with our people and our communities

## How we work with our voluntary partners

We are committed to help residents and our frontline staff to get the very best out of our health and care services.

Our voluntary partners are key in supporting this. Within NW London a group of like-minded charities have joined together to support & develop health and statutory services – called **3ST, Third Sector Together.**

Their mission is to combine our specialist skills and knowledge to ensure residents have equal access to services and to improve the health and wellbeing of all residents of the eight boroughs of NW London.

3ST are supporting us to develop the voluntary and community sector as a strategic partner and helping to drive closer links with our communities. Examples of work where they are supporting the NHS include: reducing health inequalities, engaging with patients and residents and supporting strategy and policy developments.

### Case study: Compassionate Hillingdon

Compassionate Hillingdon, funded through the Hillingdon Health Care Partnership, is a friendship programme that supports residents who have a life limiting condition, are approaching end of life or long-term health condition.

The programme currently supports 208 people, with a volunteer group of 36. We offer in person visits and telephone calls, with a focus on friendship, as well as a monthly coffee morning, with visiting speakers.

This service makes a difference – A Compassionate Hillingdon Volunteer was asked to speak at a funeral by a family because of the difference they had made.

## How we engage with our residents and communities?

Working alongside our residents and communities is critical to delivering excellent and equitable health services for our population. To ensure wide reaching involvement, our '*What Matters to You*' programme engages in a range of ways:

- Our **community outreach** programme reaches up to 60 community groups across NW London each month, going into communities and asking what matters to them as well as raising specific questions about NHS services and proposed service changes. Most of our work is targeted to specific communities to ensure we are reaching as many people as possible.
- Community representatives from some of the most deprived and marginalised communities in NW London make up our **Co-design Advisory Body (DAB)**. DAB plays a vital role in shaping the collaborative approach, ensuring that community voices and insights are central to the decision-making process. Each participant represents one community group.
- Our **Citizens' Panel is** a large group of local residents, randomly selected from people across our 8 boroughs. Some targeted recruitment took place to ensure that the panel is representative. The number of members is around 4,000 and it is used for surveys and interactive online engagement.
- We hold regular North West London **Residents' Forums** on specific topics and most borough-based partnerships hold regular forums for residents. There is an independent **Patient Participation Group Forum** which we support.
- We use a range of social media to engage with our residents and communities: Next Door, Twitter, Facebook, Instagram.
- Our Integrated Care Board and Integrated Care Partnership meet in public, with the public invited to ask questions at both meetings.
- Feedback and questions to the ICB can be submitted via our dedicated email address nhsnwl.communications.nwl@nhs.net

# The health and care needs of our residents and communities

## What our needs assessments across North West London tell us

- **Progress in improving health has slowed**, particularly in the past few years, and overall healthy life expectancy has probably declined.
- While North West London's population is generally younger than England as a whole, the **share of the elderly is growing** fastest. Our residents also tend to move more often.
- Local and national tragedies such as the COVID-19 pandemic and the Grenfell Tower fire have exacerbated long standing inequalities in health and care.
- Across all of our boroughs, **cancers**, **circulatory diseases**, and **respiratory diseases** are the leading cause of death. Ischaemic heart disease, followed by dementia and COVID-19, was the leading cause of death in 2022.
- Preventable mortality, such as those dying before their 75th birthday from diseases such as lung cancer, differs hugely between different areas in North West London. Some of our communities experience much higher death rates from diseases which can be effectively prevented.
- **Various demographic groups face health inequalities**, including those of different ethnicities and socioeconomic backgrounds, as well as individuals with autism or learning difficulties.
- **While progress has been made, stigma persists**, particularly in mental health among certain of our communities, and there's a call for more focus on prevention and healthy living.
- The rise in the cost of living has challenged many, while the gap between our communities in income, economic inactivity and unemployment has widened over the last five years.
- Despite efforts to improve, access to healthcare services remains inconsistent, with variations in delivery and quality across different areas.

## What our residents tell us

NHS North West London, in partnership with local authorities and NHS provider trusts in our area, has an extensive outreach programme to hear from local residents and communities. This includes discussions in all eight boroughs, some on specific topics, conversations via organised public events and social media, and insights collected through our borough HealthWatches.

Every month, we publish a summary of what local people have told us in our community insight reports. These insights inform and shape our thinking on health and care services across North West London.

Consistent themes from residents include:

- Difficulty in securing timely access to primary care/GPs
- Confidence in mental health services, especially waiting times and inpatient capacity
- Hospital discharge, waiting times and cancellations
- Poor communication: a range of issues including complexity/clarity, language barriers and communication with people with learning and physical disabilities
- Barriers to accessing dental care – its cost and its availability through the NHS
- Appreciation of the potential digital healthcare offers, and concern over its potential for excluding those who most need it
- Cost of living concerns
- Potential for improving community engagement and the need to be more inclusive of communities furthest from decision-making
- Requests for more information on specific health concerns, such as cancer awareness, diabetes, mental health care services, and vaccinations

More detail on health and care need, and insights from our communities, can be found on our website**: https://www.nwlondonicb.nhs.uk/**

# Our financial challenge (i)

Updated planned spend numbers
Added bottom left para in response to LA feedback

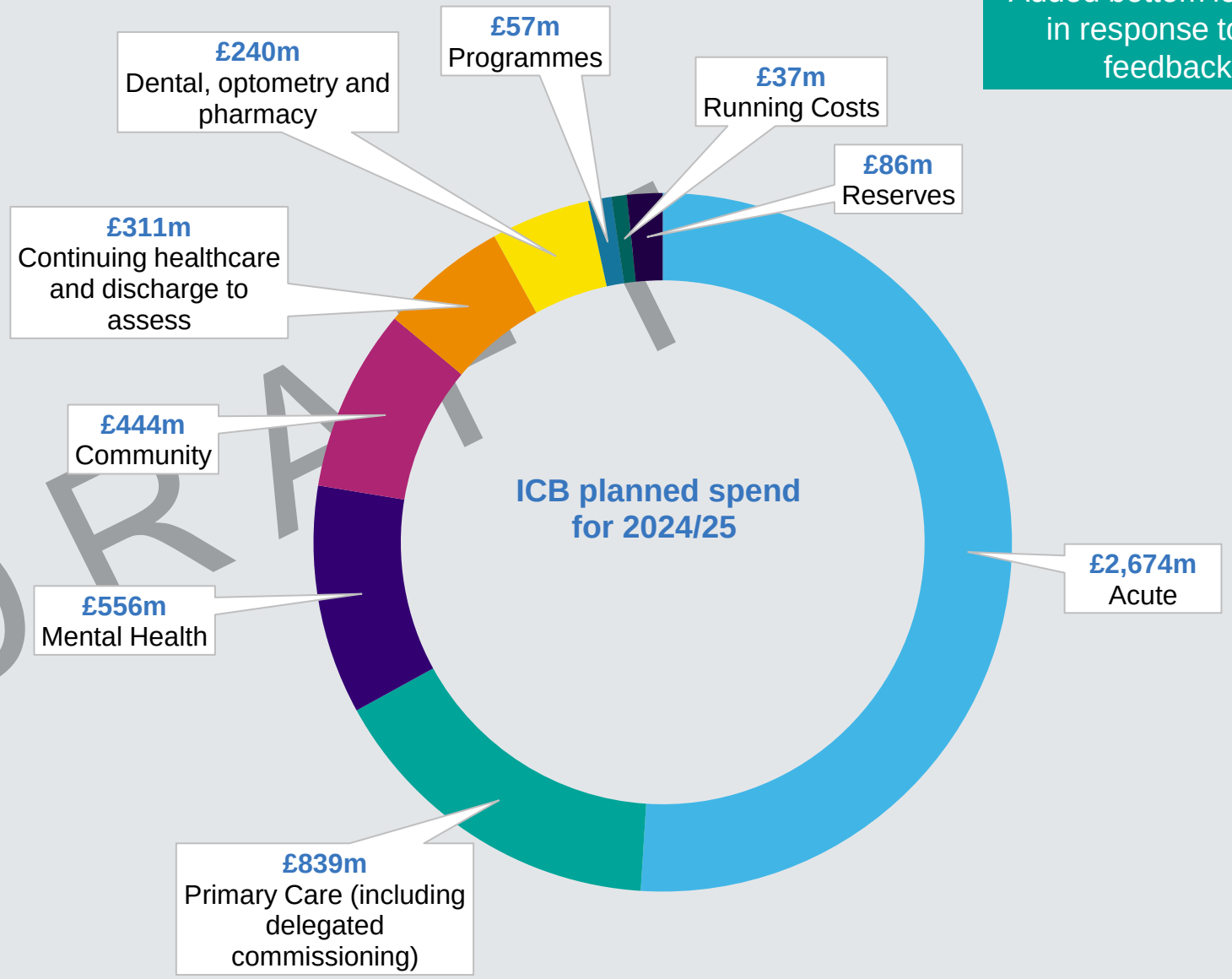
NW London Integrated Care Board receives a direct allocation of £5.3 billion. This includes spend on primary care – including dentistry, ophthalmology and pharmacy, but excludes specialised services commissioned by NHS England. This represents 4% of the national allocation to integrated care boards, and is the fifth largest nationally. The allocation is based on a formula which reflects a range of factors including demography, morbidity, deprivation, and the unavoidable cost of providing services in different areas. The formula gives North West London the sixth lowest target allocation in the country, and our actual allocation is in line with this target. This means that our allocation is 3% lower per needs weighted head of population than the national average.

**£1,887**
Year

Vs

**£1,946**
National average

Compounding the issue of the in year financial allocation, the outlook for the NHS' finances also appears challenging. The population of North West London, in common with almost all areas of England, continues to age. The Office of Budgetary Responsibility's latest fiscal risks report increased the risk of demand and cost pressures in health materialising. This suggests that pressures on health budgets – including the ICB's – are likely to be sustained.



# Our financial challenge (ii)

## Fairer financial allocations

While progress has been made, allocations within North West London are still largely based on decisions made by our predecessor clinical commissioning groups. Our aim is to ensure that resources and funding are allocated based on the needs of our residents.  In 2023/24, North West London ICB spent more on acute care (3%), community care (9%) and continuing healthcare (9%) than need would suggest we should, and less in mental health (20%).

Over a period of three years we aim to move our expenditure allocation in line with need and will address this by:

- Ensuring all expenditure is consistently captured;
- Managing growth into those overfunded areas and increasing services recommissioned in underfunded areas; and
- Commissioning services in line with the core North West London standard, eliminating duplication in services and ensuring that the correct care is provided in the most appropriate setting at the required level of productivity.

Given the low likelihood of significant growth in allocation, the bulk of this shift in allocation will need to be funded by changing models of care and improving productivity.





## Our capital challenge

The NHS in North West London has some of the most challenged infrastructure in the country with a backlog of maintenance work at a cost of £1.2bn. This is more than three times the size of some other ICBs.

Ensuring that the estate remains available for use puts significant pressure on both revenue and capital budgets, whilst driving capacity issues and poor patient experience. The capital available to us to improve our estate is insufficient; we continue to push for capital support for major investments, such as the rebuilding of our four hospitals in the New Hospitals Programme.

To prioritise how and where we invest our money, we have brought together all NHS and local authority stakeholders within each borough to plan health and social care. This includes placing primary care services where the population requires it, improving utilisation of space and, wherever possible,  bringing together services that improve user experience into fewer, higher quality buildings.

# Our productivity challenge

The NHS is experiencing unprecedented pressures,– struggling to balance being financially sustainable whilst tackling significant waiting lists and long A&E waits as our residents age, and the acuity and complexity of their needs increase. Although North West London is typically one of the better performing systems in the country, this position is also true for us.

While money and staff have increased substantially in the last two years, productivity and efficiency have not yet recovered to pre-pandemic levels and therefore remains a critical focus for us all. It is improving productivity that will free up the funds for investing in better, more equitable services for our residents and communities.

Like all parts of the country, the NHS in North West London faces a challenging position. To date, we have been able to use one off savings to ensure our expenditure matches income, but this is not sustainable in the longer term. Delivering a sustainable financial position by the 2026/27 financial year would require a 3.7% improvement in efficiency over and above normal productivity gain in each of the next three years.

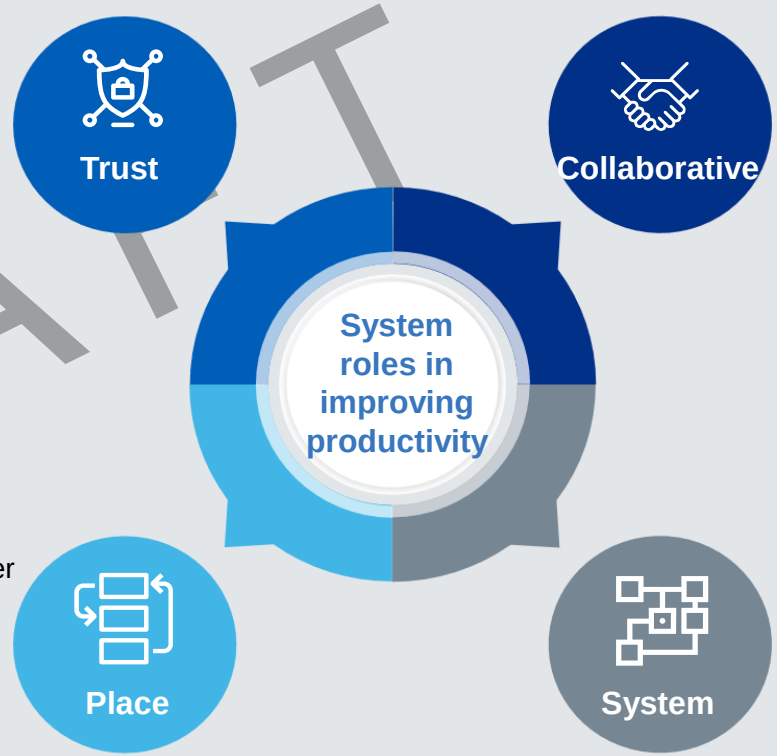
Productivity is not about telling already pressed staff to work even harder. It is about changing how we work, as the examples on the next page illustrate:

- It is about how each of organisations work smarter - for example, using technology to perform routine tasks better, or to improve scheduling and minimise waste and rework;
- It is about addressing our residents' need in the least intensive setting appropriate – for example, supporting more self-care, supporting more prevention, or establishing digital options where these improve access, quality and/ or equity at lower cost
- It is about seeking to promote wellness and actively manage illness, rather than reacting to people becoming acutely unwell

Each of four levels - organisation, collaborative, place and system - has a role in bringing the system back to balance by improving productivity as laid out opposite.

Expanded definition of productivity to include the left shift, in response to LA feedback

- Recover and increase productivity to pre-pandemic levels
- Address patient waiting lists
- Improve utilisation of space
- Treat patients in lowest acuity setting appropriate




- Review payment mechanism and local prices
- Service developments to replace Mental Health Investment Standard
- New workforce roles and Additional Roles Reimbursement Scheme (ARSS) productivity

- Reduce number of physical beds open
- Better use of the Better Care Fund, develop additional capacity / winter funding, place-based innovation to increase productivity and improve flow
- Improve data capture to inform planning
- Deliver shift to lowest acuity settings where clinically appropriate

- Standardise core offer
- Embed population health data and consistent evaluation
- Align commissioning to financial recovery
- Sector led change programmes to improve access and address unmet need
- Evaluate & consolidate non-clinical services
- Enable shift to lowest acuity setting (acute to community) where clinically appropriate

# Our productivity challenge: Case studies

### Case study: North West London Elective Orthopaedic Centre (EOC)

In autumn 2023, the APC opened a centre of excellence for planned orthopaedic care at Central Middlesex Hospital. The EOC will deliver productivity and quality of care for patients that consistently meets best practice and delivers value for money. It supports productivity through dedicated facilities, staff and economies of scale which together embed best practice pathways, support efficient scheduling and effective outcomes.

The EOC opened 3 theatres in December 2023 and 5 theatres in April 2024, achieving so far:

- An average length of stay of 2.8 days in the first 10 weeks of operation, already almost reaching the Y2 target of 2.3 days
- Productivity benefits of £545k FYE in 2023/24
- 100% patient satisfaction

### Case study: Improving flow through the autism diagnostic pathway - Community Paediatrics

The Community Paediatrics Service was struggling to cope with increased referrals and had received complaints from parents that children had to wait too long following their first appointment for assessment and diagnosis. The multidisciplinary team used quality improvement methodology to identify and test changes to the clinical pathway to reduce wait times. This resulted in:

- A reduction in time from assessment to diagnosis for children under 11 from an average of 25 weeks to 3 weeks.
- Tested new pathway for children over 11 years which has reduced journey time from referral to diagnosis from an average of 82 weeks to an average of 48 weeks.
- Improved staff morale, despite rising workload and ongoing challenges
- Encouraged a culture of improvement and learning across the department.



### Case Study: National Wound care strategy

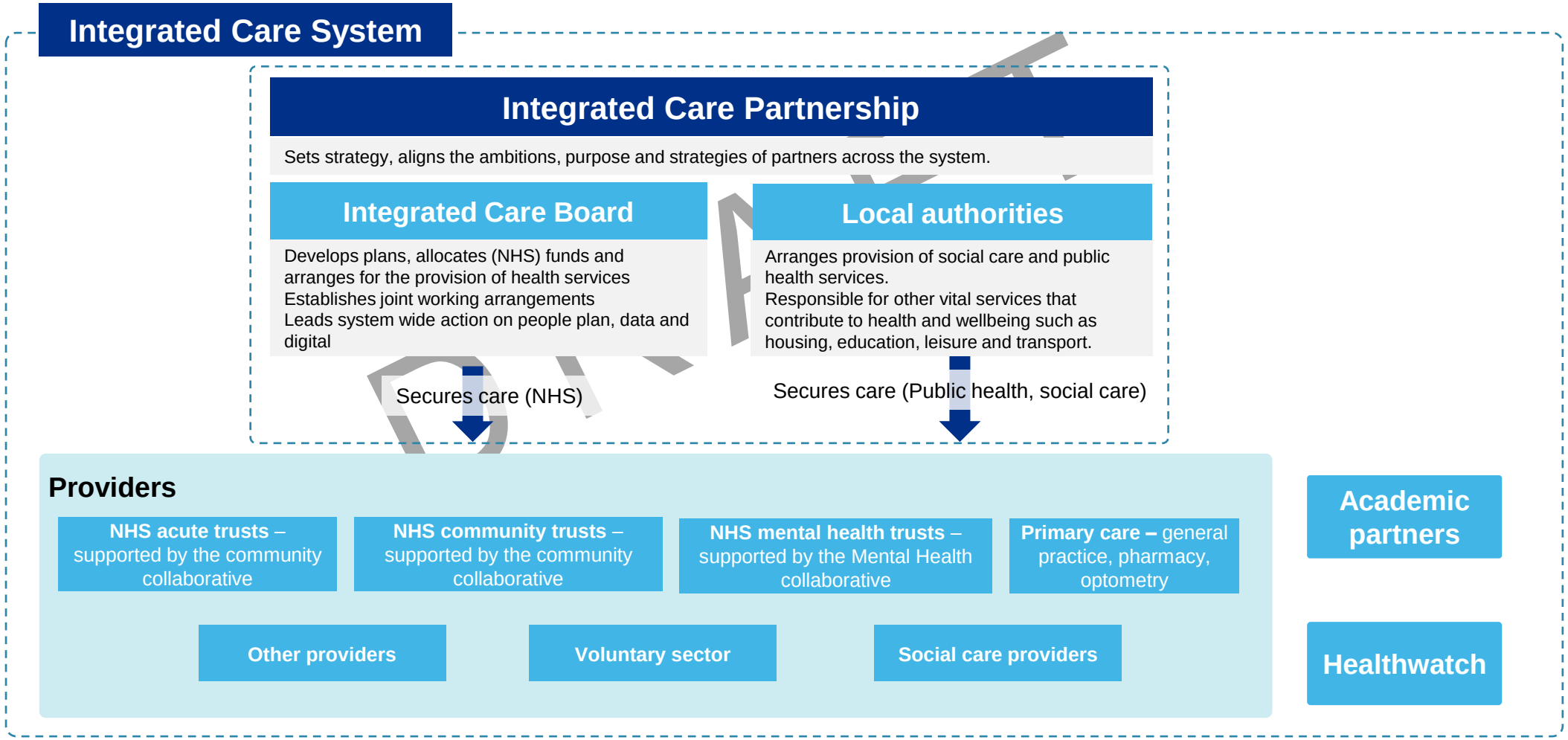
Community services in Goodall, hosted by Central North West London Community Services (CNWL) is an early implementer site for the national wound care strategy. We have focused on more consistent, and improved pathways which has resulted in wounds being healed quicker, but also not having recurring wounds which has reduced pressures on a range of services that include district nursing, complex wound care but also primary care services and acute hospitals. Patient experience has also improved.

Healing rates at 24 weeks have improved from 14% in April 2023 to 57% in December 2023 for venous leg ulcers.

There is now greater awareness across the system to identify and support wound care earlier, the new pathways support a preventative rather than reactive approach, and there is increased capability and confidence across all the teams to support patients with wounds.

# The way health and care is organised has fundamentally shifted in the last years

Integrated care systems (ICSs) are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They are part of a fundamental shift in the way the health and care system is organised – away from competition and organisational autonomy and towards collaboration.



# Our organisational challenge

## Our Integrated Care System is still new, and managing a series of changes

The Health and Care Act 2022 led to significant changes in how the NHS operates. This included establishing Integrated Care Boards with new statutory responsibilities (in place of Clinical Commissioning Groups), and the furthering of partnerships between trusts, otherwise known as provider collaboratives. As a system across North West London, including our local authority and voluntary sector colleagues, we continue to work through the implications of these changes so we can continue to deliver the changes our residents need.

## We are restructuring our workforce

In addition to the new responsibilities, the Integrated Care Board is required to reduce its internal administration (running) costs by 30% by 2025/26. The Integrated Care Board is therefore restructuring its teams to match skills more closely to expectations and duties with fewer staff. Over 2024/25 we will need to spend significant time embedding this change and developing ways of working within the resource available, This includes some of our largest areas of spend such as continuing healthcare.

## We are continuing to develop our values and operating model

Our ways of working – known as our operating model - have been agreed with partners across North West London. The model has our borough based partnerships at its core, supported by our ICS programmes and other ICB teams. Working collectively will help us to simplify across our 8 boroughs. The ICB's values stress empowered communities, always being inclusive, growing together, driving innovation and being mutually accountable, and will support us to increase our effectiveness and productivity. However, as we continue to develop, we will need to update the model so we continue to improve how we deliver our objectives.

## Our nascent provider collaboratives are establishing resilience

North West London currently has three provider collaboratives - acute care, mental health and community care. The collaboratives provide a great opportunity to capture the benefits of scale, reduce unnecessary variation and create greater resilience within our system and their role will grow and evolve over the period of this plan.

## We continue to build relationships with our Local Authorities

Improving health and care for our residents and communities requires close working with our eight local authorities – including their children's, adult social services and public health teams - to address the needs of our residents. Our borough based partnerships are the vehicle for achieving this by working differently and more effectively with local authorities to share resources and expertise across the system.

## What does this mean for our Joint Forward Plan?

The Integrated Care Board has established an organisational design programme to improve how the ICB can deliver its objectives more effectively. This includes:.

- Identifying and building the right capacity, capability and culture;
- Changing the way we work to clearly define roles, responsibilities and expectations of different parts of the system – for example aligning commissioning with local authorities;
- Redesigning our organisation to ensure functions, structures and governance enable the right conditions to deliver our objectives;
- Revamping our processes to enable our staff to work as slickly as possible; and
- Building and embedding ways of evaluating the effectiveness of all of our work.

As part of this, this Joint Forward Plan prioritises and phases the implementation of objectives over a period of five years, committing to doing the right number of things well and tracking progress effectively rather than attempting everything at once.

It also means that this plan will be updated annually as the operating model develops and the change programmes across partners in North West London deliver and evolve.

# What we promised in our Health and Care strategy

## The health and care system in North West London aims to:

**Support population health and well-being.**

North West London aims to address wider determinants of health by partnering to improve access to education and employment, utilising NHS land for housing, ensuring fair wages, boosting digital skills, supporting local businesses, and promoting sustainability efforts.

Regarding healthy behaviors, we plan to collaborate with public health partners to reduce smoking rates, improve diet and exercise, identify and treat residents at risk of high blood pressure, and increase uptake of preventative services through cross-sector collaboration and lessons from the COVID-19 vaccination programme.

**Address inequalities in health outcomes, access, and experience.**

We aim to address health inequalities through several initiatives. This includes developing a unified approach for residents regardless of location, ensuring consistent quality of care, understanding population health data, supporting unpaid carers and addressing structural racism in healthcare.

Improving access and outcomes for vulnerable groups like the homeless and asylum seekers, enhancing early cancer diagnosis and long-term condition management, combating mental health stigma. Providing tailored support for specific communities such as black women and those with learning disabilities or autism is also a key priority.

**Improve access to care.**

Efforts will focus on improving access to primary care by effectively organising and managing access to urgent care, embracing digital technology for triage and appointments, and implementing integrated neighbourhood teams, with general practice at their heart, to coordinate community physical and mental health services.

Additionally, investments in expanding capacity for mental health, learning disabilities, and autism services are a focus, along with improving access to specialist expertise and diagnosis through integrated teams and digital tools.

**Promote home-based care when possible.**

While hospitals and care homes may be the right place for some of our residents, for many we can provide a better service with less disruption to people's lives by bringing expertise and support to people's homes.

To do this we will implement joint care planning across all health and care settings, give personalised support for long-term conditions, and proactive care planning for end-of-life care. Collaboration with social care partnerships with voluntary providers aims to prevent hospital and care home admissions, while ambulatory care services will be provided in GP practices and urgent care centres.

**Prioritize the health and well-being of babies, children, and young people.**

We will invest more in supporting babies, children and young people to be happy healthy adults, by addressing obesity, promoting healthy weight in early childhood, increasing breastfeeding rates, and improving immunisation uptake and oral health.

Efforts also aim to enhance access to mental health support, especially through schools and digital platforms, and to develop consistent models of care through child health and family hubs.

**Enhance the productivity and quality of the health and care system, collaborating with residents and communities.**

We know that the resources available to providers of health and care are limited and funding available for social care and public health has constrained. While the number of health and care staff have risen, we face difficulties in recruitment and retention.

We must therefore continue to innovate, improve and deliver as effective care as we can within the budget available to us while valuing and developing our people.

# How we have reflected the Health and Care strategy in our Joint Forward Plan

In November 2023 we published our Health and Care strategy for North West London, with six key areas of focus.

The Joint Forward Plan takes the strategy, the nationally set NHS operating plan and agreed national and local targets together, and translates them into meaningful milestones and activities. This clarifies where the NHS will prioritise resources and objectives now and where we should invest in the future. We have focussed on nine specific priorities, supported by a number of enabling programmes, to deliver this Joint Forward Plan.

Our Joint Forward Plan sets out the time period for delivering these priorities and intended outcomes.

Delivery will require cross-system collaboration from our providers through provider collaboratives, ICS programme teams, clinical networks, voluntary and community sector organisations (VCSEs) and borough teams.

Our borough based partnerships and provider collaboratives will continue to have their own specific plans to improve health and wellbeing and to deliver the operating plan. However, aligning these with the Joint Forward Plan will mean that we can concentrate resources across the system in the most effective way possible.

## We published our Health and Care strategy in November 2023

- Support population health and well-being.
- Address inequalities in health outcomes, access, and experience
- Improve access to care.
- Promote home-based care when possible.
- Prioritize the health and well-being of babies, children, and young people.
- Enhance the productivity and quality of the health and care system, collaborating with residents and communities.

**Financial considerations** | **Our annual NHS operating plan**

## Which formed our nine priorities

**Our enabling programmes are vital in supporting all of our priorities**

**WORKFORCE** | **DIGITAL & DATA** | **ESTATES** | **COMMUNICATIONS & INVOLVEMENT**

## With locally-specific support driven through our Boroughs

| | | |
|---|---|---|
| Hammersmith & Fulham | Hounslow | |
| Brent | Harrow | Kensington & Chelsea |
| Ealing | Hillingdon | Westminster |

NHS partners across North West London are committed to reviewing and updating this Joint Forward Plan each year. This will enable us to respond to future pressures and changing population need. In 2024/25, we will agree strategies for **Digital and Data, Estates, Urgent and Emergency Care, Maternity and Mental Health Learning Disabilities and Autism.** Our **Acute Provider Collaborative** will also publish a strategy covering **Planned Care.**

Once agreed, these strategies will be incorporated into next year's plan

# Section 2: Our priorities for North West London

# What are North West London's priorities over the next five years?

We have collectively identified nine priorities for the NHS across North West London to focus on over the five years period covered by this Joint Forward Plan. These priorities will benefit from a system-wide approach. Our collaboratives and enabling teams will support these priorities, while our borough based partnerships will supplement these with local priorities where there is specific local need.

| | |
|---|---|
| **PRIORITY 1:** Reduce inequalities and improve health outcomes through population health management | Develop and embed a population health management capability and focus on areas where outcomes, access and experience vary most to reduce inequalities and improve health and wellbeing |
| **PRIORITY 2:** Improve children and young people's mental health and community care | Improve health and wellbeing outcomes for children and young people, including targeted interventions for our core at risk groups |
| **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) with general practice at their heart | Establish INTs with primary care at their heart to improve same day access to care for those who need it and provide proactive joined-up care for people with long term conditions or complex needs |
| **PRIORITY 4:** Improve mental health services in the community and for people in crisis | Maximise the productivity of community-based mental health services and increase access to mental health crisis services |
| **PRIORITY 5:** Embed access to a consistent, high quality set of community services by maximising productivity | Implement a common core offer in community services (initial focus on community nursing, community beds and neuro rehab) and then drive increased productivity across these services. |
| **PRIORITY 6:** Optimise ease of movement for patients across the system throughout their care – right care, right place | Deliver improvements across the system to ensure patients are treated in the most appropriate setting – avoiding admission, minimising hospital stays and supporting timely discharge |
| **PRIORITY 7:** Transform maternity care | Improve maternity services to reduce inequalities in outcomes and improve quality for all |
| **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment | Improve early diagnosis by tackling variation in screening and deliver faster and more efficient access to diagnosis and treatment. |
| **PRIORITY 9:** Transform the way planned care works | Transform planned care to reduce waiting times for diagnostics, outpatients and elective surgery and manage rise in demand for hospital services so patients can be seen in the most appropriate setting |

**Our enabling programmes are vital in supporting all of our priorities:**

- WORKFORCE
- DIGITAL & DATA
- ESTATES
- COMMUNICATIONS & INVOLVEMENT

# Our priorities build on and incorporate the objectives laid out in North West London ICB's medium-term financial strategy

## System level

- We will aim to allocate system funding to the health needs within the system and use payment mechanisms that facilitate the movement of care to the appropriate setting
- Work as a system to improve urgent and emergency care easing service pressures and reducing system cost.
- We will bring together specialist services to reduce duplication and cost whilst improving clinical pathways and clinical outcomes
- We will maximise the potential and effectiveness of London Ambulance Service (LAS), reducing the number of patients being transported to acute settings by increasing 111 services, more suitable pathways, the use of mental health cars that mean that mental health patients are initially seen by a mental health nurse, identifying and treating health issues early and making the offering central to the emergency pathway
- We will aim to consolidate non-clinical functions looking to provide once for North West London wherever we can e.g. Procurement, Payroll, Business Intelligence & Occupational Health
- We will work as a system to reduce our estate footprint and cost creating an affordable, sustainable fit for purpose rationalised estate in all sectors and North West London boroughs
- Improve our digital capability supporting improved patient outcomes, digital patient access, data quality and business intelligence to drive continuous improvement with data
- Jointly invest in North West London assets e.g. hubs for simple medical procedures that are performed frequently, shared health records and increased expert opinion
- Create a more sustainable workforce that takes advantage of flexible working, new roles and links to planned activity and staff wellbeing



## Provider level

### Primary Care

- Close the funding gap in all areas and target investment to communities with highest need
- Continue to expand the single offer of enhanced services for general practice
- Reduce unwarranted clinical variation and advice and guidance to reduce referrals to secondary care, prescribing and testing
- Ensure we get value for money for all we do, including continuing healthcare (CHC) placements, prescribing and procurement

### Acute Care

- Protect acute services by ensuring people only go to hospital when they need to and improving support for them to leave hospital safely
- Work collaboratively to increase standardised approaches, reduce the cost base and improve efficiency, using measures like Model Hospital and Reference Costs, bring our expenditure in line with population need.
- Offer support to transfer services between organisations where there are inefficiencies that cannot be improved – with appropriate public engagement

### Mental Health Services

- Invest in mental health, funding the Mental Health Investment Standard and establish a consistent set of services on offer to residents across North West London
- Improve access and target investment to those communities with the highest need
- Have a consistent way of reporting to understand drivers of the cost base and improve productivity
- Reduce the cost of, and reliance on, treating patients outside North West London
- Reduce service duplication by working as a system.

### Community Care

- Establish a consistent offer for residents across North West London, funded by improving efficiency
- Invest to ensure our out of hospital provision supports faster discharge of patients and alternative patient pathways are available
- Have standard activity reporting to understand drivers of the cost base and improve productivity.
- Improve efficiency, using measures like bench-marking against other providers and average costs of secondary care in the NHS.

# **PRIORITY 1:** Reduce inequalities and improve health outcomes through population health management

## Summary

The success of the Integrated Care Board will be judged by whether we have reduced inequalities in outcomes, access and experience for our residents and communities. We will do this in three ways:

- By establishing a common set of services that all our residents can access, no matter where they live in North West London
- By working with our communities to tailor and improve access to those services, so that all residents have confidence in seeking access and in the experience they will receive
- By complementing these services in common with activities which address the holistic needs of our communities and where the needs of particular groups of residents cannot be met by tailoring the services in common.

Population health management brings together health-related data to identify specific populations and/or individuals that can benefit from the tailoring of services, or from services that are bespoke to their particular needs. This builds on the 'Core20Plus5' – improving the equity of experience, access and outcomes to those of our residents living in the most deprived 20% of neighbourhoods, in particular in the 5 areas NHS England has identified for both adults and children.

To enable this, we will:

- Continue to expand the Whole System Integrated Care (WSIC) database, aligning this with other data sources to better understand need across our communities;
- Continue to foster closer working relationships with our communities to ensure that the quantitative data is supported by qualitative data and insight;
- Use this intelligence, and a comprehensive review of costs and activity, to support decisions which make the best use of resource and have the greatest impact on health and wellbeing;
- Develop and implement approaches to co-producing solutions that meet specific hyperlocal needs and in turn build trust with our communities;
- Develop and roll out a Population Health Management and Health Equity Academy to develop core skills across the ICS, including how we meaningfully engage with our residents;
- Work closely with our partners to encourage a proactive, preventative approach that maximises our impact on the social, environmental and behavioural determinants of health;
- Build our capacity to effectively evaluate the work of the ICB and its partners;
- Use population health as an exemplar for how we introduce and scale innovations – starting with cardiovascular health – across North West London.

We will embed these approaches across all care settings, including borough-based partnerships, primary care and Integrated Neighbourhood Teams. We will also give all staff the tools they need to demonstrate value and evidence impact, and systematically embed evaluation through all our work and build skills in our frontline staff to make every contact count.

Through these changes we will reduce inequalities in access, experience and outcomes, increase levels of trust with marginalised communities, improve value for money and opportunity to build on 'what works' across the system.

# **PRIORITY 1:** Reduce inequalities and improve health outcomes through population health management

## Case for change

- In in our least resourced neighbourhoods in North West London people are dying a over decade earlier than in other areas. This is a long-standing issue and the inequalities gap in health and life expectancy has widened in recent years.

- When our communities don't have the things they need, such as warm homes and healthy food, and are in low-paid or unstable jobs, it can lead to chronic stress, poor physical and mental health and lives being cut short. For example, children from households in the bottom fifth of income distribution are over four times more likely to experience severe mental health problems than those in the highest fifth. There is a high level of overcrowded households in NW London, more than double the national average, and this is strongly correlated with non-White British ethnicity

- Creating an environment which does not support healthy behaviours and lifestyles will also have a negative impact on health – risk factors such as smoking and obesity are strongly causally linked to our population's most common long term conditions such as cardiovascular disease, chronic respiratory disease, cancers and diabetes. NWL's hospital admission rate is one of the highest in the country (even when taking into account the needs of our population), demonstrating that we are not investing in upstream, proactive, preventative care.

- People from our different communities also have very different experiences of the health and care services that we provide, including differential access to preventative care, meaning that we are not routinely identifying people early at risk of illness and are diagnosing conditions later. Examples include gaps in the early diagnosis of prostate cancer amongst black communities and in maternity outcomes for black and Asian mothers compared to white mothers.

- We are not tailoring services to be culturally competent to meet people's needs, meaning that they are not provided in a way that meets their cultural, ethical or religious needs. This is leading to very different and varying health outcomes in different neighbourhoods.

- In a challenging financial environment, it is essential that activity across the system is aligned with need so spend can be targeted on the most effective interventions to ensure equitable and proactive care for our population.

# **PRIORITY 1:** Reduce inequalities and improve health outcomes through population health management

## What do we want to achieve?

| | Aim | Target date | Outcomes | Dependencies | Owner / governance |
|---|---|---|---|---|---|
| **Improving PHM capability** | Embed Population Health Management (PHM) skills through PHM & Health Equity Academy | March 2025 | • Health and care services designed around the needs of our communities<br>• Improved value for money through delivery of services that are most appropriate for the local population | • BI to enable data sharing and investment in technology<br>• OD/CPOs to embed PHM skills in BAU | • Health Equity Programme team and board, PHM steering group<br>• ICB effectiveness governance |
| | PHM roll out across functions, including primary care and INTs | 2027/28 | • PHM approach embedded in all services. Services designed around population need and addressing inequalities | • Primary care, community services redesign<br>• Data and digital capabilities to enable data-driven decision making in different settings | • Health Equity Programme team and board, Primary Care Board<br>• Borough partners |
| **Targeted interventions to reduce healthcare inequalities** | Embed tools and frameworks to address barriers to access and differential outcomes, building a culture of tackling inequity | 2027/28 | • Consistent system-wide approach to inequalities<br>• Improved trust in health and care services, overcoming hesitancy and supporting delivery of the common offer<br>• Clearer oversight of differences across North West London and where action is needed, through common core metrics<br>• Improved connection to local communities<br>• Reduced levels of digital exclusion<br>• Fewer access barriers related to communication | • Ownership of equity metrics/planning by ICB teams, and commitment to action plans<br>• Co-delivery of metrics with BI and performance teams<br>• Digital team to improve access to services<br>• Communications and engagement | • Health Equity Programme team and Board, Data and Digital programme boards, wider Programme boards |
| | Co-design interventions to reduce inequalities in access, experience and outcomes, focusing on areas of greatest inequity. | 2027/28 | • Reduced variation with a focus on conditions with worst outcomes/highest inequalities, complementing common offer through additional services tailored to need<br>• Integration of actions, incentives and tools to drive equity for our population | • Prioritisation of Core20Plus5 clinical areas in programme workplans<br>• Whole system collaboration<br>• On-going support from primary care to increase reach, referrals, treatment targets | • Health Equity Programme team and wider Programme boards, CRGs and North West London ICB Board |
| **Take action on wider determinants of health** | Build partnerships to address the wider determinants of health | 2027/28 | • Reduced gap in healthy life expectancy<br>• Increased employment with focus on Core20Plus<br>• Reduced poor health related to housing conditions<br>• Reduced levels of smoking and unhealthy weight | • Public health teams<br>• Local authorities and West London Alliance<br>• NHS Trusts as Anchor institutions<br>• VCS organisations | • Programme team<br>• Local Authorities |

# **PRIORITY 1:** Reduce inequalities and improve health outcomes through population health management

## What do we want to achieve?

| | Aim | Outcomes | Dependencies | Owner / governance |
|---|---|---|---|---|
| **Enabling functions** | Workforce | • Increased local employment, increasing black and ethnic minority staff in senior roles to reflect North West London population<br>• PHM skills in workforce, including analytics and co-production: services to better meet community needs.<br>• More opportunities for Making Every Contact Count | • Business intelligence (BI) and data and digital programmes<br>• Wider workforce programme<br>• Primary care workforce programme | • North West London People Board with oversight by the Joint Lead Chief People Officers |
| | Data and digital | • Strategic reporting to support ICB teams, BBPs and INTs, identifies inequalities and areas of need.<br>• Development of an easy to use front-end for primary care, and other care settings, to case find patients | • Interoperability with FDP to make use of existing data feeds in Foundry and linking with primary care and community data held in WSIC | • North West London Data and Analytics Steering Group, reporting to Digital Transformation Board and ICB Board |
| | Communications | • Communication/engagement with communities are culturally competent, build trust and reduce inequalities | • Consistent approach to co-production with communities, working with Borough teams | • Communities and engagement, BBPs |

# **PRIORITY 1:** Reduce inequalities and improve health outcomes through population health management

## How will we achieve our outcomes?

| | Aim | Focus year | Year 1 | Year 2 | Year 3 + |
|---|---|---|---|---|---|
| **Improving PHM capability** | Embed Population Health Management (PHM) skills through PHM & Health Equity Academy | Year 1 | • Delivery of PHM & Health Equity Academy – upskilling ICS staff<br>• Map financial position to need (activity/costs plus demographic, geographic etc. data) | • Expansion of PHM Academy with focus on analytics across all staff and working with ICS partners<br>• Start to develop a medium term financial strategy aligned to need | • Embed PHM Academy into wider ICB training offer and expand connection with system partners. Monitoring and maintaining support in line with need.<br>• Development of ICS Intelligence Function – supporting BI maturity against known criteria/development framework |
| | PHM roll out across functions, including primary care and INTs | Years 2-3 | • Trial PHM in Primary Care across reactive, planned/preventative care services<br>• Start to roll-out clinical effectiveness | • Embed PHM in Primary Care<br>• Undertake impact assessment<br>• Fully embed clinical effectiveness | • PHM pilot in wider system and community; built on learning.<br>• Identify functions to enable PHM implementation/evaluation<br>• Embed PHM in all INTs to drive service design and investment decisions. |
| **Targeted interventions to reduce healthcare inequalities** | Embed tools and frameworks to address barriers to access and differential outcomes, building a culture of tackling inequity | Years 1-2 | • Focus on increasing trust, addressing hesitancy, and digital inclusion<br>• Update inequalities metrics/dashboard<br>• Develop use of metrics and community insight to drive action<br>• Embed equity in ICB processes | • Focus on addressing barriers related to communication<br>• Consistent tracking of metrics; spread equity index approach<br>• Embed co-production approach<br>• Deep dive and redesign of HIT funding | • Deliver inequalities community impact report<br>• Redesign Health Inequalities Transformation funding to have maximum impact, mainstreaming successful interventions into BAU<br>• Embed closer link to communities and culture of learning, sharing and co-production |
| | Co-design interventions to reduce inequalities in access, experience and outcomes, focusing on areas of greatest inequity. | Years 1-5 | • Focus on hypertension, mental health, maternity, and cancer diagnosis in black communities<br>• Map inequalities in ICB priorities, using PHM approach<br>• Implementation of High Intensity Use programme in Urgent and Emergency Care | • Focus on diabetes and gynaecological conditions<br>• Tackle inequalities in ICB priorities, complementing common offer | • Target PHM approaches to deliver interventions to reduce inequalities of access and outcomes across other pathways<br>• Focus on specialist services and dementia |

# **PRIORITY 1:** Reduce inequalities and improve health outcomes through population health management

## How will we achieve our outcomes?

| | Aim | Focus year | Year 1 | Year 2 | Year 3 + |
|---|---|---|---|---|---|
| **Take action on wider determinants of health** | Build partnerships to address the wider determinants of health | Year 1-4 | • Focus on tobacco dependency<br>• Test system approach to, and strengthen ICB delivery in prevention through ICP priority areas (oral health, vaccinations, and cancer screening)<br>• Focus on employment and housing<br>• Delivery of Anchor Charter and VCS infrastructure support | • Focus on healthy weight<br>• Refresh Anchor Charter; and monitor impact<br>• System volunteering strategy<br>• Grow VCS relationship and support | • System-wide approach to proactive prevention<br>• Continued focus on healthy weight<br>• Roll out refreshed Anchor Charter and create networks to share expertise and ideas<br>• Roll-out training on Making Every Contact Count<br>• Embed VCS ways of working and infrastructure development |
| **Enabling functions** | Workforce | | • Embed PHM skills in BAU<br>• Deliver leadership training schemes for local graduates | • Improve capability for data-driven decision making and engagement with communities to reduce inequalities<br>• Create opportunities for Core20plus communities to access high-quality work, including in health and care | |
| | Data and digital | | • Link 111, 999, VCS data to WSIC<br>• Create population health dashboards for whole sector | • Roll out Additional use cases for linked data<br>• Further development of technical PHM infrastructure | |
| | Communications | | • Improve ICB link to our communities: focus on engagement, culture of learning from and working with our communities, and targeted and co-produced messaging. | | |

# **PRIORITY 2:** Improve children and young people's mental health and community care

## Summary

Our aim is to ensure for children, and young people to have the opportunity for the best start in life – leading safer, healthier, more fulfilling lives. Our strategy confirms we will do this by:

- Implementing new 'models of care', for example: integrated neighbourhood teams of GPs, social workers, and community paediatric teams work identifying and reaching out to families at risk of missing out on preventative care through family hubs and child health hubs;
- Establishing 'system enablers', for example: using innovative models of age-appropriate engagement and changing some of the contracts to incentivise preventative care; and
- Coordinating 'programmes of work' with the aim of reducing waiting times, improving access and focussing prevention activities where we know there are high inequalities of outcomes.

Our focus in year one will be full implementation of the Thrive Framework to ensure comprehensive improvement across mental health services leading to a reduction in waiting times, improved quality in CAMHS and a reduction in the high levels of mental health attendances for children. We will extend the successful model of family hubs and child health hubs across all boroughs and focus on reducing inequalities in educational settings by ensuring children and young people with Special Educational Needs and Disabilities (SEND) or in Local Authority Care (LAC), have the same access to specialist school nurses wherever they live.

Our focus in future years will be to extend Mental Health Support Teams (MHSTs), already operating in over 40% of schools, to all publicly funded schools in North West London to support greater prevention and early intervention for our young people who may be susceptible to mental ill health. In community services we will reduce waiting times for ADHD and autism assessments, which are among the highest in London, and provide a common offer for speech and language therapy.

To support all segments of the population in a proactive way, we will use the WSIC dataset to share intelligence between health, education and social care. This will also support longer term transformational improvements and ensure that children and families who have the highest level of need have better access, outcomes and experience of care than now.

The expected impact of our actions include:

- Children and families have better access to timely advice, they are less reliant on emergency care and are seen in the most appropriate setting
- Consistent core healthcare offers for children so that everyone has equitable access to the same offer of care, focussing on mental health provision and early intervention in schools, CAMHS, specialist nursing support and speech and language therapy
- Reduction in children seen in emergency departments for mental health crisis
- Equity of outcomes for the most vulnerable children with Special Educational Needs and Disabilities (SEND) or in Local Authority Care (LAC)

# **PRIORITY 2:** Improve children and young people's mental health and community care

## Case for change

Current ICS strategic plans do not adequately identify and tackle the needs of children

- **Lack of data:** Far more evidence on health equity and outcomes is available for adults than children in our ICS data sharing systems. This hampers progress to improve and integrate care for young people.
- **Inequity in health outcomes for children**: from deprived areas and low-income families; from minority ethnic backgrounds; from population groups that suffer social discrimination.
- Delays and inequity in **emotional wellbeing and resilience** from as early as Year 2 for boys, children of Black or traveller ethnicity, and children with SEND.
- NW London has the **longest waiting list  for ADHD and ASD assessment in London**. There is greater demand for services, a decrease in workforce availability and deterioration in mental health whilst waiting for a diagnosis.
- The number of children and young people with identified mental health needs have approximately doubled since 2019, and the severity and complexity of issues and needs has also increased. Young people consistently say that emotional health is their greatest concern
- **Speech and language therapy services** have some of the highest waiting lists and variation in outcomes.

# **PRIORITY 2:** Improve children and young people's mental health and community care

## What do we want to achieve? (i)

| Priority area | Sub priority | Target date | Outcomes | Dependencies | Owner / Governance |
|---|---|---|---|---|---|
| **CYP mental health provision and access** | **Improve mental health community services provision** | 2024 - 25 | • Reduction in waiting times, shorter waiting list and improved quality for CAMHS.<br>• Improvement of Community-Based Crisis services to ensure 7 day service. | • Joint working with other CAMHS pathway commissioners in ICB<br>• LA partners<br>• Capital support form NHSE/ICB | Led by the North West London programme teams, with support from the BCYP network and collaboratives<br><br>Key governance:<br>• Primary Care Partnership Board<br>• MHLDA PC ODG<br>• MHLDA Programme Board |
| | | 2026 - 27 | • Reduce known gaps, including for children known to be at high risk of health inequity (Y3) | | |
| | **Inpatient and acute provision** | 2025 - 26 | • Low numbers of Tier 4 admissions<br>• Lowest appropriate length of stay<br>• Thrive Framework implemented across North West London | | |
| | **Mental Wellbeing in Schools** | 2026 - 27 | • Increased access to Mental Health Support Teams across all boroughs (at least 200 contacts per team, per year in 2024/2025)<br>• An MHST, or equivalent, is available to 100% of NW London's publicly-funded schools. | | |
| **CYP community support** | **Community services** | 2024 - 25 | • Close known gap in special school nursing<br>• Improved consistency of services for children and young people with SEND<br>• Supportive care and prevention at the earliest opportunity<br>• Improved compliance with statutory duties relating to SEND and LAC | • Acute elective care<br>• Child health hubs<br>• Borough based partnerships<br>• Provider collaboratives<br>• organisational design and workforce teams<br>• Parent and/or family groups<br>• Voluntary services | • Led by the North West London programme teams, with support from the BCYP network and collaboratives<br>• Community collaborative lead on speech and language therapy project |
| | | 2025 - 26 | • Equity in access and outcomes for speech and language therapy<br>• Reduce the waiting times for ADHD and autism assessments<br>• Increased access to pre and post diagnostic support | | |
| | **Transformational improvements for specific conditions with known health inequity** | 2026 - 29 | • Reduced inequity for epilepsy and asthma<br>• Reduced inequity in oral health outcomes<br>• Reduced inequity for people with a learning disability and/ or autistic people<br>• Reduced inequity for diabetes and healthy weight | | |
| | **Equity of experience of care** | 2027 - 29 | • Equitable access to core, essential community health services | | |

# **PRIORITY 2:** Improve children and young people's mental health and community care

## What do we want to achieve? (ii)

| Priority area | Sub priority | Outcomes | Dependencies | Owner / Governance |
|---|---|---|---|---|
| Enabling functions | **Workforce** | • Sufficient specialist nurses recruited to support SEND<br>• Sufficient staff available to community CYP MH services – in particular, MHSTs, eating disorder services, and neurodevelopmental services. | • Wider workforce programmes | • North West London People Board with oversight by the Joint Lead Chief People Officers |
| | **Digital and data** | • Incorporate children's social care data into WSIC<br>• NHS and LA data linked so better able to assess need | • Partner agencies integrating contract monitoring<br>• Closing the data gap for child health care and disaggregating activity / finance with adult services | • North West London Data and Analytics Steering Group, reporting to Digital Transformation Board and ICB Board |
| | **Estates** | • Child health hubs in place across all boroughs<br>• Forensic examination hub for child sexual abuse in operation | • Input and engagement from Boroughs, Programmes and Trusts | • TAP, Estates Board & respective internal ICB Scheme of Delegation |

# **PRIORITY 2:** Improve children and young people's mental health and community care

## How will we achieve our outcomes? (i)

| Priority area | | Focus year | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|---|
| CYP mental health provision and access | **Improve mental health community services provision** | Year 1 | • Support implementation of the Thrive Framework<br>• Improve access and quality of community CYP MH services. Develop Integrated CAMHS framework. | • Improvement of community-based crisis services<br>• Integrated pathway for NW London to reduce the waiting times for ADHD and autism assessments<br>• Improve access and outcomes for care-experienced children with mental health needs. | • Improve data on known gaps, including for children known to be at high risk of health inequity<br>• Review of non-NHS community CYP mental health services. |
| | **Inpatient and acute provision** | Year 2 | • Identify innovation to improve CYP crisis provision | • Implement plans for sustainable provision to meet demand and changing needs | |
| | **Mental Wellbeing in Schools** | Year 3 | • Roll out Wave 11 and Wave 12 MHSTs (6 additional teams).<br>• Enable access to non-MHST equivalent for schools that are not currently partnered with an MHST. | • Additional roll out of MHSTs (subject to funding from NHS England). | |
| CYP community support | **Community services** | Year 1 | • Special school nursing: closing known gap in SEND and LAC<br>• Implementation of child health and family hubs across North West London<br>• Identify children and young people speech and language therapy priority quick wins | • Reduce school exclusion rates<br>• Improved consistency of services<br>• Development of a common core SALT offer | • Implementation of a common core SALT offer |
| | **Transformational improvements for specific conditions with known health inequity** | Year 3+ | | • Oral health<br>• Diabetes and healthy weight | • Epilepsy<br>• Asthma |
| | **Equity of experience of care** | Year 4-5 | | | • Equitable access to core, essential community health services<br>• Children's palliative care common standard |

# **PRIORITY 2:** Improve children and young people's mental health and community care

## How will we achieve our outcomes? (ii)

| Priority area | | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|
| Enabling functions | **Workforce** | • Recruitment of specialist nurses to support SEND (for asthma, epilepsy, and diabetes management at school) | • Recruitment of staff to community CYP MH services – particularly MHSTs and eating disorder services. | • Support any further areas of targeted recruitment required |
| | **Digital and data and innovations** | • LAC & SEND linking NHS and LA data – improve quantitative data on health assessment notification (LA) and completion (NHS) timeliness | • Trial and roll out digital innovations for neurodevelopmental pathways | • Further development of reporting tools in WSIC to support teams, helping them identify inequalities and areas of need e.g. Children's Social Care data<br>• Further explore options for the Federated Data Platform to support CYP Transformation Programmes, in line with INT requirements |
| | **Estates** | • Forensic examination hub for child sexual abuse to open in North West London (NHSE, ICB, & police funded)<br>• Start to roll out child health hubs across all NW London Boroughs | • Continue, with the aim to complete, the full roll out child health hubs across all NW London Boroughs | |

# **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

## Summary

Integrated Neighbourhood Teams (INTs), with general practice/primary care at their heart, are central to delivering North West London's Health and Care Strategy  preventing, reducing and delaying the onset of need while improving access to care, quality of care and health outcomes, supporting population health and wellbeing, and enhancing productivity through integrated working.

INTs will bring together all health and care services – primary care, community services, community mental health services and social care (excluding care that requires specialist expertise and equipment and/or inpatient care) including the voluntary sector  around general practice for a defined neighbourhood, typically around 50-70,000 population (around one square mile in central London, 2-3 square miles in outer London). The neighbourhoods are areas that are meaningful to local residents and allow efficient service delivery. They will be run by a single management and leadership team with services designed and planned around residents' health and care needs, using population health data. Teams will be organised in a coordinated way to ensure a single location of care provision wherever possible (e.g., for child health hubs and/or women's health hubs). There will be a common core operating model across North West London, with Borough Based Partnerships leading local implementation and delivery. Where the core set of services does not meet local need (e.g., a bespoke service is needed to address inequalities), the INT can offer supplementary services.

Our focus to date has been on defining the boundaries, establishing the constituent leadership and putting in place community engagement programmes within INTs. Our focus for 2024/25 will be to develop and implement improvements in urgent care – particularly for those with non-complex needs, in order to improve access and to free up resource to define and deliver a proactive common offer for frail and complex patients who most need continuity of care. We will roll out child health hubs followed by other pathways in line with a population management approach that makes best use of the available resource – including community rapid response, additional roles in primary care (paramedics, pharmacists, physios, etc.) across all sectors – all tailored towards the specific needs of our residents to ensure their needs are met in a holistic, integrated way.

Our intended outcomes for our residents in establishing integrated neighbourhood teams:

- Clarity for residents on how to get the care they need.
- Reduction in hospital led emergency care, enabled by support in homes and care homes across both pre-admission and post admission pathways
- Earlier detection of people at risk of ill health and earlier diagnosis of ill health
- Improved quality of care for people with long term conditions
- Easier access to specialist opinion, often without having to travel
- Reduction in health inequalities by providing more outreach services targeted at local populations and by improving access to care
- A safe and manageable workload for practice/ PCN staff, improving their satisfaction and retention and reducing sickness absence

# **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

## Case for change

- The population across NW London is getting older and sicker with more people at risk of, or suffering from, one or more long term conditions.
- We currently have a very fragmented model of care delivery outside of hospitals, typically with GPs working in very small teams, not very well aligned to community or mental health or social care services, not effectively working with the voluntary sector
- This fragmented model of care makes it difficult to effectively plan services, deploy digital tools or to link in with specialist expertise based in hospitals, it does not make the most of the significant and highly skilled non GP workforce (paramedics, pharmacists, physios etc.) and it also doesn't work for residents who view it as impersonal and difficult to navigate.
- We can now see examples of larger, more integrated service models from other parts of the country, and internationally, which bring all staff together into a single team. In so doing, they are better able to provide same day access to care, earlier identification and diagnosis of ill health, better management of care when people do have a long term condition and far better support for people increasingly living with frailty or pre-frailty. Better care improves quality of lives and life expectancy.

# **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

## What do we want to achieve? (i)

| | Sub priority | Target date | Outcomes | Dependencies | Owner / Governance |
|---|---|---|---|---|---|
| **Form and function** | **Leadership and operating models** | April 2025 | • Clarified management structure with single team per INT<br>• Common range of services in places in all INTs, including early help services, voluntary and community sector, 0-19 and children's community teams and other primary care services (pharmacy, dentistry, optometry)<br>• Population health needs mapped | • ICS/ICB programmes, acute, LAs, community collaborative | • Local borough team governance<br>• INT executive Group<br>• INT oversight group<br>• Local Care Board |
| | | 2028/ 2029 | • Appropriate care plans in place for all population segments based on population health management approach<br>• Operating model that makes best use of the resource across primary, community, mental health, social and voluntary sectors and creates capacity for preventative and pro active care | | |
| **Improve core areas** | **Same Day Access** | 2024/25 | • All residents of North West London can access same day primary care services with confidence<br>• Increase of availability of appointments in General Practice (5% increase)<br>• 2-hour Urgent Community Response (UCR) first care contacts 90% | • Place Input, Finance, BI, Acute/Community Services where shift of activity is required | • North West London ICB<br>• Primary Care Programme Board<br>• Boroughs |
| | | 2026/27 | • Sustainable primary care capacity to meet population needs (same day urgent care access, support to manage long term conditions) | | |
| | **Complex, elderly and frail patients** | 2025/26 | • Proactive care providing timely impact on people with escalating health and care risks, improved patient experience and outcomes,<br>• Elimination of inequality and differential access to current services that support the frail population and focus on the right care, at the right place and at the right time | • Close collaborative working with all place/ borough Frailty stakeholder forums or delivery groups, wider Frailty stakeholders (including Local Authorities, Acute providers, Primary Care, and community providers) | • North West London ICB<br>• NW London JHOSC<br>• LA overview and scrutiny committees; |

# **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

## What do we want to achieve? (ii)

| | Sub priority | Target date | Outcomes | Dependencies | Owner / Governance |
|---|---|---|---|---|---|
| **Improve core areas** | **All long term conditions** | 2028/29 | • Reduction in the number of people living with unidentified LTCs.<br>• All residents and their carers / families with long term conditions have access to prevention, advice and support to help them stay well at home, with 90% of high/medium need with a care plan and 70% adherence to care plan<br>• Care plans make best use of local authority and community resources, alongside more traditional health services.<br>• Increased ability of patients to self-manage and support, ensuring they access the most appropriate services in a timely and safe manner.<br>• Improved patient experience through early and accurate diagnosis of disease<br>• Rapid clinical access to specialist advice and guidance which will also support elective recovery and reduce long waits | • All place/ borough stakeholder forums or delivery groups, Local Authorities, Acute providers, Primary Care, and community providers | • Boroughs, ICB Board TBC |
| **Enabling functions** | **Workforce** | 2028/29 | • A safe and manageable workload for practice/ PCN staff, with reduced sickness/absenteeism and increased satisfaction from staff surveys<br>• Clear workforce model included new and fulfilling roles with demonstrable productivity gain | | • North West London People Board with oversight by the Joint Lead Chief People Officers |
| | **Digital and data** | 2028/29 | • Data available to enable top-down management of demand, capacity and patient flows across the ICB, and clinical and service decision-making across all services (with implementation across more services within each year of the JFP).<br>• Multi-disciplinary integrated care pathways spanning health and social care settings will be enabled via shared digital care records, tasks and plans.<br>• Enhancement of Primary Care systems to enable neighbourhood working | • Further enhancement of data and intelligence tools – acquire VCSE data and link with WSIC<br>• NHSE One London<br>• Potential additional funding for software and transformation | • ICB Digital Transformation Board |
| | **Estates** | 2028/29 | • Fit-for-purpose estate, improved utilisation, sustainable estate, cost efficiencies. | • Input and engagement from Boroughs, Programmes and Trusts | • TAP, Estates Board & respective internal ICB Scheme of Delegation |

# **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

## How are we going to achieve our outcomes? (i)

| | Aim | Focus year | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|---|
| **Form and function** | **Leadership and operating models** | Year 1 | • Core common approach to working with local adaption/variation depending on starting point and local assets (workforce, estate), linked to PHM and community core offers<br>• Common approach to PHM and care planning<br>• Standard operating procedures for the three Fuller areas, plus elective care, based on evidence based care and with greater consistency of deployment | • Tailored preventative programmes and preventative service delivery operating within the INTs based on local priorities | |
| **Improve core areas** | **Same Day Access** | Year 1 | • Launch of same day access model<br>• Design, develop outcome-based payments for both service and system level services<br>• Implement North West London Target Operating Model for same day access (SDA), to increase capacity and manage demand, including establishing pathways for UCR links to same day access model | • Ongoing implementation and monitoring of primary care same-day demand (forward, seasonal, over the 24-hour period) | • Potential integration within wider IUC contract, along with 111 as a fully integrated service |
| | **Child and Women's Health Hubs** | Year 1 | • Roll out child health hubs to remaining boroughs<br>• Define and start implementing women's health hubs | • Roll out women's health hubs | |
| | **Complex, elderly and frail patients** | Year 2 | • Determine core common offer – including links with district nursing | • Full implementation and mobilisation across all Boroughs | |
| | **Other areas / pathways** | Years 2+ | • Review and improve primary care clinician access to specialist advice and guidance<br>• Proactive care planning in line with PHM approach | • Identification of areas and pathways for common implementation<br>• Supporting development and scale of in-reach models across Core20plus groups<br>• Borough specific initiatives | • Implementation across Boroughs |

# **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

## How are we going to achieve our outcomes? (ii)

| | Aim | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|
| Enabling functions | **Workforce** | • Maximise the impact of ARRS funded roles to enable Primary Care to deliver Integrated Neighbourhood teams, GP Access and joint MH ARRS roles<br>• Shared approach to workforce management agreed with community services enhancing capacity and demand and improving productivity | • Scope the workforce elements of the system wide ICS programmes to enable new ways of working in support of INTs | • New roles in place across INTs |
| | **Digital and data** | • Deploy London Care Record to all remaining healthcare settings and tackle data quality.<br>• Enhancement of Primary Care systems to enable neighbourhood working<br>• Requirements for shared records and cross-organisation workflows articulated and agreed | • Reprocurement of primary care systems<br>• Plan and implement the transformation required to make use of shared records across multi-disciplinary patient pathways to support optimisation of resources and safe management of patients. | |
| | **Estates** | • Co-location of teams<br>• Numerous big ticket projects, including developing hubs, increasing primary care-at-scale offerings and supporting national programmes (e.g. CDCs). | | |

# **PRIORITY 4:** Improve mental health services in the community and for people in crisis*

## Summary

We have expanded mental health services considerably across North West London in recent years, with an extra ~£78m allocated to mental health services from 2019/20 to 2023/24. The number of residents in contact with community mental health teams has increased by ~50%. Provision for those experiencing crisis has expanded, with the expansion of healthcare based places of safety, psychiatric liaison in our hospitals, Mental Health Crisis Assessment Centre, and community crisis teams. Nonetheless, we know we have more to do – addressing variation in outcomes and productivity will deliver a consistently better experience for patients and enable us to meet more need. Ensuring accessible and effective mental health support within the community – tailored where appropriate for vulnerable groups that may face barriers to accessing care through traditional routes - helps prevent crises, reduces hospital attendances and admissions, and promotes early intervention, improving overall mental well-being.

Effective crisis mental health services are crucial for providing immediate support during times of acute distress, reducing the risk of harm and preventing crises from escalating.

We will:

- Implement a consistent core set of services for community and crisis care for adults, including severe mental illness, that can be tailored where needs differ; services will be responsive to population health needs with no unwarranted variation in outcomes, we will reduce long waits in ED and provide new pathways, including with partners in the voluntary sector;
- Reduce variation and increase productivity in caseloads and staffing across community services, with no person staying longer in a mental health bed than they need to and both patients and staff reporting better experiences.
- Continue to raise awareness across North West London so that every resident knows how to access mental health support both in crisis and in the community; all people known to mental health services will have a crisis management plan that supports them to use crisis alternatives to A&E where possible;
- Integrate care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness.
- Work together with our Local Authority partners to develop solutions to the housing and employment pathway challenges, providing integrated solutions to housing pathways and resulting in more people gaining and staying in meaningful employment.

Our intended outcomes include:

- Reducing unwarranted variation in outcomes.
- Patients and staff reporting better experiences.
- Optimal community capacity to respond to growth in need whilst delivering our transformation goals and increasing care in a community setting.
- All people known to mental health services with a crisis management plan that supports them to use crisis alternatives to A&E where possible
- No person staying longer in a mental health bed than they need to.
- More people gaining and staying in meaningful employment.



**Please note:** all Mental Health services related to children are covered in priority 2

# **PRIORITY 4:** Improve mental health services in the community and for people in crisis*

## Case for change

- Mental health disorders are the fourth largest driver of years lost to disability and death in North West London and therefore presents one of our biggest opportunities to improve the health and wellbeing of our residents.
- While we have expanded community and crises services significantly, many of our population do not yet have confidence in the services that we offer.
- Demand and complexity are increasing, demonstrated by a greater number of people presenting at A&E in mental health crisis who are not previously known to services.
- In order to be successful North West London needs to establish appropriate systems and frameworks that enable Provider Collaboratives to design, commission and deliver a wide range of pathways and services is key to driving the transformation and improvement of all mental health, learning disabilities and autism services across North West London.



**Please note:** all Mental Health services related to children are covered in priority 2

# **PRIORITY 4:** Improve mental health services in the community and for people in crisis*

## What do we want to achieve? (i)

| Priority area | Sub-priority | Target Date | Outcomes | Dependencies | Owner/ governance |
|---|---|---|---|---|---|
| **Community mental health** | **Capacity Improvements and reduction in waiting times** | 2024 - 25 | • Improve Dementia diagnosis rate to 66/7% and post-diagnostic care | • Primary care<br>• Borough based partnerships<br>• NHSE London and other national NHSE teams<br>• Acute & Community Collaboratives<br>• Population Health management ICB programme | • Mental Health team and Mental Health Collaborative<br>• MHLDA Provider Collaborative Operational Delivery Group and Board<br>• Provider Boards and sub-committees<br>• North West London ICB MHLDA Board and sub-committees<br>• North West London ICB Finance |
| | | 2025 - 26 | • Improved capacity and reduce waiting times of Adult ADHD and Autism | | |
| | | 2025 - 26 | • Improved access and capacity of Talking therapies to enable reliable improvement (67%) and reliable recovery (48%) | | |
| | | 2025 - 26 | • Consistent performance reporting for primary care providers | | |
| | | 2025 - 26 | • Core common offer of services for all residents<br>• Reduce variation in caseloads and staffing across community services.<br>• Develop an assets-based approach to promoting mental health and wellbeing | | |
| | **Inpatient care** - maintain flow and reduce variation across the specialist bed base | 2028 - 29 | • High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment. | | |
| | | 2025 - 26 | • Improve flow and quality for all inpatient care<br>• Improved integration with community provision | | |
| | | 2026 - 27 | • Improved culture across wards | | |



**Please note:** all Mental Health services related to children are covered in priority 2

# **PRIORITY 4:** Improve mental health services in the community and for people in crisis*

## What do we want to achieve? (ii)

| Priority area | Sub-priority | Target Date | Outcomes | Dependencies | Owner/ governance |
|---|---|---|---|---|---|
| **Community mental health** | **Capacity Improvements and reduction in waiting times** | 2024 - 25 | • Improve Dementia diagnosis rate to 66/7% and post-diagnostic care | • Primary care<br>• Borough based partnerships<br>• NHSE London and other national NHSE teams<br>• Acute & Community Collaboratives<br>• Population Health management ICB programme | • Mental Health team and Mental Health Collaborative<br>• MHLDA Provider Collaborative Operational Delivery Group and Board<br>• Provider Boards and sub-committees<br>• North West London ICB MHLDA Board and sub-committees<br>• North West London ICB Finance |
| | | 2025 - 26 | • Improved capacity and reduce waiting times of Adult ADHD and Autism | | |
| | | 2025 - 26 | • Improved access and capacity of Talking therapies to enable reliable improvement (67%) and reliable recovery (48%) | | |
| | | 2025 - 26 | • Consistent performance reporting for primary care providers | | |
| **Crisis mental health** | **Mental health in ED** | 2026 - 27 | • Reduction seen in the use of s136<br>• Reduction seen in 12 hour waits in ED | • Primary care<br>• Borough based partnerships<br>• NHSE London and other national NHSE teams<br>• Acute & Community Collaboratives | |
| | | 2027-28 | • Increased use of alternative care pathways and VCSE services | | |
| | **Suicide prevention and support** | 2026 - 27 | • Reduction in suicide rates, and increased support for people bereaved by suicide | | |
| **Enabling functions** | **Workforce** | | • Reduction in variation between Mental Health nursing support in EDs<br>• Improved recruitment on Mental Health nurses | • Wider workforce programmes | • North West London People Board |



**Please note:** all Mental Health services related to children are covered in priority 2

# **PRIORITY 4:** Improve mental health services in the community and for people in crisis*

## How are we going to achieve our outcomes? (i)

| | Aim | Focus year | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|---|
| **Community mental health** | **Capacity Improvements and reducing waiting lists (add in rows 3 &4)** | Y1 | • Review to ensure sufficient and appropriate capacity<br>• Dementia diagnosis and care<br>• Agreed set of core performance metrics | • Improve capacity and reduce waiting times of Improved capacity of Adult Autism<br>• Joint performance and VFM dashboards<br>• Improve productivity of core community services | • Improve capacity and reduce waiting times of Talking therapies |
| | **Impatient care -** maintain flow and reduce variation across the specialist bed base | Y2 | • Improve flow and quality for all inpatient care | • Review of the Limes and Rehab inpatient models<br>• Improved integration with community provision | • Improved culture across wards |
| **Crisis mental health** | **Mental health in ED** | Y2 | • 111 first for Mental Health implemented 24/7<br>• Drive initiatives to reduce 12 hour waits in ED | • Drive initiatives to reduce use of s136 | • Increased use of alternative care pathways and VCSE services |
| | **Suicide prevention and support** | Y2 | | • Development of a multi-agency suicide prevention plan | • Expansion of suicide postvention offer |



**Please note:** all Mental Health services related to children are covered in priority 2

# **PRIORITY 4:** Improve mental health services in the community and for people in crisis*

## How are we going to achieve our outcomes? (ii)

| | Aim | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|
| **Enabling functions** | **Workforce** | • Recruitment to the top five hard to fill vacancies (MH nurses) | • Drive to reduce variation between Mental Health nursing support in EDs | • Develop and implement Mental Health workforce models for Acute Trusts |
| | **Digital and Data** | • Data to be acquired and linked to WSIC<br>• Implement plan for enhancement of Community and Mental Health EPRs<br>• Articulate digital requirements for better sharing of MH crisis plans and requirements of community and crisis care (e.g. IAPT data) | • Embed evidence based practices | |





**Please note:** all Mental Health services related to children are covered in priority 2

# **PRIORITY 5:** Embed a consistent, high quality set of community services by maximising productivity

## Summary

We want to support people in North West London to stay well and live independently; supported by integrated neighbourhood teams that deliver a seamless service to our residents by bringing together community physical and mental health services, social care and the voluntary sector health around primary care. To ensure these services are high quality, comprehensive, and timely, we need to improve productivity and reduce unwarranted variation.

This means we will:

- Develop a consistent, productive set of effective and equitable community services, tailored to the needs of our residents, using the population health management approaches in priority one to support residents who would benefit from proactive care, prevention programmes and/ or bespoke services
- Support our borough teams to implement the consistent set of services – starting with community nursing, urgent care response (including support to care homes) and children's speech and language therapies – improving productivity to the highest levels in North West London to ensure we level up;
- Work with primary care to continue to develop models of care for cohorts of residents as part of the integrated neighbourhood teams, e.g., for frailty, diabetes and cardiovascular disease;
- Deliver a consistent musculo-skeletal and specialist palliative care services across North West London;
- Embed co-production as a way of developing and delivering services, with patient and carer voice at the centre of our offer.

Our initial focus is on maximising productivity and reducing waits across those areas that will most contribute to system resilience and recovery.

As a result, we aim to achieve:

- Reduction in waiting times for community services (5% in 2024/25)
- Increase in Urgent Community Response for first care contacts
- Reduction in length of stay in community beds
- Reduction in demand for emergency care with stable provision of community services
- Best use of clinical time and greater staff satisfaction
- Consistency in access and patient experience of services across North West London
- Clear and transparent understanding of how services are used, resulting in optimal use of resources across North West London

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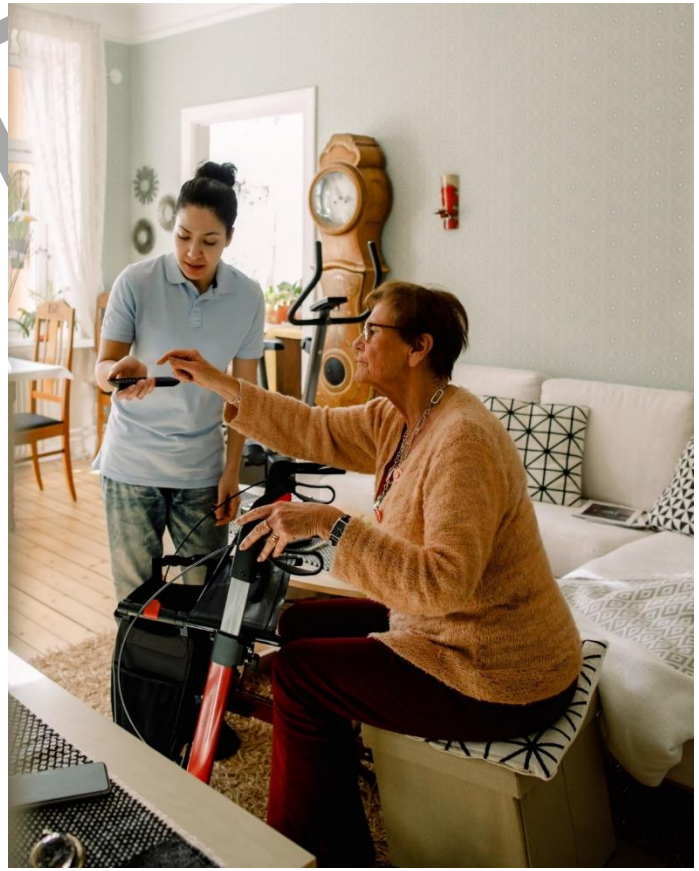
# **PRIORITY 5:** Embed a consistent, high quality set of community services by maximising productivity

## Case for change

- The health and care system are currently under significant pressure and waits for some community outpatient services can be long – this has an adverse impact on patient experience and can result in unnecessary attendances/ admissions at hospitals;
- Data across services is not consistent, which means that we do not have a clear picture of baseline demand and capacity or the impact that this may have on equity of access to services. It is likely that productivity and experience vary considerably;
- Some services exhibit high levels of vacancies (e.g., community nursing).





# **PRIORITY 5:** Embed a consistent, high quality set of community services by maximising productivity

## What do we want to achieve? (i)

| | Sub priority | Target date | Outcomes | Dependencies | Owner / Governance |
|---|---|---|---|---|---|
| **Quality** | **Data quality improvement** | April 2025 | • Reduction in workload on Trusts<br>• Clear understanding of demand on services supporting planning and productivity work | • ICS/ICB programmes, acute, LAs | • Community collaborative |
| | **Service design** | 2027/28 | • All services designed together with, and responding directly to, service users and communities | | |
| **Common core offer** | **Implement consistent, high quality set of community services** | April 2025 | • Reduce community waiting list numbers by 5%<br>• Specialist palliative care offer in place for all residents at end of life | • ICS/ICB programmes, acute, LAs | • NW London ICB<br>• Community collaborative |
| | | April 2025 - 2026/27 | • Equitable access, better outcomes and reduction inequalities initially in community beds and nursing and subsequently to all community services | • ICS/ICB programmes, acute, LAs | • NW London ICB<br>• Community collaborative<br>• Boroughs |
| **Maximise productivity** | **Maximise productivity Demonstrate value for money** | 2025/ 2026 | • Best use of resources and maximum value for money at trust and system level | • ICS/ICB programmes, acute, LAs | • NW London ICB<br>• Community collaborative<br>• Boroughs |

# **PRIORITY 5:** Embed a consistent, high quality set of community services by maximising productivity

## What do we want to achieve? (ii)

| | Sub priority | Target date | Outcomes | Dependencies | Owner / Governance |
|---|---|---|---|---|---|
| **Enabling functions** | **Workforce** | 2028/29 | • Right sized workforce from local communities equipped with skills for new models of care, supported by the delivery arm of the NW London Health & Social Skills Academy | • Wider workforce programmes | • NW London People Board |
| | **Digital and data** | 2024/25 | • Standardised and consistent reporting across all community services and measures | • Inter-operability with FDP to make use of existing data feeds in Foundry and linking with primary care and community data held in WSIC | • NW London Community and MH Digital Steering Group, reporting to ICB Digital Transformation Board |
| | | 2028/29 | • Records shared across providers to enable efficient wraparound care<br>• Best use of digital tools to support clinical decision making | | |
| | **Estates** | 2028/29 | • Most efficient use of community assets<br>• Interoperability across estate and infrastructure | • Input and engagement from Boroughs, Programmes and Trusts to ensure all needs are captured and acted on. | • TAP, Estates Board & respective internal ICB Scheme of Delegation |

# **PRIORITY 5:** Embed a consistent, high quality set of community services by maximising productivity

## How are we going to achieve our outcomes? (i)

| | Aim | Focus year | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|---|
| **Quality** | **Data quality improvement and service design** | Y2 | • Develop and start to implement data quality programme with QI focus<br>• Establish Data Quality strategy & procedures<br>• Review, rationalize and standardize quality indicators | • Embed data quality programme and quality of community care services using standardised metrics<br>• Implement best practice approach to enhancing our patient, staff and community voices in design of services | |
| **Common core offer** | **Implement consistent, high quality set of community services** | Y1 | • Determine core offer for community nursing linked into the Integrated Neighbourhood teams common range of services and common core offer<br>• Mobilise core offer for community beds<br>• Mobilise Length of Stay reporting<br>• Implementation of core common offer for other services – MSK<br>• Implementation of common core standard for care homes, linked to integrated neighbourhood teams<br>• Develop and agree new model of care for specialist palliative care | • Implementation of model of care for specialist palliative care | • Lead a sector wide approach to uplift and make stroke and neuro service provision equitable across NW London |
| **Maximise productivity** | **Deliver productivity Demonstrate value for money** | Y2 | • Demand & Capacity Modelling across all services starting with (1) Podiatry, (2) Community Nursing, (3) Urgent Care Response (4) Children's SALT<br>• Review how we best use BCF and funding arrangements to deliver best outcomes<br>• Drive productivity: focus - community beds<br>• Drive productivity and reduce waiting list: focus – community nursing | • Demand & Capacity Modelling across remaining community services<br>• Drive productivity: focus – neurorehab and other key focus areas<br>• Implementation of consistent activity collection and data reporting | • Deliver economies of scale through infrastructure |

# **PRIORITY 5:** Embed a consistent, high quality set of community services by maximising productivity

## How are we going to achieve our outcomes? (ii)

| | Aim | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|
| Enabling functions | **Workforce** | • Recruitment to high impact roles community roles utilising the Integrated Recruitment Hub<br>• Promote volunteer-to-career pathway<br>• Standardisation of workforce dashboard<br>• Introduction/expansion of new roles<br>• Shared approach to workforce management agreed within INTs, enhancing capacity and demand and improving productivity | • Expand and develop workforce now and for the future including development of future roles<br>• Use and act on local data and insights to positively impact workforce planning | |
| | **Digital and data** | • Data standardisation across partners<br>• Delivery of strategic reporting for community | • Implement community collaborative digital and data strategy<br>• Shared records across multi-disciplinary patient pathways | • Identify and implement consistent digital offer |
| | **Estates** | • Implement current community estates priorities | • Implement future community estates priorities | |

# **PRIORITY 6:** Optimise ease of movement for patients across the system throughout their care – right care, right place

## Summary

Patient flow is about directing residents to the most appropriate place that can meet their needs, and moving patients through care settings as expeditiously as appropriate – e.g., directing to alternatives to admission and ensuring timely discharge from hospital. It involves coordinating medical care, social care, physical resources, and systems between hospitals, the local authorities, GPs and community support services to work effectively.

Lengthy, unnecessary stays in hospital can arise for several reasons: People may be admitted when other settings of care, closer to home, are more appropriate to their needs; they may have to wait a long time in an emergency department to be seen or wait to return home if they are admitted. Ambulances may be delayed at hospital handing over people to the care of hospital staff. This can have an impact on patients' wellbeing, as it harder for patients to return home and their outcomes are poorer. It also has an impact on the system as a whole, as it impacts access and waiting times for everybody.

Efficient care pathways for patients improves patient flow, reducing waiting times, boosting satisfaction, and minimising patient risk by ensuring needs are met in the right setting of care, and by preventing unnecessary delays (e.g., ambulances responding to emergency calls or long waits in emergency departments). Efficient flow helps deliver faster access and enables better capacity management to respond to varying demand within healthcare facilities.

To improve patient flow, the system needs to work together, with collaboration vital across all care partners including community health, social care and housing. Flow is our third area of focus for introducing and scaling innovation - we will use technology and data enabled pathway solutions to optimise discharge coordination and increase the types of condition that can be managed while people remain at home. The national Federated Data Platform will enable data to flow across organisations, making flow easier to track and manage. Our Urgent and Emergency Care Strategy planned for publication in autumn 2024 will include further detail on the concrete actions we are taking to strengthen in hospital flow and discharge in emergency departments.

As a result, we aim to achieve:

- Fewer admissions to hospital where people can be as well – or better – treated in settings closer to (or at) home
- Patients spend more time at home
- Reduced delay for patients in hospital who are medically fit to be discharged, especially for those who need support in the community.
- More patients are discharged directly back to their place of residence than in previous years
- Reduced risk of harm by swifter discharge from hospital (when clinically appropriate)
- Reduced long waiting times in emergency rooms

# **PRIORITY 6:** Optimise ease of movement for patients across the system throughout their care – right care, right place

## Case for change

- As the population ages, demand for healthcare naturally increases. But many people who are currently admitted to hospital could receive better care in other settings, while others who need a hospital bed stay in that bed for longer than clinically necessary – we know that prolonged hospital stays can increase confusion and undermine independence.
- Additionally, inefficient patient flow as currently experienced contributes to longer waiting times, reduced patient satisfaction, and higher costs, highlighting the urgency for improvement.
- Meeting performance targets and regulatory standards requirements is a directive from NHSE and often reflected in the operating plan.

# **PRIORITY 6:** Optimise ease of movement for patients across the system throughout their care – right care, right place

## What do we want to achieve? (i)

| Priority area | Sub-priority | Target Date | Outcomes | Dependencies | Owner/ governance |
|---|---|---|---|---|---|
| **Flow and discharge improvements** | **System flow** | 2024 – 25 | • Reduced length of stay for patients that are in hospital for a long time (21 days +) by at least 5%<br>• More patients able to access virtual ward and therefore discharged from hospital faster, with virtual ward average occupancy to be at least 80% occupied. | • Local Authorities/ASC<br>• Data/BI for Optica rollout and ongoing analysis<br>• Finance, contracts and procurement<br>• Community and Provider Collaboratives<br>• UEC team<br>• LAS | • North West London ICB<br>• Acute Trusts and provider collaborative<br>• Community collaborative<br>• LAS |
| | | 2025 - 26 | • Reduced the identification gap through transformation of discharge hubs to true Transfer of Care Hubs where different services such as social care, housing and voluntary services are linked to coordinate support for those patients who need it. | | |
| | **Front door improvements** | 2024 – 25 | • All Medical SDECs within the acute providers live with LAS trusted assessor model and 111 direct booking<br>• Fewer patients taken to ED who could better be seen elsewhere | | |
| | | 2025 - 26 | • More patients are discharged back to their place of residence than in previous years | | |
| | **Discharge improvements** (including pathways 0-3) | Mar 2025 | • Delays reduced for patients who are discharged from hospital and either need further support at home, care home or a community bed<br>• More patients have access to bridging services, helping to get patients home quickly and safely after hospital.<br>• Internal hospital delays eliminated for patients who are leaving hospital to return home with no additional care needed | | |
| | | 2025 - 2026 | • Reduced treatment gap for pathway 3 patients with behaviour concerns, dementia and delirium | | |

# **PRIORITY 6:** Optimise ease of movement for patients across the system throughout their care – right care, right place

## What do we want to achieve? (ii)

| Priority area | Sub-priority | Target Date | Outcomes | Dependencies | Owner/ governance |
|---|---|---|---|---|---|
| Enabling functions | **Digital and data** – tech and innovation | 2024- 25 | • Effective usage of Care Co-ordination Solution, migrating to the national NHSE Federated Data Platform spanning pathways across organisations. | • Funding model for Federated Data Platform and local implementation<br>• Discharge hubs | • ICB Digital Transformation Board<br>• Research & Innovation programme |
| | | 2026-27 | • Real time clarity of demand, capacity and patient flows across the ICB enabling accurate clinical and service decisions<br>• Technological/ pathway solutions to optimise discharge coordination | | |
| | **Estates** | 2024 - 29 | • Healthcare Hubs developed across the Boroughs | • Input and engagement from Boroughs, Programmes and Trusts | • TAP, Estates Board & respective internal ICB Scheme of Delegation |
| | **Workforce** | 2024 - 29 | • Reduced number of priority vacancies across acute hospitals, social care and primary care<br>• More efficient deployment of staff to areas where they are most needed, enabled by improved staff mobility | • Wider workforce programmes | • North West London People Board |

# **PRIORITY 6:** Optimise ease of movement for patients across the system throughout their care – right care, right place

## How are we going to achieve our outcomes? (i)

| | Aim | Focus year | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|---|
| **Flow and discharge improvements** | **System flow** | Year 1 | • Implement discharge to assess or equivalent model compliant with Hospital discharge and community support guidance<br>• Embed system escalations and operational support to improve access to onwards discharge destinations<br>• Enhance support to care homes to improve intermediate care | • Support discharge hubs to meet priorities and standards for Transfer of Care Hubs | • Launch additional virtual ward pathways |
| | **Front door improvements** | Year 1 | • Deliver the national 5 priority areas for the delivery of the waiting times standard, including standardised Rapid Assessment and Treatment (RAT)<br>• Enable direct referrals to SDEC services from all appropriate services, including ambulances, GPs and other HCP's<br>• Enhanced planning for discharge at the point of attendance<br>• Bring pre-dispatch and post-dispatch ambulance initiatives into a single care co-ordination approach and integrate with other pathways such as 111 and UCR. | • Paediatric Transformation Programme, supporting acute service improvement in tandem with integrated working across system services<br>• Implement learning form work with LAS to | • Identify and reduce patients experiencing inequality of access, experience and outcome in UEC services |
| | **Discharge improvements** (including pathways 0-3) | Year 1 | • Improve access to bridging services, enabling improvements in pathway 1 discharges<br>• Reduce treatment gap for non CHC health related pathway 3 patients<br>• Implement a clear process, pathway and funding source for those patients who need a package of care when being discharged from hospital that isn't funded by the NHS (also known as non-CHC) | • Embed initiatives to reduce the treatment gap for pathway 3 patients with behaviours of concerns, dementia and delirium<br>• Improve access to out of hospital provision to support faster discharge of patients<br>• Identify and reduce Pathway 0 and internal hospital process discharge delays | |

# **PRIORITY 6:** Optimise ease of movement for patients across the system throughout their care – right care, right place

## How are we going to achieve our outcomes? (ii)

| | Aim | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|
| **Enabling functions** | **Digital and data** – tech and innovation | • Improve the local Care Co-ordination Solution through the National NHSE Federated Data Platform so that it will span pathways across organisations.<br>• Pilot a technological / pathway solution to optimise discharge coordination<br>• Start to roll out OPTICA tool to Local authorities and create of a monitoring dashboard for demand and capacity data | • Scale up technological / pathway solution to optimise discharge coordination to 50% sites | • Data available to enable top-down management of demand, capacity and patient flows across the ICB<br>• Launch shared digital care records which enable multi-disciplinary integrated care pathways spanning health and social care settings |
| | **Workforce** | • Improve staff mobility process for more efficient deployment of staff to areas where they are most needed<br>• New models of care in North West London EOC, Ophthalmology Hubs, one stop clinics in gynae<br>• Use North West London Integrated Recruitment Hub to reduce priority vacancies across acute/social care/primary care, supporting patient flow | • Identify workforce requirements using evidence-based establishment setting tools or capacity and demand where evidenced based tools do not exist<br>• Develop training programme for data driven workforce redesign skills | • Workforce redesign: use new roles, new ways of working and competency-based approaches to transform the workforce in line with changing patient needs and service models |
| | **Estates** | • Development of Healthcare Hubs across the Boroughs | | |

# **PRIORITY 7:** Transform maternity care

## Summary

The national delivery plan for maternity services sets out four ambitions - listening to, and working with, women and families with compassion; growing, retaining, and supporting our workforce with the resources and teams they need to excel; developing and sustaining a culture of safety, learning, and support; and standards and structures that underpin safer, more personalised, and more equitable care.

North West London has six maternity units – three rated outstanding by the CQC, one good, and two as requires improvement. Following the 2015 maternity review, all are collocated with level II neonatal care units and there are no plans consolidate units. North West London's award winning Mum & Baby app continues to be adopted widely. While having half of our units rated as outstanding means our maternity services are among the best in the country, there is still more to do to improve services so that every family in in North West London has positive experience of NHS maternity services. In addition to ensuring that our two units requiring improvement do continue to improve, we also need to ensure that outcomes, in particular for black and Asian women and their babies, improve – at the moment, outcomes for these women and babies are worse than for the population as a whole. We need to ensure that we foster a culture of safety which will benefit everyone who touches our services.

This is achieved through delivering improved strategic capabilities for:

- Transformation – via the ICS Local Maternity & Neonatal System, a ICS Senior Responsible Officer, and an emerging acute provider maternity collaborative
- Assurance – via the ICB Chief Nurse, the ICB Performance Committee, and emerging ICB assurance arrangements

Over the next 5 years, we will aim to:

- Reduce the inequity of pregnancy care and outcome
- Improve the quality of our services, with more support from maternity services to higher risk cases
- See low numbers of still births and intrapartum brain injuries
- Improve access to pregnancy advice (including digital access, and real-time translation services)

# **PRIORITY 7:** Transform maternity care

## Case for change

This work will tackle the following challenges:

- Ensuring continuity of midwife care throughout antenatal, perinatal, and postnatal care
- User representatives (Maternity & Neonatal Voices Partnership chairs) not able to spend enough time building trust and lead coproduction of innovations with higher risk communities
- Higher risk of poor pregnancy outcomes for black and Asian pregnant women and their babies
- Pre-existing poor mental and physical health (often associated with deprivation) contributing to higher risks in pregnancy
- Asylum seekers who are pregnant at higher risk due to lack of antenatal reviews, disrupted care, stress, and risk of infectious disease

# **PRIORITY 7:** Transform maternity care

## What do we want to achieve? (i)

| Priority area | Sub priority | Target date | Outcomes | Dependencies | Owner |
|---|---|---|---|---|---|
| **Service improvements and transformation** | **Service improvements and transformation** across a range of key maternity services | 2024/25 | • Provide Postbirth Contraception Service in all trusts within North West London sector<br>• Aligning postnatal care in line with the NICE quality standards | • Maternity Triumvirates across the sector<br>• Trusts' and ICB digital leadership teams<br>• ICB digital inclusion steering group<br>• ICB BI team<br>• External partners<br>• ICB Overseas Recruitment team<br>• North West London NHS Academy<br>• MNVP<br>• Health Equity programme | • North West London ICB<br>• Maternity Network |
| | | 2025/26 | • All North West London trusts to achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding<br>• Achieve NHSE safe staffing standards<br>• Improved outcomes for BME women within North West London | | |
| | | 2026/27 | • Availability of bereavement services 7 days a for women and families who sadly experience loss | | |
| | | 2027/28 | • Pregnant women and new mothers have equitable access to pelvic health services | | |

# **PRIORITY 7:** Transform maternity care

## What do we want to achieve? (ii)

| Priority area | Sub priority | Target date | Outcomes | Dependencies | Owner |
|---|---|---|---|---|---|
| Enabling functions | **Workforce** | 2025/26 | • Increased international recruitment of midwives<br>• implementation and Assurance of the CNST safety action 4&5 | • Maternity Triumvirates across the sector<br>• Trusts' and ICB digital leadership teams<br>• ICB digital inclusion steering group<br>• ICB BI team<br>• External partners<br>• ICB Overseas Recruitment team<br>• North West London NHS Academy<br>• MNVP | North West London People Board |
| | **Data & Digital** | 2024/25 | • Inequalities Dashboard launched<br>• Improve MISs/EPRs data | • ICB BI team<br>• Trust clinical and digital teams<br>• ICB Digital Leadership team | ICB digital transformation Board<br><br>Acute Provider Collaborative |
| | | 2025/26 | • Digital maternity record standard and maternity services data set standard<br>• System wide integration<br>• Use of digital tools and enablers at point of care<br>• Standardise digital maturity across 4 maternity units | | |
| | **Collaboration** | 2025/26 | • Improved engagement and joint working between public health teams and the NHS to support healthy preconception and pregnances | • Public health teams<br>• Borough based partnership teams | |

# **PRIORITY 7:** Transform maternity care

## How are we going to achieve our outcomes? (i)

| | Sub priority | Focus year | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|---|
| **Develop a North West London maternity strategy** | **Strategy development** | Y1 | • Develop and publish North West London wider Maternity Strategy | • Work to deliver the published strategy | |
| **Service improvements and transformation** | **Service improvements and transformation** across a range of key maternity services | Y2+ | • Provide post-birth contraception Service in all trusts within North West London sector<br>• Align postnatal care in line with the NICE quality standards | • All North West London trusts to achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding<br>• Achieve NHSE safe staffing standards<br>• Develop inreach offer for ethnic communities adversely affected by poor outcomes in maternity services | |

# **PRIORITY 7:** Transform maternity care

## How are we going to achieve our outcomes? (ii)

| | Sub priority | Focus year | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|---|
| Enabling functions | **Workforce** | Y2 | • Support the implementation of operational policies<br>• Monitoring the implementation of the NHS Single delivery plan | • Review workforce data across the sector<br>• Develop a maternity support workers apprenticeship programme<br>• Designing retention strategy for staff retention<br>• Appoint cultural safety lead midwives and roll out training | • Comprehensive analysis of various metrics related to maternity roles<br>• Highlight retention challenges and escalate them to the regional team<br>• Establish with the ICB Overseas team to internationally recruit midwives<br>• Multidisciplinary training and training dashboard#<br>• Apprenticeship programme go live<br>• Implement Core Competency framework v2 across the sector<br>• Develop and implement a plan to support for newly qualified staff and clinicians |
| | **Digital and Data** | Y1 | • What Good looks like - digital Maturity Assessment<br>• LMNS Dashboard review<br>• Ensure that all Trusts submit the digital maturity report, and a gap analysis is undertaken to identify key points for improvement | • Develop a data strategy, improve and promote Bioinformatics analysis, develop E&E dashboard | • M&B app development |

# **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment

## Summary

Cancer accounts for 3,134 deaths per year (2020/21) in North West London and is the leading cause of death in the over 40s in every borough. Over 62,000 people are living with or beyond cancer in North West London. Improving cancer outcomes is a key strategic aim for North West London ICS, and the national priority for cancer is to increase survival by focusing on early diagnosis, with the ambition to ensure 75% of patients are diagnosed at stage 1/2. As at 2018, the early diagnosis rate across NW London stood at 55%. This average masks variation in terms of both early diagnosis rates by borough and by tumour type by borough. We also know that people from our more deprived populations, or from ethnic minorities, wait longer before presenting with symptoms of cancer and can also experience greater delays in diagnosis.

Our approach to improving early diagnosis is to tackle variation in screening, time to diagnosis, and treatment by deploying both universal interventions and targeted interventions focused on those least likely to be diagnosed early. We will harness emergent innovations and work closely with partners involved in life science innovation to ensure more people get diagnosed earlier and codesign approaches with people from groups who are less likely to be diagnosed early.

Over the next 5 years, we aim to see the following outcomes:

- Reduced variation of stage of diagnosis at borough level by 8% (starting with Brent which will have the greatest impact)
- Fewer people diagnosed with cancer in emergency settings
- Narrowing of the cancer disparities gap faced by the black communities in North West London; through equity in access to information, testing, pre-treatment and post treatment options.
- Faster diagnosis: standardised secondary care cancer pathways, minimised handoffs, sustainable staffing
- Adoption of new technologies and accessible treatments that will lead to better access and faster, more efficient treatment

# **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment

## Case for change

- North West London has among the worst rates of cervical and bowel breast screening nationally and poor uptake in HPV vaccination rates
- Bowel screening rates are significantly impacted by deprivation, with a 17% difference in participation between high and low deprivation; Cervical screening rates also differ by age, with women under 30 least likely to receive cervical screening
- Early stage diagnosis has significant benefits in terms of 5 year survival and this is a significant focus. There is a 10% difference in early stage of diagnosis in the boroughs with the earliest and latest stage diagnosis
- We know that there is a strong correlation with deprivation with a 7.4% difference in early stage diagnosis between the least and most deprived population.
- There is rising demand for people with suspected cancer, and those requiring treatment for cancer means we have to plan now for the future.

# **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment

## What do we want to achieve? (i)

| Priority area | Sub priority | Target date | Outcomes | Dependencies | Owner |
|---|---|---|---|---|---|
| **Prevention** | HPV vaccination | 2026 | • HPV uptake in school age children improved from bottom to middle compared to other England boroughs | • Public health agreement PGD that enables efficient delivery | • Public Health |
| **Early diagnosis** | Screening | Continuous improvement commencing 2024/25 | • Reduced variation in screening uptake from national screening programmes (cervical and bowel)<br>• Increased proportion of early-stage cancer "stage shift" in lung cancer diagnosis | • Regional screening teams and hubs<br>Primary care<br>ongoing funding for Targeted Lung Health Checks (TLHC) | • NSP- Joint working between Regional screening team/ ICS/ RMP Partners (West London Cancer Alliance)<br>TLHC- RMP |
| | Symptomatic presentation | 2028 | • Variation of stage of diagnosis at borough level reduced by 8%, by addressing inequalities and variation<br>• Reduction of number of people diagnosed with cancer in emergency settings | • Borough based partnerships | • RMP, working with Primary care and places team, specifically in Brent in 2024 |
| **Faster diagnosis** | | 2024/5 onwards | • Delivery of the Cancer Faster Diagnostic Standard | • Acute Provider Collaborative and Specialist Trusts | • RMP via Acute Provider Collaborative membership |
| | | | • Delivery of the National Aspiration for 31 and 62 day treatment target | | |

# **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment

## What do we want to achieve? (ii)

| Priority area | Sub priority | Target date | Outcomes | Dependencies | Owner |
|---|---|---|---|---|---|
| **Treatment and care** | | Continuous improvement commencing 2024/25 | • Adoption of new technologies and accessible treatments that will lead to better access and faster, more efficient treatment<br>• Reduction in waits in genomic lung pathway | • Acute Provider Collaborative and Specialist Trusts<br>BRC's and availability of novel approaches | • RMP/ BRC's |
| **Enabling functions** | Workforce | 2028 | • Better recruitment and retention of nurses & AHP's, through the North West London Integrated Recruitment Hub with support for retention delivered by the North West London Health & Social Skills Academy | • Acute Provider Collaborative, Radiotherapy operational delivery network | • RMP Partners (West London Cancer Alliance)<br>• Radiotherapy operational delivery network |
| | Digital and data | 2028 | • Use of population health data to support interventions to improve early diagnosis, particularly in more deprived and ethnic minority communities<br>• More efficient use of clinical decision tools | • Health Equity ICB programme | • WSIC team<br>Primary care team<br>Acute Provider Collaborative tech team |

# **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment

## How are we going to achieve our outcomes?(i)

| | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|
| Early diagnosis | • Targeted Lung Health checks (TLHC) - ensure all high-risk wards are invited in 2024, and ensure opportunities to stop smoking are harnessed | • Continued rollout of TLHC into eligible population | • Continued rollout of TLHC into eligible population as age extension |
| | • Targeted population campaign to group less likely to receive bowel screening- Men | • Support age extension awareness in all populations, focussing on known groups who do not engage | |
| | • Focus community links support on Brent population to increase screening rates with real time coverage of rates | • Focus on delivery of breast screening pathway improvement and support new contract holder in delivering equitable service | |
| | • Agree actionable approaches through a series of Co-production events with the Black community, reduce population differences in the access to help and information for concerns around Prostate Cancer, focussing on Brent population<br>• Adopt EBI policy which empowers men at increased risk of prostate cancer to have conversations with their GP about Prostate Cancer and creates a better shared decision making process | • Spread adopt and personalise approaches to our wider population in North West London, focussing on next two boroughs | • Spread adopt and personalise approaches to our wider population in North West London, focussing on boroughs as rolling programme |
| | • Focussed support to Brent Primary care increase early diagnosis | • Focussed support to Ealing and Hammersmith and Fulham primary care to increase early diagnosis | • Focussed support to other boroughs as rolling programme and consolidate approaches across network |
| | • Trial earlier approaches to earlier detection (e.g. multi cancer early detection tests) | • Continue trialling emergent early diagnosis approaches, ensuring spread and adoption of useful technology | |
| Faster diagnosis | • Deliver and maintain national performance requirements 77% FDS target and treatment target in North West London at Trusts by end of Q4 2024/5 | | |
| | • Support Trusts to deliver models of cancer diagnostic approaches based on best evidence and reduce inequalities focussing on:<br>- gynaecology, lung and head and neck<br>- embedding urology<br>- working in partnership with endoscopy networks | • Embed:<br>- gynaecology, head and neck and lung, endoscopy<br>- supporting other tumour specialities | • Support other tumour specialities |
| | • Support approaches to non cancer pathways (breast and gynae) that will relieve pressure on cancer pathways through developing integrated community models | • Support approaches to non cancer pathways- breast and gynae specifically that will relieve pressure on cancer pathways through developing integrated community models<br>• Ensure breast model is BAU | |

# **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment

## How are we going to achieve our outcomes? (ii)

| | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|
| **Treatment and care** | • Map access and capacity of chemo and treatment across North West London and develop workforce plan to support areas of concern | • Implement new models of systemic anti-cancer therapy (SACT) approaches on pilot basis | • Spread and adopt new models of chemotherapy provision |
| | • Implement Radiotherapy physics apprenticeships at Imperial, and Radiographer training supervisor post at Royal Marsden to support and retain staff in training | • Spread and adopt apprenticeship model if successful, and implement next workforce approach | |
| | • Implement improvement in the genomics pathway for lung cancer to increase speed to treatment between RMH and Imperial | • Spread approach trialled in x1 centre to other centres | |
| | • Continue to audit against best practice and NICE guidance for treatment, implement any changes required to standardise practice via tumour groups, MDTs and Trusts | | |
| **Enabling functions: Workforce** | • Implement recommendations from workforce programmes, and ensure BAU approach exists | | |
| | • Implement NHS England's Aspirant Cancer Career and Education Development (ACCEND) programme and novel ways of recruiting and retaining nurses & AHP's | | |
| | • Implement clinical nurse specialist support programme | | |
| | • Model demand and capacity requirements, and understand inequality impacts | | |
| **Enabling functions: Digital and data** | • Share performance data and forecasts to enable system-wide | | |
| | • Testing and use of Apps and Technology and AI to improve cancer pathways (breast and haematology)<br>Implementation of a surveillance system for gastrointestinal cancers | • Testing and use of Apps and Technology and AI to improve cancer pathways (other cancers) | |

# **PRIORITY 9:** Transform the way planned care works

## Case for change

### Summary

A major priority since Covid-19 has been to reduce the backlog of patients who are waiting for specialist appointments and procedures. In order to do this, we need to increase activity to above historic levels. While there have been significant increases in the clinical workforce, activity hasn't increased in line with this. So our immediate priority is to increase productivity, in order to reduce elective long waits and backlogs and improve performance against the core diagnostic standard. Examples of process improvements to achieve this include reducing follow up outpatient appointments with no procedure, fully validating waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups.

The increase in demand also has an impact on our workforce. We have mitigated some of this with agency staffing, but we need sustainable staffing models where we can maximise productivity and offer rewarding jobs. We are exploring alternative ways of working, prioritising the North West London Elective Orthopaedic Centre implementation; Ophthalmology Hub and the new Community Diagnostic Centres.

Success will require digital transformation – this includes the effective use of the Care Co-ordination Solution, which provides joined-up visibility of patient and service needs, where the patient is in the pathway and innovative tools to support making the most of our capacity, it will include new care models, such as virtual clinics and remote monitoring, and it will mean driving improvements to information exchange with patients.

Transforming services is not just about improving productivity in acute settings – it will also mean reviewing clinical pathways to move services out of the acute sector into the community, delivered through our neighbourhood teams and backed up by efficient and timely access to specialist expertise.

The Acute Care Collaborative strategy – to be published in summer 2024 – will set out in more detail how the acute trusts will work together to transform elective care pathways.



### ICB challenge

- Long waits for elective care and diagnostics leads to worse outcomes and a poor patient experience, impacting their physical and mental health and wellbeing, work and financial stability and relationships
- Staffing challenges leads to staff burnout, a hard to recruit workforce and high agency pay
- Too many patient initiated follow up appointments return to primary care, which is frustrating for patients and increases the burden for clinicians
- Primary care clinicians report that they are unable to access consistently timely advice and guidance from specialists
- There is a growing consensus that long waits worsen health inequalities – poor communications mean the patient is less likely to attend the appointments (DNAs) and a longer care pathway and late presentations mean that the condition may have progressed further at the point they are referred

### Outcomes / Impact

- Elimination of waits over 52 weeks for elective care (initially 62 weeks)
- Reduction in avoidable outpatient referrals and activity
- Improved MDT working across Primary and Secondary care
- Effective use of Advice and Guidance from primary care clinicians
- Reduction in Follow Up Outpatient Attendances without procedure
- Increase in percentage of patients who receive a diagnostic test within six weeks
- More meaningful and effective communications with patients, leading to fewer DNAs and a better patient experience
- More productive use of estate
- More productive use of resources across the system
- Increase staff satisfaction, reduction in staff burnout

# **PRIORITY 9:** Transform the way planned care works

## Summary

A major priority since Covid-19 has been to reduce the backlog of patients who are waiting for specialist appointments and procedures. However, as waiting lists have been growing since even before the pandemic, we need to increase activity to above historic levels. Our immediate priority is to increase productivity, in order to reduce elective long waits and backlogs and improve performance against the core diagnostic standard. Examples of process improvements to achieve this include work to improve throughput and theatre utilisation for elective surgery and diagnostics, validating waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups.

Although we have increased our workforce in North West London, we have not maintained productivity at the same level to meet increased demand. We have mitigated some of this with agency staffing, but we need sustainable staffing models where we can maximise productivity and offer rewarding jobs. We are exploring alternative ways of working, prioritising the North West London Elective Orthopaedic Centre implementation; Ophthalmology Hub and the new Community Diagnostic Centres.

Success will require digital transformation – this includes the effective use of the Care Co-ordination Solution, which provides joined-up visibility of patient and service needs, where the patient is in the pathway and innovative tools to support making the most of our capacity, it will include new care models, such as virtual clinics and remote monitoring, and it will mean driving improvements to information exchange with patients.

Transforming services is not just about improving productivity in acute settings – it will also mean reviewing clinical pathways to move services out of the acute sector into the community, delivered through our neighbourhood teams and backed up by efficient and timely access to specialist expertise.

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# **PRIORITY 9:** Transform the way planned care works

## Case for change

- Long waits for elective care and diagnostics leads to worse outcomes and a poor patient experience, impacting their physical and mental health and wellbeing, work and financial stability and relationships. At end February 2024, there were 296,892 patients in North West London waiting for an outpatient appointment and 454 waiting more than 78 weeks.
- Staffing challenges leads to staff burnout, a hard to recruit workforce and high agency pay.
- Poor pathways mean that there is too much avoidable follow up activity, including unnecessary clinical referrals, and many follow up appointments that are patient initiated return to primary care which is frustrating for patients and increases the burden for clinicians.
- Primary care clinicians report that they are unable to access consistently timely advice and guidance from specialists.
- There is a growing consensus that long waits worsen health inequalities – poor communications mean the patient is less likely to attend the appointments (DNAs) and a longer care pathway and late presentations mean that the condition may have progressed further at the point they are referred.

# **PRIORITY 9:** Transform the way planned care works

## What do we want to achieve? (i)

The domains and outcomes below reflect an initial prioritisation; the Acute Provider Collaborative will publish a more detailed overview of their activities, intended outcomes and how they intend to phase them over the coming years.

| | Sub priority | Target Date | Outcomes | Dependencies | Owner |
|---|---|---|---|---|---|
| **Quality** | **Communications with patients** | 2025/26 | • Better patient experience through more targeted, accessible communications with patients<br>• More self management | • Borough based partnerships<br>• NHSE London and other national NHSE teams<br>• Providers | • NW London ICB<br>• Acute Provider Collaborative<br>• Community collaborative |
| | **Population health and advice** | 2026/27 | • Improved health outcomes through supporting MECC, prehabilitation and continuing being well through recovery | | |
| **Elective Recovery & Access** | **Drive elective productivity** | 2024/25 | • Elimination of waits over 52 weeks for elective care (initially 62 weeks)<br>• Reduction in avoidable outpatient referrals and activity<br>• Improved MDT working across Primary and Secondary care | | |
| **Outpatients Transformation** | **New care models** | 2027/28 | • More care closer to home in primary care through better access to specialist expertise in primary care<br>• More efficient use of primary care resources through a more effective approach to “patient initiated follow ups”<br>• Better use of estate, more productive workforce and increased patient satisfaction through use of digital clinics | | |
| | **Productivity** | 2024/25 | • More activity through more efficient utilisation of resources, increasing activity and booking<br>• Reduction in Follow Up Outpatient Attendances without procedure | | |
| | **Diagnostics** | 2025/26 | • Expansion of GP Direct Access to new modalities<br>• Increase in percentage of patients who receive a diagnostic test within six weeks through maximising use of CDCs | | |

# **PRIORITY 9:** Transform the way planned care works

## What do we want to achieve? (ii)

The domains and outcomes below reflect an initial prioritisation; the Acute Provider Collaborative will publish a more detailed overview of their activities, intended outcomes and how they intend to phase them over the coming years.

| | Sub priority | Target Date | Outcomes | Dependencies | Owner |
|---|---|---|---|---|---|
| Enabling functions | **Workforce** | 2026/27 | • Better and more productive utilisation of staff<br>• Increase staff satisfaction, reduction in staff burnout<br>• Reduction in agency staff expenditure | • Wider workforce programmes<br>• NHS England | • North West London People Board with oversight by the Joint Lead Chief People Officers |
| | **Digital and Data** | 2024- 25 | • Effective usage of Care Co-ordination Solution for Elective Care across the APC, migrating to the national NHSE Federated Data Platform. | • Funding model for Federated Data Platform and local implementation<br>• Discharge hubs | • ICB digital transformation Board<br>• APC tech team |
| | | 2026-27 | • Real time clarity of demand, capacity and patient flows across the APC enabling accurate clinical and service decisions<br>• Technological/ pathway solutions to optimise discharge coordination | | |
| | **Estates** | 2027/28 | • Effectively utilised estate, designed to support the needs of patients and the services delivered in them | • Input and engagement from Boroughs, Programmes and Trusts | • TAP, Estates Board & respective internal ICB Scheme of Delegation |

# **PRIORITY 9:** Transform the way planned care works

## How are we going to achieve our outcomes? (i)

The domains and activities below reflect an initial prioritisation; the Acute Provider Collaborative will publish a more detailed overview of their activities, intended outcomes and how they intend to phase them over the coming years.

| | Sub priority | Focus year | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|---|
| **Provider strategy** | | **Y1** | • Develop, publish and commence delivery of North West London acute provider collaborative strategy | • Work to deliver the published strategy | |
| **Quality** | **Communications with patients** | **Y2** | • Activities to improve communications with patients to reduce DNA, including patient education, use of language, provision of languages other than English | • Activities to support MECC, prehabilitation, continuing being well through recovery<br>• Better use of NHS App | |
| | **Population health and advice** | **Y2-3** | • Implement new national patient safety strategy (incl PSIRF) | | • Best practice approaches to reduce inequalities in outcomes across elective care taking a population health management approach |
| **Elective Recovery & Access** | **Drive elective productivity** | **Y1** | • Demand and capacity modelling<br>• Increase theatre utilisation – maximising time used and any one time<br>• Increase number of throughput per list<br>• Review length of stay (day case rather than inpatient)<br>• Standardisation of pathways working with CRGs | • Development of a long term commissioning model that encourages North West London standard delivery of services, making best use of hub & spoke services | |
| **Outpatients Transformation** | **New care models** | **Y2-3** | • Development and better use of Advice and Guidance platform. | • Trialling and rollout of automated triage pathways in a number of specialities<br>• Innovation of workforce models (nurse led clinics) | • Focus on care in most appropriate setting through transformation of clinical pathways, moving closer to home |
| | **Productivity** | **Y1** | • Activities to increase productivity, including appointment scheduling, clinical workflow<br>• Focus on reduction of avoidable follow up activity, including through continued development and implementation of PIFU pathways across specialties | | |
| | **Diagnostics** | **Y2** | • Embedded diagnostic centres<br>• Review triage and criteria for direct access diagnostics | • Drive efficient use of diagnostic centres | |

# **PRIORITY 9:** Transform the way planned care works

## How are we going to achieve our outcomes? (ii)

The domains and activities below reflect an initial prioritisation; the Acute Provider Collaborative will publish a more detailed overview of their activities, intended outcomes and how they intend to phase them over the coming years.

| | Sub priority | Year 1 | Year 2 | Year 3+ |
|---|---|---|---|---|
| **Enabling functions** | **Workforce** | • Delivery of diversification of routes into employment and new models in work streams that address known shortfalls using North West London Integrated Recruitment Hub | • Scope workforce elements to drive system wide new ways of working in support of new models of care | • Use new roles, new ways of working and competency-based approaches to transform the workforce in line with service models |
| | **Digital and Data** | • Implement the local Care Co-ordination Solution for Elective pathways across the whole of the APC.<br>• Pilot a technological / pathway solution to optimise discharge coordination | • Scale up technological / pathway solution to optimise discharge coordination to 50% sites | • Data available to enable top-down management of demand, capacity and patient flows across the APC |
| | **Estates** | • Rolling programme on major projects including developing hubs and national programmes (e.g. CDCs)<br>• Support for new hospital programmes | | |

# Section 3: Our enabling teams

# Our digital and data strategy underpins our programme of business and clinical transformation

The aim of the NW London ICS Digital and Data Strategy is to deliver the digital and data enablement needed to underpin the ICB's programme of business and clinical transformation; and to support the objectives to sustain a stable and secure ICT infrastructure, improve providers' digital maturity, implement shared records across health and care settings and use them for better integrated care, share data with citizens to help them manage their own health and care, harness data and use it intelligently to improve population health and reduce inequalities, and take advantage of digital healthcare innovation.

| Workstream | Description | Outcomes / Impact | Activities in 2024/25 | Activities from 2025/26 |
|---|---|---|---|---|
| ICT Infrastructure | Level up our organisations to modern levels of cyber security and resilience, to ensure our systems, staff and service users are protected from risks; and address technical debt that has built up over time because of underinvestment. | Our strategic ambition is to provide ICT infrastructure that gives staff seamless access to digital records from wherever they are located. | • Develop ICB Cyber Security Plan by end 2024/25 (dependent on NHS England funding for cybersecurity)<br>• Implement ICT Infrastructure Plan over the period to 2028/29, including deployment of Microsoft M365 | |
| Acute EPR Enhancement Programme, including Digital Diagnostics | Standardise the way in which we use our EPR to minimise variation in patient pathways and support new initiatives as well as rationalising clinical system contracts. | Effective and efficient delivery of care requires recording it in a digital format, structuring and coding records to enable sharing, transfers of care and analysis. | • Ongoing programme to enhance Cerner EPR, specialist clinical systems, radiology and pathology systems to increase digital maturity and reduce variation across the APC, over the period to 2028/29 (dependent on Trust Capital and NHSE Frontline Digitisation funding). | |
| Community and Mental Health EPRs | Enhance EPR systems for Community and Mental Health Trust core activities | Improved digital maturity, better support care for delivered by clinicians and increased integration between services. | • Ongoing programme to enhance SystmOne, EMIS Community and RiO clinical systems, to increase digital maturity and support the strategy of the Collaboratives over the period to 2028/29 (dependent on Trust Capital and NHSE Frontline Digitisation funding). | |
| Primary Care EPRs | Support and enhance Primary Care EPR systems in response to clinical needs. | Better neighbourhood working and improved integration between primary care and other settings. | • Enhancement of Primary Care systems in line with Primary Care and INT definition of requirements (dependent on specification by Boroughs and INTs, may require ICB funding). | • NW London's Primary Care EPRs must be re-procured by the end of 2025/26. |
| Primary Care Digital Transformation | Promoting the implementation, understanding and improvement of digital tools within general practice, particularly in relation to improving patients' access to GP services. | - Improved access to care, digital inclusion and reduction of inequalities through technologies<br>- Improved Patient experience at the centre of selection and implementation | • Detailed outcomes and timescales will depend on funding from NHSE and/or NW London ICB for 2024/25 and subsequent years, which is still to be determined. | |
| Data Sharing - London Care Record | Continued deployment of London Care Record | Clinicians able to see patient records from other settings in NW London and other parts of London (e.g. for the 15-20% of our patients treated by out-of-area acute providers). | • Deploy London Care Record to all remaining healthcare settings by end 2024/25. At the same time start to tackle data quality issues, including standardisation of coding. | • Enhance London Care Record to include social care (will require NHSE London funding)<br>• During the period to 2028/29, plan and implement the transformation required to make use of shared records across multi-disciplinary patient pathways |
| Digital Patient Empowerment | Many people want to understand their care better, to help them stay well; many want to manage their interactions with the care system using more efficient digital apps; though some people cannot, or do not want to, use digital channels. | Through user-centred design, transform patient and service users' interactions via digital tools to improve efficiency and outcomes, including online appointment management and patient-initiated follow-up. | • Extend Acute Patient Empowerment self-service capabilities<br>• Deploy Care Information Exchange to all remaining settings – including social care – and recruit beyond 660,000 to include most of the people in NW London.<br>• Develop strategy for patient-facing systems across ICS | • From 2025/26 extend Patient Empowerment beyond Acute to Community and Mental Health settings.<br>• Rationalise the different patient-facing systems to give citizens a more consistent experience. |

# Our digital and data strategy underpins our programme of business and clinical transformation

| Work stream | Description | Outcomes / Impact | Activities in 2024/25 | Activities from 2025/26 |
|---|---|---|---|---|
| Digital Support for Integrated Care (including Federated Data Platform) | The ICS needs better tools to support demand and capacity management. Integrated pathways require health and care professionals to work together more effectively using shared records. | • Data available to enable top-down management of demand, capacity and patient flows across the ICB, and clinical and service decision-making.<br>• The national NHSE Federated Data Platform, building on our local Care Co-ordination Solution, will span pathways across organisations.<br>• Multi-disciplinary integrated care pathways spanning health and social care settings will be enabled via shared digital care records, tasks and plans. | • Complete migration from Care Co-ordination Solution to Federated Data Platform<br>• Further development of Federated Data Platform to support APC and wider ICS<br>• Digital support for ICS Transformation Programmes to implement multi-disciplinary integrated care pathways in line with INT requirements which are yet to be confirmed (Shared records and transformation across care settings likely to require ICB and NHSE funding) | • Future milestones to be confirmed in line with agreed ICB programme requirements and pending NHS governance and funding |
| | | | | |
| Population Health Data and Intelligence | Our Whole Systems Integrated Care (WSIC) data base already contains records from all NW London health and social care settings, covering 99% of the population. There is ongoing work to link the quantitative data with qualitative data generated from patient engagement. Additional data feeds will further enhance the platform. | • Support for Health Equity objective to reduce inequalities<br>• Single source of information for place-based partnerships for their population health management projects and cohort identification for intervention.<br>• Better intelligence and needs analysis through use of qualitative data and other data feeds.<br>• Extension of WSIC to the whole of London for population health management and clinical research purposes via Sub National Secure Data Environment. | • Migration of WSIC to a modern cloud platform to enable more cost-effective and reliable pathway analysis and commissioning decisions.<br>• Integrating WSIC into clinical workflows to help apply data analysis to individual patients and cohorts.<br>• Further development of reporting tools in WSIC to support teams, helping them identify inequalities and areas of need.<br>• Implementing further feeds (e.g. Children's Social Care data and VCSE data)<br>• Enabling data feeds from FDP to flow into WSIC.<br>• Further development of an easy to use front-end for Primary Care and other care settings to case-find patients.<br>• Further development of NW London Data Strategy. | |
| | | | | |
| Digital Innovation in Health and Care | We want to make use of new technology innovations and research, to improve care and patient experience. We need to exploit process automation technologies to improve our back-office processes and deliver care more efficiently. | • Innovative technologies (e.g. learning systems and AI; process automation) will be applied regularly to support clinical decision making.<br>• New, transformational models of care will be made possible by digital innovations such as ambient documentation. | • Establish the principles, approach and governance mechanism for the evaluation, implementation and exploitation of Artificial Intelligence in NW London.<br>• Continue the programme of innovation to support Primary Care Access through Digital Transformation.<br>• Continue the pilots of Robotic Process Automation to improve the efficiency of back-office processes | • Future milestones to be confirmed in line with agreed ICB programme requirements |
| | | | | |
| Digital Workforce | Digital Workforce Plan - for digital professionals and care professionals using digital and data | • Increase retention and effectiveness of digital workforce<br>• Free up staff time and improving the efficiency of services.<br>• Improve accuracy and efficiency in diagnostic services and administrative processes. | • Develop a Digital Workforce Plan for ICB, covering digital professionals (to be mandated by NHSE) and reflecting the need of the clinical and business workforce to use digital systems and data effectively as part of their roles (Trust investment in resources will be required). | • Implement Digital Workforce Plan. |
| | | | | |
| Digital Clinical Safety | ICS-wide clinical systems must have clinical safety built in as a fundamental requirement | • Assure the quality and safety of clinical systems and data in providing care | • Recruit a Digital Clinical Safety Officer to support ICS-wide clinical systems (funded by a levy on NHSE Frontline Digitisation funding to Trusts) | • Will require ICB funding from 2025/26 onwards |

# Our workforce plan supports each priority and will make North West London a great place to work

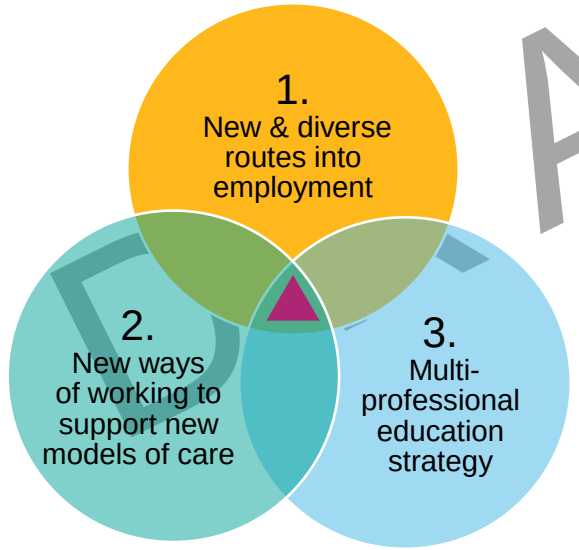
**Our ICS workforce priorities** are grouped together into two strategic intentions:

**A great place to work** by bringing together our ICS wide collective **recruitment** and **retention** initiatives to ensure availability of the workforce capacity required, minimise attrition and maximise the capability of the registered and non-registered workforce.

**Transform for the future** by conducting strategic workforce planning within 'collaboratives' and 'place', informed by modelling and forecasting to support **new ways of working,** improved workforce planning, efficiency and productivity and to maximise the opportunities afforded by **digital and technological innovations.**

These align to the NHS Long term workforce plan. **'A great place to work'** speaks to 'Recruit: Grow the workforce' and 'Retain: Embed the right culture and improve retention'. Whilst '**Transform for the future**' is our approach to 'Reform: Working and training differently'.

We have identified at system level, **three high impact programmes**, two that fit with the two workforce strategic intents within the ICS strategy; and a third which addresses the development and delivery of a clear vision and delivery plan for education and training in NW London. Each ICB has a duty to promote education and training as an essential lever of an integrated workforce plan:




Strategic workforce planning is central to all three programmes

We will focus on NW London challenges and opportunities but with alignment with NHS Long term Workforce Plan requirements

## 1. Expand and diversify routes into employment

At system level, we will maximise the investment in the Health and Social Care Skills Academy to raise awareness of health and care roles, create more diverse entry routes; focus on key system wide retention initiatives; and design skills programmes. Key initiatives include:

- Recruitment to the top five hard to fill, high impact roles that are a core driver for temporary staffing usage
- Provide a pipeline of staff into our entry level roles, to enable progressive employment with career pathways
- 100% of NW London's NHS Trusts to be fully accredited as London Living Wage employers
- Recruit 50 Senior carers into roles across 8 boroughs; 70 refugees and 50 volunteers into employment across health and social care by March 2025

## 2. New ways of working to support new models of care

The lack of staff to fill traditional roles, high temporary staffing costs and the need to maximise productivity require us to re-design roles, teams and staffing structures to improve productivity through a more efficient use of skill mix within teams. There is a two phased approach, key initiatives include

- The **first phase** covers the current known priorities: including the NW London EOC initial launch, Ophthalmology hubs, and Community Diagnostics centres.
- Supporting the key workforce deliverables for the community nursing collaborative and supporting the delivery of the mental health strategy and transformation .
- The **second phase** will be to scope the workforce elements of the system wide ICS programmes to enable new ways of working in support of new models of care
- Improve capability of staff in making best use of digital systems towards more data-driven decision making
- Create and implement a productivity tool

## 3. Multi-professional education and training strategy

The NHS long term workforce plan signals a significant expansion to fund additional education and training places. Each ICB also has a duty to promote education and training as an essential lever of an integrated workforce plan. Key initiatives include:

- Develop an education strategy that sets out a clear vision for education and training
- Launch the NW London Graduate Leadership scheme
- Set up a NW London undergraduate placements scheme to fill hard to recruit roles.
- Develop an ICS Oliver McGowan Mandatory Training Hub

# Our Estates strategy seeks to make best use of all community assets in delivering our ambitions for integration

## Our NW London ICS Estates Strategy

We have recently revised the North West London ICS Estates Strategy. Through this it is outlined that we seek to improve the use of key primary & community care sites; support the transformation of mental health services; improve accessibility and fitness-for-purpose of primary and community sites; support PCN and ICP delivery; delivery an achievable and affordable capital pipeline of projects; improve trust estates performance measures; support the delivery of North West London's Covid Recovery Plan' and process plans for affordable housing for healthcare staff.

We will deliver this by providing primary care at scale, delivering from hub locations in all of our boroughs; reducing our void and using space effectively and efficiently; managing a reduced footprint of fit-for-purpose estate and making best use of technology and hybrid working best practice; working collaboratively without internal and external partners.


## Our delivery principles

In delivering our Estates strategy we aim to deliver according to four important principles:

1. **Our estate is designed to support services and patients**

   Buildings support/facilitate services which respond to the needs of the local population and is service led.

2. **Our buildings are effectively utilised**

   Every building meets a set of core standards (85% clinical utilisation rate, Sites open for a minimum of 10 hours every weekday, and 5 hours on a Saturday for 50 hours p/a, Virtual consultations accounting for around 27% of total consultation rate (growing to 45% by 2040), An overall contract rate (contracts per patient per year) of 7.5 used for primary care activity, No void/unused sessional space – active management of flexible sessional space, Clinical rooms prioritised for face-to-face appointments.

3. **Our buildings are integrated**

   All buildings with best design for integrated working, improved efficiency and multi-agency.

4. **Our investment is focused on estate important to us in the long-term**

   Investment (DCC, IPC, building survey conditions, patient experience, NZC) prioritised in sites which are long-term integrated solutions.

# Our Estates strategy seeks to make best use of all community assets in delivering our ambitions for integration

| Description | Activities in 2024/25 | Activities from 2025/26 |
|---|---|---|
| **Business-as-usual (BAU) Schemes** | | |
| The ICB has already identified a minimum of 40 BAU schemes in need of address. The programme will implement a system for governance and resource allocation to prioritise, oversee and support local BAU schemes across the ICS. | Ongoing BAU activity | |
| **Digitisation of Records** | | |
| This programme will support Technology teams with ongoing digitisation of records to free up additional space across NW London ICB estate which can be re-allocated to in-demand services and other clinical activity. | • Digitisation of records across Community and Primary Care Estate in collaboration with IT. Will also include conversion where possible of space into clinical, consulting or administrative space. | |
| **Infrastructure Planning and Delivery** | | |
| This work involves the development of individual Borough Infrastructure Delivery Plans (IDPs) developed with key internal and external stakeholders (e.g. LAs). It further includes responding to large-scale planning applications and bidding for, securing, allocating and drawing down funding across a number of North West London schemes. | • Responding to large scale planning applications<br>• Revising every boroughs Infrastructure Delivery Plans with Local Authorities and ICS stakeholders (incl. Trusts/Borough Leads)<br>• Overseeing S106 and CIL funding and bidding | |
| **London Improvement Grant** | | |
| Annual programme of work which seeks to identify GP practices in need of external NHSE capital funding to improve condition of estate as aligned to Six Facet Survey / Estate Strategy data and the Equality Act. Successful schemes receive a 33% reimbursement. | Allocating national LIG funding to GP sites across NW London and monitoring delivery/expenditure with the London Estates Delivery Unit | |
| **Major Projects** | | |
| These schemes offer significant space e.g. from void and unused bookable space, provide opportunities for urban expansion, and offer potential financial savings that can be reinvested back into the NHS. These also focus on developing hubs, increasing primary care-at-scale offerings and supporting national programmes (e.g. CDCs). | • HQ Rationalisation Activity<br>• Alexandra Avenue Hub Optimisation<br>• Community Diagnostic Centres - Ealing<br>• Chiswick Health Centre Rebuild<br>• Grand Union Village GP expansion<br>• The Old Vinyl Factory<br>• Wembley Park Practice GP Scheme<br>• Hillcrest Surgery Relocation<br>• South Kilburn GP Scheme<br>• Golborne Medical Centre / Kensal Road | • Heart of Hounslow Hub Optimisation Project<br>• Alperton Health Centre<br>• Northwood & Pinner<br>• Nestle<br>• North Ealing Hub<br>• Southall Gasworks & Park Avenue<br>• Beaufort House - Uxbridge Hub development<br>• Newcombe House<br>• OPDC related projects, including Willesden CFH Moves. |
| **New Hospital Programme** | | |
| Supporting the development of the two new hospital development programmes in Hillingdon & Imperial. | - | - |
| **Right Size, Right Place** | | |
| Assesses space across NW London estates and encourages boroughs to work together to use space more effectively and collaborative. Leases will be proactively reviewed, helping to inform decision-making and current and future use of space and business case proposals, whilst highlighting circumstances where it may be appropriate to surrender leases or close single GP practices in favour of utilising vacant space to enhance at-scale delivery. | • Lease negotiations and relocations of Hounslow, Brent, Hillingdon, Harrow and Ealing Borough Teams into new HQ premises<br>• Renting of flooring space of Marylebone Road | • GP, NHS PS and CHP proactive lease management |
| **Void Management** | | |
| A joined up void, sessional and unused bookable space programme of work designed and delivered in collaboration with other NHS property companies and stakeholders. Includes bringing void space back into use for clinical, consulting or administrative activity; handing back no longer fit-for-purpose sites; and transferring space to the 'Open Space' booking system where possible to generate additional revenue for the ICB. | • Handback of Wealdstone Health Centre<br>• Strategic Review of all unused void, bookable and sessional space<br>• Scrunitinising Annual Charging Schedule Costs with NHS PS and CHP | • Full or partial handback of The Meadows Health Centre<br>• Ongoing void reduction at a number of sites, including: Jubilee Gardens, Feltham Centre for Health, St Charles and South Westminster |

# The views and experiences of our local residents are a key factor in shaping the success of our priorities

The NW London communications and involvement team are key in the successful delivery of many of the priorities, whilst balancing the delivery of their own. Their key areas of focus are outlined below:

| Work stream | Description | Expected outputs |
|---|---|---|
| **Insights into action** | Programme to combine resident insights with other data and ensure central to decision-making. | • Plan developed with BI, ICHP, Population Health and other teams<br>• Biannual insight/data reports to ICB Board, programmes and partners<br>• Strong focus on specific metrics: reduction of patients not attending appointments; reduction of unnecessary A&E attendances; uptake of vaccination/screening |
| **Keep it Simple** | Communications campaign to simplify use of language across ICB and then wider ICS | • Publication of ICB guidance, 'Plain language' approach to ICB website and publications<br>• Involvement of residents, e.g. via a reading group, Rollout to wider ICS including consistent use of terminology |
| **Delivery of ICB involvement strategy** | A range of activities including: Community outreach, Community insight reports, Resident and patient forums and Lay partner programme | • Range of activity planned quarterly |
| **Corporate communications** | A range of activities including: Public communications, Public health messaging, Staff communications, annual report, ICB website, ICS/ICB publications, FOI and Media relations | • Range of materials as required |
| **Equality, Diversity and Inclusion** | Deliver EDI strategy, Ensure ICB meets and Public Sector Equality Duty | • Implementation of first stage of EDI strategy, including Race Equality strategy, Clear system for ensuring EHIAs take place when changes proposed and Ensure involvement strategy reaches groups with protected characteristics |



For each identified North West London priority, the Communications and Involvement team will organise support as follows:

| | How communications and involvement will support our NW London priorities |
|---|---|
| **PRIORITY 1:** Improve health outcomes through Population Health Management | • Continued communication of population health approach including strategic advice and specific support to initiatives<br>• Key metrics to be applied to ICB communications and involvement team. |
| **PRIORITY 2:** Improve Children and Young People's Mental Health and Community Care | • Involvement of children, young people, parents and schools<br>• Development of communications materials |
| **PRIORITY 3:** Establish Integrated Neighbourhood Teams (INTs) | • Maximise understanding and involvement across system and communities |
| **PRIORITY 4:** Improve mental health services in the community and for people in crisis | • Publication and communication of mental health strategy<br>• Communicating decisions on Gordon/Hope and Horizons proposals<br>• Resident involvement on mental health strategy |
| **PRIORITY 5:** Embed the core community offer and maximise productivity | • Involve residents in developing standardised services<br>• Potential for public consultation where changes proposed |
| **PRIORITY 6:** Optimise patient flow across the system – right care, right place | • ICS winter plan,<br>• Co-design of solutions with residents e.g. primary care changes<br>• Communication of changes to residents |
| **PRIORITY 7:** Transform maternity care | • Support acute provider collaborative with messaging and reaching community groups |
| **PRIORITY 8:** Increase cancer detection rates and deliver faster access to treatment | • Further work with residents and the cancer alliance to address barriers to screening uptake |
| **PRIORITY 9:** Transform elective care pathways | • To be led by Acute Collaborative communications |

# Section 4: Our Provider Collaboratives

# **Who we are –** our Provider Collaboratives

Our provider collaboratives span acute, mental health and community services. These collaboratives are central to delivery of our ICS vision: recovering core services and productivity, delivering a consistent offer for all our residents and meeting operational planning requirements.

NHS
North West London
Acute Provider Collaborative

Our provider collaborative is a formal partnership of the four acute NHS trusts in north west London:

- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- London North West University Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust

Between us, we run 12 hospitals and employ 33,000 staff.

Collectively we have developed a structured approach to collaborative working across the 4 Trusts:

- **"Do it once"** – priorities we can only deliver by working collaboratively together
- **"Do it the same"** – priorities we could chose to deliver as 4 Trusts as it will enhance the efficiency, benefits and/or shared learning
- **"Do it locally"** - Priorities we need to get on and deliver within each of our individual Trusts, while sharing learning

**Our vision:** Our core reasons for collaborating are to improve equities in access, experience and outcomes for our patients and the experiences of our staff across our acute services within North West London.

The acute provider collaborative is currently developing its own strategy (building on the ICS strategy). Publication is anticipated in summer 2024.

**Our areas of focus over the next 5 years include:**

**Quality**

- Clinical harm review, access and inequality
- Infection prevention and control
- Peer reviews of Emergency pathways
- Developing a stronger user insights focus
- Care of the deteriorating patient
- End of life care
- Maternity and neonatal – delivery plan
- Mental health in an acute setting
- Implement new national patient safety strategy including PSIRF and a shared system for incident and risk management

**Finance, Productivity and Performance**

- Delivery of the activity and performance targets in our operational plan
- Support services consolidation
- Discharge planning and reducing medically optimised patient LOS with ICB and collaborative partners
- Improving productivity and financial sustainability
- Outpatient Transformation

**Workforce**

- Reduce premium rate staffing expenditure
- Elective orthopaedic centre workforce transition
- Recruitment hub for hard to fill vacancies
- Career hub and staff transfer scheme
- Increase apprenticeship levy uptake
- Reduce violence, aggression, bullying and discrimination

**Digital programmes**

- Finalise the APC digital and data strategy
- Implementation and optimization of Cerner system
- Improving patient flow and capacity using care coordination solution

# **Who we are –** our Provider Collaboratives

NWL Mental Health, Learning Disabilities & Autism Provider Collaborative

Our Collaborative comprises two NHS Trusts:

- Central & North West London NHS Foundation Trust (CNWL)
- West London NHS Trust (WLT)

We are the delivery arm for transformation of MHLDA services in North West London. Our focus over the next five years is on using a productivity lens to drive consistency of patient outcomes and better manage rising demand. We will be the principal engine of transformation and operational delivery by working with and amplifying the voices of Experts by Experience, clinicians, strategic partners and supporting coalitions to reimagine integrated care pathways across providers and within Borough Based Partnerships, working with them to agree shared priorities and offering high quality, equitable, responsive and more sustainable services.

**Our areas of focus over the next 5 years include:**

**Reduction in unwarranted variation**

Deliver shared offer, improve productivity for and demonstrate improvements to waiting times.

**Crisis and acute demand management**

Improve patient flow, reduce length of stay LOS and minimise use of out of area beds.

**Child and Adolescent Mental Health Services**

Review and improve inpatient and A&E provision, including Learning Disability provision.

**Sustainability**

Work with data, digital and workforce programmes to embed changes.

**Programme and strategy**

Deliver agreed programme priorities and operating plan targets and implement priorities in new strategy.

North West London Community Collaborative

Our Community Collaborative comprises four NHS Trusts:

- Central & North West London NHS Foundation Trust
- Central London Community Healthcare NHS Trust Hounslow & Richmond Community Healthcare NHS Trust
- West London NHS Trust

Our key aims of the Collaborative are to work together to:

- **Drive service consistency** - reducing unwarranted variation for service users
- **Manage operational performance** - transparency and collective accountability
- **Increase collective efficiencies and effectiveness** - benefitting from scale

**Our areas of focus over the next 5 years include:**

**Community Nursing**

Demonstrate community nursing productivity and a core offer

**Community beds**

Mobilise Length of Stay reporting, demonstrate community beds productivity and a core offer

**Neuro rehab**

Uplift and make stroke and neuro service provision equitable and productive across NW London

**Children's Speech and Language Therapy (SLT)**

Mobilise a core offer and realise quick wins

**Digital and data**

Identify and implement a consistent digital offer

**Community Waits**

Reduce children and adults waiting list numbers and develop Community Access Policy

**Productivity**

(1) Podiatry, (2) Community Nursing, (3) Urgent Care Response (4) Children's SLT

**Workforce**

Building capabilities and supporting health and wellbeing

# Section 5: Our Borough Based Partnerships

# Working together at place – our Borough Based Partnerships

We are clear that the key to health and care improvement lies in each of our seven borough partnerships to address the health and care needs of local people. Recently, local health and care partners refreshed local health and care strategies, of a which a core number align with NW London common priorities.

Our local place-based partnerships bring together the NHS, our eight local authorities and public health teams, Healthwatch, voluntary and community sector organisations and local residents to work together to understand and meet local health and well-being needs.

We want to make sure that our Joint Forward Plan and the priorities take proper account of local health and wellbeing strategies.

We have set out local plans, where these align with NW London priorities and can therefore be delivered at scale and additional activities that will be implemented in line with local population needs in agreement with their Health and Wellbeing Boards. As with the priorities, we have set a clear expectation that the plans be deliverable within the resource envelope available.

# **Bi-Borough –** bringing together Westminster, Kensington and Chelsea

**Our Bi-Borough's vision is "People want to live healthy and happy lives to the fullest, in ways they choose, in communities that are safe"**

The Bi-Borough is a partnership between the boroughs of Kensington and Chelsea with Westminster into one partnership team. The bi-Borough's Health and Wellbeing Board published a Joint Health and Wellbeing Strategy across 2023-2033. and has implemented a process of oversight to monitor and assure itself that the priorities agreed in the Strategy are being implemented with an annual update on each thematic area prepared for the Board.

The strategy has is supported by a clearly articulated vision

- Live longer and fulfilling lives.
- Have their mental wellbeing regarded as equally as important as their physical health
- Live in communities that are healthy, safe and with good quality schools, housing and environment.
- Have access to good quality and fair services that meet their needs.

Priorities and annual plans set out in the strategy align closely with the NW London priorities.

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Westminster has **205,100 residents**. Kensington has **143,900 residents**.

About **1 in 4** adults report high levels of anxiety for both Boroughs.

About **1 in 4 children live in poverty** within Westminster and about **1 in 5** live in poverty in Kensington and Chelsea.

**18 years** Westminster has the **highest life expectancy gap** for men, Kensington has the 4th highest life expectancy for women.

**Unemployment is at ~ 5%** across both Boroughs.

**39%** in Westminster and **31%** in Kensington and Chelsea identify themselves as from a Black, Asian and Multiple Ethnic background.

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# **Bi-Borough –** bringing together Westminster, Kensington and Chelsea

## Priorities for Bi-Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Bi-Boroughs resourced through partners

### Integrated Neighbourhood Teams

**Outcomes:** Reduce health inequalities in local population and tackle underlying causes of ill health. Delivered through a number of focused programmes.

#### Adult mental health

- Dementia Assessment and Diagnosis*
- Talking Therapies access rates*
- SMI Physical Health Gloji MIND weight management pilot project*
- Early Intervention and Prevention**
- Overrepresentation of people from the Global Majority detained under the MHA**

#### Care homes

- Implementation of signs of deterioration training across all care homes – Q2 24/25**
- Implementation of personalised care and community connections programme across all care homes – Q4 24/25**
- Development of workforce strategy for care home staff**

#### Healthy weight

- Increased bi-borough primary care prevalence of adults on obesity register**
- Delivery of 3 Change4Life neighbourhood projects**
- Delivery of the Westminster Superzone project**
- Improving living conditions via maximisation of income of people on benefits and work to improve housing conditions**

#### Children and Young People

- Family Hubs Q4 25/26*
- Autism Waiting times Q4 24/25*
- Mental Wellbeing in Schools Q3 24/25*
- Asthma Friendly Schools*
- Speech, Language and Communication Needs Q4 25/26*
- Occupational Therapy Q4 25/26 **

#### Homelessness

- Integrated Care Network services**
- Health and Wellbeing/Seasonal Vaccinations**

#### Primary Care Development

- Primary Care Networks**
- Patient Access & Technology**
- Out of Hospital Services**

#### Hospital discharge

- Pathway 1*
- Pathway 3*
- Mental Health*
- Housing**
- Social Isolation**

#### Vaccinations and Screening

- Covid & Flu Vax**
- Cancer Screening*

### North Kensington Recovery

**Outcomes:**
- Local community-led initiatives, engagement feedbacks, and health data.
- Those affected by the Grenfell Tower fire can feel and express that they have received the right support from the NHS.
- NHS's Regulation 28 responsibilities are fulfilled.

- Supplementary Personalised Health Assessments**
- Future services (2024-9) co-design phase – Q2 24/25**
- Future services (2024-9) transition phase – Q4 24/25**

### Vibrant and healthy communities

**Outcomes:**
- Enhanced delivery of preventative healthcare work
- Minimum 50% uptake of Cervical screening by end Q1 24/25 via identified cohorts
- Additional 35 connector roles in bi-Borough by end Q4 23/24
- Reduced A&E attendances for HIUs by 25% by end Q4 23/24

- Building Voluntary and Community Sector capacity and influence*
- Understanding and measuring impact*
- Community based approaches to address health inequalities*
- Our workforce*

### Enabling functions

**Business Intelligence**

**Organisational Development & Workforce**

**Digital**

**Estates**

# Brent

## About Brent

Brent has published their Joint Health and Wellbeing Strategy for 2023-27. Informed through community conversations it agreed the following priorities:

- Prosperity and stability in Brent,
- Thriving Communities,
- A Healthier Brent.
- A Cleaner, Greener Future,
- The Best Start in Life.

This will be delivered through a number of workstreams, those areas which are supported through delivery with NW London ICB are outlined to the right. Brent's priorities and annual plans set out in the strategy align closely with the NW London priorities.



With a **population of 339,800 (with 500,000 registered patients)** Brent is the seventh most populous London borough.

Brent covers an area of **4,325 hectares**, 22% of this is green space.

**65% of the local population is from Black, Asian and other minority groups** – the second most ethnically diverse borough.

**Brent's median age is 35,** with **22%** of local people are under the age of 18, it has a young population.

**56% of Brent residents were born overseas**, over 149 languages are spoken and 37% of residents do not have English as their main language.

**66%** of residents aged **16-64** are in employment, including **16%** who are self employed.

**27%** of workers earn below the London Living Wage.

# Brent

## Priorities for Brent's Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Brent resourced through partners

### Community

**Outcomes:** focused activities to improve outcomes and access prioritising frailty, respiratory, heart failure, rehab, reablement and care homes, and discharge (BCF).

**Activities**
- Align core offer for community frailty service by September 2024*
- Reduce HF preventative admissions and activity in hospital**
- Improve outcomes and goals following 6-week rehabilitation treatment*
- Reduce A&E attendances from care homes**
- BCF and Discharge*

### Mental Health, Learning Disabilities, Autism and Complex Care

**Outcomes:** several areas of focus including employment, housing, access and demand, complex care and children and young people.

**Activities:**
- Crisis outreach to key neighbourhoods (NW10 and NW2), Community connectors, Community Mental Health Wellbeing and Living Well hubs, Educating and Empowering Communities*
- Neurodiversity for 0-5 *
- Reducing waiting times for ADHD/ASD*
- IAPT - Talking Therapies - All Age*
- Reducing LoS and Rehab for complex care patients*
- Improve access and inequalities in mental health services for children and young people – waiting well initiatives*
- Implementation of THRIVE programme for young people *
- Reduce reliance on specialist CAMHS. Reduce waiting list and waiting times for specialist CAMHS referrals*

### Primary Care

**Outcomes:** focus on primary care access, proactive and planned care, enhanced services, workforce and community pharmacy.

**Activities**
- Development of the Same Day Access Hub with sign posting to appropriate partner organisations*
- Improving management of Proactive and Planned Care at practice level *
- Development the workforce to manage triage and proactively planning for future needs.*
- Communications and Engagement: Empowering patients to manage their own health through the NHS App/self care and peer support**

### Health Inequalities

**Outcomes:** focusing on community involvement, informing and supporting residents, improving access and active community partners.

**Activities:**
- Co-produce and co-deliver local action plans with communities**
- Support people to register with a GP**
- Health education, digital inclusion and peer support groups**
- Co-produce and deliver health and wellbeing events in the community (includes health checks and mental health support) **
- Contact target patient groups on GP lists on the clinical priorities (bowel cancer screening, SMI health checks and hypertension)*
- Award Community Grants to local organisation
- To reduce Health inequalities for children and young people a new work programme and funding streams established**
- To improve uptake and accessibility of key immunisations and vaccines for children and young people**

### Integrated Neighbourhood (Spans across all the 4 priority work streams to the left)

**Outcomes:** We aspire to have core 'team of teams' in 5 Neighbourhood areas, co-located in integrated health + care hub sites, supported by specialists.

**Activities**
- Ensuring that we are developing the roles and skills (Workforce & OD) and supporting even greater collaboration and partnership working (Leadership).*
- Developing 'integrated hubs' within the neighbourhoods to deliver services together in campus of premises (Estates Optimisations).*
- Ensuring that staff can access the information they need about a patient/resident to deliver the best possible care**

### Children Programme (Spans across all the 4 priority work streams to the left)

**Outcomes:** focused activities to improve outcomes and access focusing on special school nursing, children continence, CAMHS, paediatric Hublets, asthma, SEND , THRIVE and neurodiversity.

**Activities**
- Participating and aligning with NW London wide Special School Nursing programme to identify service gap and resources required*
- Reducing Waiting Times for ADHD and ASD assessments in the shorter and longer-term*
- Clinical leaders and the Place based team established 4 operational hubs**
- Asthma - Epipens and spacers Business Case approved and rollout of initial 6 participating schools*
- We worked collaboratively to prepare our narrative and documentation for a SEND inspection
- We ran a workshop interrogating which of the 4 quadrants each of the services sit in – service mapping.

# Ealing

**"Together in Ealing" – we will see Ealing's communities thriving, with good health and wellbeing, and with fairness and justice in the building blocks of health and wellbeing.**

Ealing's Health and Wellbeing Board published a Joint Health and Wellbeing Strategy for five years across 2023-2028. and has implemented a process of oversight to monitor and assure itself that the priorities agreed in the Strategy are being implemented with an annual update on each thematic area prepared for the Board.

The strategy has is supported by underlying principles of:

- Putting communities at the heart of everything
- Systems and structures that leave no one behind
- Connecting the building blocks of health and wellbeing

Priorities and annual plans set out in the strategy align closely with the NW London priorities.



The proportion of children (under 16 years) in Ealing living in poverty is **14%**, having increased by **10% since 2015**.

Men and women on average in Ealing live to **80.3 years and 84.4 years** respectively. However, there are differences for men and women living in different areas.

Ealing has **4 residential areas** that are in the **10%** most deprived in the country, with the highest deprivation concentrated in and around Southall, Northolt and Acton.

Ealing is the third most ethnically diverse borough in England and Wales, with **less than 50%** identifying in the overall White ethnicity category.

The number of people stating they had a limiting long-term health problem or disability is approximately **12%**.

Approximately **15%** of all households receive housing benefits, with **13%** living in overcrowded conditions.

The number of people stating they had a limiting long-term health problem or disability is approximately **12%**.

# Ealing

## Priorities for Ealing Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Ealing resourced through partners

### Population Health

- Reducing health inequalities in the most 20% deprived areas
- Increase hypertension detection
- Improve uptake of Immunisations
- Increase physical health checks for people with SMI
- Increasing utilisation of IAPT

- Academic Partnership**
- Core20Plus5*
- Establish Population Health Capability*
- Outreach to vulnerable groups**
- Development of JSNA chapters*
- Planetary and Healthy Food Choices**
- Race Equality Commission**
- Working with Voluntary Sector**

### Children & Young People

- Reduce school exclusion rates
- Implementation of the iThrive model for CYP Mental Health
- Child Health Hubs across all PCNs/INT
- Transition to Family Hubs
- 'Good' CQC/Ofsted rating for SEND
- Improve child Dental hygiene

- Care Leavers*
- Children's Asthma*
- Emotional Wellbeing and Mental Health Resilience*
- Giving children a health start in life*
- Inclusion for all Children and Young People - SEND Board*
- Supporting Children to Achieve Healthy Lives*

### Integrated Neighbourhood Teams

- Embedded Integrated Neighbourhood Teams across Ealing
- Annual priority programme in place that incorporate inequalities and HIU
- Robust community engagement programme implemented
- Community of teams and services working together

- Ealing Community Partners and Mental Health Integrated Network Teams Stocktake*
- Implement agreed priorities for Programme Year Two*
- Implement key learnings from 2022/23 Evaluation*

### People with Complex Needs

- Establish Care Home Liaison Service
- Reduce care home callout and conveyancing to LAS
- Improve utilisation of UCP
- Review EoL services at Meadow House
- Bring Reablement and Rehabilitation pathways together

- Care Homes*
- Falls and Frailty*
- Dementia*
- Reablement and Rehabilitation pathways*
- End of Life Pathway*

**Value for Money & Contracts**

**Communications & Engagement**

### Seasonal Summits & Patient Flow

- Increased utilisation and accuracy of Same Emergency Care Data Set
- Increase Adult Social Work capacity
- Improve Reablement Bed pathway
- Implement Care Home Liaison and staff training
- Expand Bridging Service

- Data systems at Ealing and London North West Acute Hospitals Trust*
- Improving Discharges (Mental and Physical Health)*
- Seasonal Summit**

### Primary Care

- Implement Same Day Access Programme
- Evaluation of enhanced services
- Improvement in Flu, Pneumococcal and COVID vaccinations uptake
- Increase Children's vaccinations rates
- Resilient and Sustainable Primary Care

- Access*
- Clinical Effectiveness**
- Immunisations and Vaccinations Programme**
- Procurement

**Corporate & Other**

**Enablers-** Estates, Workforce and Digital

# Hammersmith and Fulham

**The Hammersmith & Fulham Health and Care Partnership is a collective of health, care and wellbeing organisations dedicated to improving health and wellbeing for local people.**

We are doing this by working with and for our different communities in Hammersmith and Fulham, making the changes that matter most to them, placing the resident at the centre of care and tackling health and wellbeing inequalities that exist across the borough.

To deliver on these priorities, we have a number of work streams, outlined to the right, that are implementing changed to health and care services. In addition we have two specialist partnership boards – the Children's Health, Education and Social Care Partnership Board and the Dementia Partnership board:

- The Dementia Partnership Board drives the implementation of the H&F dementia strategy with a focus on co-produced activities, and in doing so works to address the eleven local priorities identified by our residents with dementia, their carers, the organisations and services and local businesses supporting them.
- The Children's Health, Education and Social Care Board holds the local area to account on the progress of actions and priorities across a range of programmes within Children's health, education and social care. It is co-chaired by health and social care leaders.

The largest proportion of residents are working aged adults between **25-49 years (46%)**.

Hammersmith and Fulham has **201,400 residents**.

Children and young people make up the second largest age group in H&F, with **29% aged 0-24 years**.

**8%** of the population are aged 69 years and above.

Potential years of life lost due to alcohol in males is significantly **worse than the national average**.

**65%** of residents are from a 'White' ethnic group and **79% speak English** as a first language This is larger than the London average of **56%**.

Hammersmith and Fulham has the **highest rates of preventable mortality** in North West London.

# Hammersmith and Fulham

## Priorities for Hammersmith and Fulham Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hammersmith and Fulham resourced through partners

### Partnership boards

**Dementia Strategy Implementation**
***Via Dementia Partnership Board***

The Dementia Partnership Board will drive the co-production (working together) activities going forward and in doing so address the eleven local priorities identified by our residents with dementia, their carers, the organisations and services and local businesses supporting them.

- Implementation of the H&F Dementia Strategy**

**CYP Strategy & Transformation**
***Via the Children's Health, Education and Social Care Board***

The Partnership Board holds the local area to account on the progress of actions and priorities across a range of programmes within Children's health, education and social care.

- Performance monitoring of Children's services in the borough*
- Preparedness for SEND inspection*
- Family hub development in the borough*
- Implementation of the SEND strategy*

### Integrated Neighbourhood Teams

Support our complex patients, through proactive care planning and delivery, enabling early intervention and prevention, and reduction in escalation of need therefore improving outcomes for our population; remove the barriers to integrated working and work towards a having a single team around place.

- Agree geographies & principles of Integrated Neighbourhood Teams in H&F*
- Embed Family Hubs in H&F through a fully integrated, multidisciplinary approach to supporting residents in the community*
- Further develop the MINT offer to INTs within H&F*

### Children and Young People

Support our children and young people to thrive by delivering earlier support, reducing wait times and personalizing care where appropriate

- Support Mental Wellbeing in schools.*
- Ensure equity in access and outcomes for speech and language and occupational therapy**
- Deliver a flexible and dynamic offer for Initial Health Assessments*
- Prepare young people for adulthood through timely Health transitions*/**
- Reduce waits for autism assessments*
- Support children in or on the edge of Tier 4 NHS provision without a mental health diagnosis but clear mental health need**

### Mental Health

The work stream strives to expand the community offer, guaranteeing residents access to timely services, including employment support, VCSE services, and secondary care. Additionally, services will be co-produced with residents, utilizing a population health approach to cater to the local community.

- Improve community mental health service provision via the improvement of flow in acute wards, the development of the MINT teams, the wrap around of voluntary sector providers and interface with primary care*
- Increase quality and availability of supported living so fewer people are placed in residential placements far from home**
- Improve physical health for people on the SMI register*

### Tackling Inequalities

To agree a shared understanding of the principles of population health management, and how the HCP wants to work collectively to tackle inequalities, looking at both short term projects and interventions and longer term collective transformation across the system.

- Act on the findings of the Building Trust project**
- Implementing a project management approach in H&F*
- Administer and monitoring the Health Inequalities Transformation fund locally*
- Develop a long term local approach to tackling inequalities based on the Health and Wellbeing Strategy*

### Access to Health and Care Services

Reduce health inequalities and improve health outcomes in Hammersmith & Fulham by ensuring access to health and social care is equitable across the whole borough regardless of the patients postcode.

- Improve same day access*
- Complete Access Surveys across all practices*
- Expand the work stream across health and care.*
- Patient videos on routes through healthcare facilities*

### Enabling functions

**Communications and engagement-** communication purpose externally, strengthening links with VCS and further embed co-production**

**Estates –** maximising the use of public estates in H&F, including Parkview*

**HR, OD and identity –** develop shared roles, standard induction process and cross organisation training.**

**Data and insights –** systematic embedding of data, develop population health management capability.*

**Finance and resources –** implementing an open book policy across providers.**

**Local Response to system issues** – flexibly respond to system pressures and operational/quality issues.*

# Harrow

## Working with children, families, and communities, in Harrow to support better care and healthier lives

Within Harrow, the Harrow Borough Based Partnership brings together our NHS organisations, London Borough of Harrow, our GPs, and local Voluntary and Community Sector. This strong partnership that operates within the Integrated Care System for North West London and works to both support delivery of the wider system objectives. This includes a range of statutory and non-statutory partners.

Harrow Health and Wellbeing Board has adopted its Health and Wellbeing Strategy for 2022-2030 and this is supported by a three year delivery plan for which 2024/25 is the final year. As a system, system partners have committed to coming together annually to consider our approach for the following year.

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Harrow is **culturally diverse** with most residents coming from an Asian or Black background.

Poverty is a key determinant of health outcomes. Parts of Harrow are in the most **deprived 20% nationally**.

**31%** total burden of ill health is caused **by tobacco, hypertension, inactivity, alcohol, and obesity**.

Harrow **has 28 large parks** and other green spaces, although this is more limited in poorer parts of the borough.

Most **adults would be regarded as overweight or obese** (BMI>25). 1 in 5 children starting primary school are an unhealthy weight.

High rate of hospital admissions due to falls in older adults.

Housing affordability and overcrowding are **significant problems**.

# Harrow

## Priorities for Harrow Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hammersmith and Fulham resourced through partners

### Mental Health

**Outcomes:**
- Targeted preventative intervention in the community through the expansion of our community offer
- Improve access and reduce inequalities in mental health services for residents

- Improve community mental health service provision via the improvement of flow in acute, voluntary sector services. and community and wrap around of voluntary services. interface with primary care*
- Establish a robust post diagnosis dementia pathway for Harrow*
- Improving physical health for people on the SMI register**
- Review and redesign of supported living model and pathway for Mental Health accommodation**

### Proactive care and reducing health inequalities

**Outcomes:**
- Reducing health inequalities through embedding PHM, CORE20Plus 5 focus and increasing community capacity for action and strengthening our preventative approach

**Activities:**
- Deliver our community leadership programme, evaluation impact and align to the development of neighbourhood teams.*
- Build on the Harrow winter wellness programme to secure a robust preventative approach for the Harrow population**
- Secure our Population Health Management capacity and capabilities as a partnership and within our neighbourhoods, with focus on delivering CORE20 plus 5 programme*

### Integrated Neighbourhood teams

**Outcomes:**
- Deliver and embed our integrated neighbourhood teams and create the conditions for them to succeed

**Activities:**
- Deliver and embed integrated neighbourhood teams in Harrow in partnership with local communities to deliver proactive, complex and reactive care for the Harrow population*
- Leverage our partnership with local higher education institutions to secure the Harrow workforce**
- Digital integration between health and social care*
- Focus on delivery of our integrated care pathways at a neighbourhood level (with priorities in complex adults and frailty) *

### Reactive care

**Outcomes:**
- Admission (and A&E attendance) prevention (with a strong focus on frailty for admissions and preventing A&E attendance for those in mental health crisis), discharge pathway, reducing readmissions

**Activities:**
- Implement the integrated intermediate care pathway for Harrow and more widely, support the safe and timely discharge of patients to the most appropriate setting*
- Implement our admission and attendance avoidance plans for physical and mental illness to secure a stable health and care system*

### Children and Young People

**Outcomes:**
- Strengthening our integrated approach for children, young people and families.

**Activities:**
- Delivery of integrated CYP care pathway at a neighbourhood level, including the alignment of Family Hubs to INTs. *

### Complex Care

**Outcomes:**
- Delivering truly integrated community based care, leading to improved citizen and staff experience and reduction in unplanned care episodes

**Activities:**
- Implement the Harrow frailty model
- Secure the integrated model of diabetes care in Harrow*
- Strengthen our support to carers and deliver the Harrow Carers strategy**
- Implement community focused HIU MDT**

### Primary Care

**Outcomes:**
- Support the development of a resilient and sustainable primary care offer.
- Improve primary care access, delivery of enhanced services and community pharmacy.

**Activities**:
- Implement Same Day Access Programme
- Improve delivery of enhanced services
- Improve Flu, Pneumococcal and COVID vaccinations uptake
- Increase Children's vaccinations rates
- Embed the Pharmacy First offer

# Hillingdon

**Hillingdon's Joint Health and Wellbeing Strategy 2022-2025 seeks to improve the health and wellbeing of all our residents and to reduce disparities in health and care across our communities. Our strategy aims to deliver a vision shared by all health and care partners in the borough.**

Our shared vision is that by 2025 most people who live in Hillingdon are able to say:

- "I am helped to take control of how my own health and social care needs are met."
- "I only have to tell my story once and my details are passed on to others with an appropriate role in my care."
- "If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay."
- "Social care and health services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital."
- "I am treated with respect and dignity, according to my individual needs."
- "It doesn't matter what day of the week it is - as I get the support appropriate to my health and social care needs."
- "Systems are sustainable and money that once might have been spent on hospital care for me is now spent to support me at home in my community."

Hillingdon **includes more affluent areas** (within the top 20% nationally) as well as areas of deprivation (within the lowest 20% nationally).

**Overweight and obese children** between ages 4 and 5 and 10 and 11 is higher than the national average.

The 2011 census showed that there were over **25,000 carers** in Hillingdon providing unpaid support.

Life expectancy in Hillingdon is estimated at **80.8 years** for males and **83.8 years** for females.

**34,000 people** in Hillingdon are known to have one or more **long-term conditions**.

Dental health of children is **worse than the national average**.

An estimated **3,033 people aged 65 or over in 2020** are likely to have dementia.

# Hillingdon

## Priorities for Hillingdon Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hillingdon resourced through partners

### Year 1

#### Defining place governance and accountability within the wider NW London Integrated Care system

- Agreement to, and implementation of a Common Framework for Place Leadership and Accountabilities ((by July 2024) **

#### Developing and progressing the required new clinical models

Fast Track development of Integrated Neighbourhood Teams using PHM approach and mobilising local communities to tackle health inequalities with 3 core functions:

1. Same Day Urgent Primary Care for people with non complex needs*
2. Proactive Care for at risk population cohorts with a emphasis on Frailty in the first instance*
3. Preventative Care for a range of population health JSNA priorities with an emphasis on Hypertension, Anxiety/Depression and Obesity in the first instance.*

### Years 1-5

#### Delivering the main priorities in our Place based Transformation Programmes

- New model of reactive care through:
  - Development of a new 24/7 Place Based Out of Hospital Reactive Care delivery model for those with complex needs and multi morbidity. *
  - Move from 'Good to Great ' in hospital discharge*
- Improve the health and wellbeing of CYP & families in Hillingdon - Experts by experience; THRIVE; Access and school based MH support; community based crisis; CYP neurodevelopmental pathway, Care experienced children; Health and Justice*
- Improve quality of care & health and wellbeing of people with a Mental Health or emotional wellbeing issue*
- Improve the health and wellbeing of people with a Learning Disability and/or autism**

#### Workforce estates and digital enablers to underpin integrated teams

- Building three integrated neighbourhood teams supporting 2 PCN's each, led by neighbourhood director, to include adult mental health in the team*

#### Embedding integrated neighbourhood teams and linking in community assets

- Deliver the priority programmes as agreed in the business case - hypertension, obesity, falls prevention, Children's oral health, proactive care and MH with a particular focus on the health needs in the south of the borough. Recruit to PHM roles to support PHM infrastructure and support recruitment of neighbourhood directors for INT's to support PHM into BAU*

#### Integrated end of life

- Implement integrated end of life hub*
- Hub developed in 23/24 - continued development of integrated team in 24/25*

#### Ensuring best use of resources to address financial deficit

- Developing a 3-5 Year Place Based Financial Recovery Plan**
- Commission Reviews of those Services non recurrently funded by the ICB to ensure that they represent value for money and do not duplicate other services**
- Ensure Benefits realisation of the 3 HHCP Transformation Scheme**

#### Change management programme

### Years 2-5

#### PHM priorities and programmes to underpin integrated neighbourhood teams and embedding PHM into BAU

- Development of HHCP estates strategy and 10 year plan; HHCP workforce passport, supporting new ways of working and building workforce skills within neighbourhood teams**

#### Integrated therapy reablement and rehabilitation

- Development of an integrated therapy team across THH, CNWL and ARRS First Contact Practitioners to support discharge and prevention of admission*

# Hounslow

**Vision: Our communities are healthy, happy, connected and enabled to realise their full potential.**

Hounslow Health and Wellbeing Board published a Joint Health and Wellbeing Strategy for the three years 2023-2026 and has implemented a process of oversight to monitor and assure itself that the priorities agreed in the Strategy are being implemented with an annual update on each thematic area prepared for the Board.

The strategy is supported by underlying principles of:

- Promoting a life course approach
- Place based and localities focused
- Prevention and early intervention

Priorities and annual plans set out in the strategy align closely with the NW London priorities.

Hounslow has a **diverse population 52%** of the population from Black, Asian and Minority Ethnic groups.

Hounslow's population is ageing. Between 2020-2041, the number of **residents aged 65 and over** is projected to increase by **71%**.

Hounslow's infant mortality rate (2018-20) is the highest in London at **4.7 per 1000 live births**.

**8%** of the population living in Hounslow live in the 20% **most deprived** areas in England.

The suicide rate for people of all ages in is **11.1 per 100,000 population**, the second highest rate of suicide in any London borough.

The rate of emergency admissions to hospital **due to dementia** for residents aged 65 and over has continued to increase in Hounslow.

Hounslow has a **higher rate of alcohol specific hospital admissions** than the national average.

**34.3% of 5 year olds** have experience of visually obvious dental decay.

# Hounslow

## Priorities for Hounslow Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hounslow resourced through partners

### Health and Care Integration

Aim to reduce health inequalities and improve health outcomes in Hounslow by ensuring access to health and social care is equitable across the whole borough regardless of the patients postcode.

**Activities:**
- New Frailty Model of Care Implementation*
- Health and Care Integration Outline Business Case Implementation*

### Frailty programme

Our aim is for Hounslow residents with frailty, living with dementia, or those who are receiving end of life care to be able to live more independently at home and in the community through our redesigned 'Home First' model.

**Activities:**
- Falls Prevention*
- Dementia*
- Intermediate Care*
- Integrated Discharge*
- End of Life Care*

### Prevention and health inequalities

The purpose of the work stream is to reduce health inequalities in the population so that fewer residents miss life opportunities due to avoidable long-term health conditions. This will be achieved through prevention and early detection of illness to reduce people developing long term conditions.

**Activities:**
- Core20PLUS5 and Health Inequalities Projects*
- Wellbeing Services (includes cancer screening)*
- CVD, Hypertension & Atrial Fibrillation*
- Childhood Obesity and Oral Health**

### Community mental health

Aim to reduce health inequalities and improve health outcomes in Hounslow by ensuring access to health and social care is equitable across the whole borough regardless of the patients postcode.

**Activities:**
- Integration with Primary Care*
- Link Workers across the System*
- VCSE Programmes*
- Older Adults Interface Work*

### Children with SEND, Disabilities and Complex Needs

Enable children with SEND and / or complex needs to achieve their potential by building system capacity to enable families and children to effectively support them

**Activities:**
- SEND*
- Children's Therapies*
- Children and Young People Mental Health*

### Integrated Neighbourhood Teams

The INT essential offer will be based on:
1. Streamlining access to care & advice for those that get ill but use health services less frequently.
2. To give people more choice about accessing care & make sure it is always available when they need it in their community.
3. Providing more proactive & personalised care with support of a Multi-Disciplinary Team to those with complex needs but not necessarily limited to those with Long-Term Conditions.
4. Helping people stay well for longer with a joined approach to prevention.
5. To support better management of the demand & capacity & build resilience and sustainability.

**Activities:**
- MDT Working at Neighbourhood level through improved interface with housing*
- Alignment with Family Hubs and Community Hubs*
- Local Workforce and mapping into INT footprints*
- Estates*

# Section 6: Supporting plans

# Our commitment to delivering the ICB statutory functions relating to quality, safeguarding and infection prevention and control (i)

## Quality

We have a responsibility to coordinate the approach to oversight patient safety incidents response to all the services within the system. The current SI process is currently been transition to the Patient Safety Incident Response Framework (PSIRF) and the ICB is responsible for reviewing provider's PSIRF policies and processes and endorsing their move to the new system. The quality team receives quality and safety information which is discussed and challenged at System Oversight Meetings and areas of concern are raised at the ICB Performance and Quality Meetings. To review opportunities for learning and improvement plans and lessons learnt at the System Quality Group meetings. Promote positive safety culture, encouraging staff to gain insight and share learning from good and poor practice. Providing Patient Safety Specialist advice to the ICB. We will use the learning from complaints to improve patient experiences.

The complaints team receives and manages complaints that are received at the ICB. They mainly involve complaints regarding Primary Care and CHC. Complainants are encouraged to engage with the service for which they have raised concerns. The ICB provides clinical oversight of complaints as required.

- Support providers in the transition to PSIRF. This will also involve support in closing SIS that are currently in the system.
- Work with NHSE with regarding the delegation of specialist commissioning and clinical networks.
- Review the ICB Quality Impact Assessment process for procurement.
- Assume responsibility for maternity services which will need to be embedded within current roles and responsibilities.
- Work with the CQC following their new inspection process which includes inspection of ICSs.
- Support the development of Primary Care Quality Improvement and Assurance Framework
- Work with independent providers to provide quality assurance data
- Manage complaints that are sent to the ICB in line with best practice and ensure that learning is reviewed and shared.

## Continuing Healthcare

The function of the continuing healthcare service (CHC) is to provide comprehensive and ongoing healthcare and support to individuals with complex, long-term health needs. Following being assessed as eligible for continuing healthcare. The eligibility outcome is based on the use of national frameworks and in line with the statutory responsibilities of the ICB for CHC.

The key objectives of the service include undertaking; assessment, care planning, brokering care, monitoring and review of care packages, quality assurance of care providers. As well as providing an appeals process for individuals who have been assessed as not eligible for CHC. We will also ensure that people who have multiple care health and social care conditions are supported in an environment to keep them safe and provide high quality care.

- Promote and support collaboration to ensure high quality offer across key areas that affect provision of care for patients, such as, CAMHS, children community nursing, adult community nursing and mental health to reduce inequalities and the need for individualised commissioning.
- Understand he domiciliary and care home market capacity across North West London against future demand, including the type of beds, and support into nursing homes to ensure adequate provision and what they need to manage increasingly complex people.
- Promote and support the provision of consistent bladder and bowel support for nursing homes. This is to ensure, appropriate evidence based continence assessments and appropriate containment products are in place.

# Our commitment to delivering the ICB statutory functions relating to quality, safeguarding and infection prevention and control (ii)

## Safeguarding

Strategic leadership and partnership working support the efficiency of the safeguarding system in place across all boroughs. Assurance is achieved through working closely with Safeguarding Adult Boards, Children's Safeguarding Partnerships, health providers and partner agencies. The ICS Safeguarding group and ICS Violence against Women and Girls group ensures that the profile of Domestic Abuse and Sexual Violence is high on the agenda, with due regard to provisions of the Domestic Abuse Act 2021. Updates and system learning is discussed within the ICS System Quality Group. In addition, in line with legislative change (Police, Crime, Sentencing and Courts Act, 2022), and to support reduction of serious violence, implementation of the Serious Violence Duty is achieved through utilisation of health based data collection initiatives that support borough based strategies in each local area. Equity of health offer for children and young people in care is monitored through review of service provision and for children placed in and outside of NW London. The Safeguarding Strategy ensures practice is aligned with NHS England recommendations and ICS ambitions. The ICB has a statutory responsibility to review child deaths on behalf of the Child Death Partners, the ICB and Local Authorities across North West London. The ICB also has a similar duty to review adult deaths where Learning Disability and Autism are identified.

- Review the ICB's function following publication of Working Together to Safeguard Children (2023)
- Continue to progress with work initiatives related to Domestic Abuse and Violence against Women and Girls including White Ribbon accreditation and Sexual Safety in Healthcare
- Work with providers to ensure that Children Looked After health assessments are completed in a timely manner
- Work and support providers to ensure statutory safeguarding responsibilities are met

## Infection Prevention and Control (IPC)

To provide oversight and scrutiny of ICS and individual provider progress against IPC related ambitions / thresholds / regulatory and contractual requirements / intelligence and improvement programmes. Oversight of local compliance with IPC training. Support to local networks re professional development opportunities and succession planning. Seek assurance that local services are commissioned against and are working to national IPC guidance and policy. Work towards the Antimicrobial Resistance agenda (AMR) with colleagues in pharmacy and diagnostics for an integrated approach for individuals and communities at greater risk of ill-health.

- With Provider organisations develop a robust IPC assurance system ensuring that IPC related risks and learning are identified and shared and improvement programmes are put in place and develop and implement strategies for preventing and reducing avoidable HCAIs
- With Local Authorities review and understand provision of IPC and continence services in care homes and ensure policies and processes are in place to identify and manage patients with infections.
- With Urology and Continence leads to undertake a mapping of Trial without Urinary catheter services across NW London to ensure that all patients have the same access to urinary catheter services
- Support the development of the IPC services across Acute, Primary Care and Community, ensuring leadership, capability, capacity, and succession planning in all roles and areas of IPC

# Our Joint Forward Plan aligns with and meets our legislative requirements (i)

As an ICB we have several statutory duties that we are required to fulfil by law. The key priorities outlined through this Joint Forward Plan details how these duties will be delivered. We have outlined below a summary response in how we are fulfilling each requirement:

| Legislative requirement | Description | NW London ICB response |
|---|---|---|
| **Duty to promote integration** | Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health-related or social care services, where this would: improve quality of those services reduce inequalities in access and outcomes. | Our Joint Forward Plan outlines how the ICB will meet the health needs of our population in an integrated way. This is worked through each priority – in particular please see *Priority 1* and *Priority 3*. |
| **Describing the health services for which the ICB proposes to make arrangements** | The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions. | We have outlined the health services we will make arrangements for in the section on *'Who we are'.* Additionally, each priority outlines the services in which it will impact. |
| **Duty to consider wider effect of decisions** | In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the triple aim of: (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies. | NW London ICB is committed to the 'triple aim' and our Joint Forward Plan outlines our plans to reduce inequalities – see *Priority 1*, improve quality of our services – see *quality section* and ensure sustainability of our services – see our *medium term financial strategy summary*. |
| **Implementing any JLHWS** | The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007. | Within our Joint Forward Plan we have outlined for each of our places (our Boroughs) their plans, as reflected in their JLHWSs, please see *'Borough section'*. |
| **Financial duties** | The plan must explain how the ICB intends to discharge its financial duties. | Our financial duties are outlined in detail through our medium term financial strategy, we have summarised this in the *'Our financial challenge'* section and ensured our priorities align to the plan and it's expenditure limits. |
| **Duty to improve quality of services** | Each ICB must exercise its functions with a view to securing continuous improvement in: the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illnessoutcomes including safety and patient experience. | Ensuring quality of services is a key priority for the ICB and is woven through each of the priorities in our Joint Forward Plan. Please see the *'Quality, safeguarding and IPC section'* for further detail. |

# Our Joint Forward Plan aligns with and meets our legislative requirements (ii)

| Legislative requirement | Description | NW London ICB response |
|---|---|---|
| **Duty to promote involvement of each patient** | Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions that relate to: (a) the prevention or diagnosis of illness in the patients or (b) their care or treatment. | Involvement of both residents and patients are key in every decision we make. We have outlined how we include them in our decision making in the Joint Forward Plan – please see the section '*How we have engaged and continue to work with our residents*'. |
| **Duty to involve the public** | ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided. | |
| **Duty to patient choice** | Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them. | |
| **Duty to obtain appropriate advice** | Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in: (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health. | NW London ICB has a range of ways in which it gathers advice – predominately this is through its various governance forums which cross a broad range of professional expertise. Our CRGs are integral in providing clinical advice. |
| **Duty to promote innovation** | Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision). | NW London ICB has a dedicated programme whose purpose is to research and develop innovative solutions to support our health services. These are key activities with our priorities. |
| **Duty in respect of research** | Each ICB must facilitate or otherwise promote: (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research. | |
| **Duty to promote education and training** | Each ICB must have regard to the need to promote education and training[1] so as to assist the Secretary of State and Health Education England (HEE) in the discharge of the duty under that section. | Promotion of education and training is integral part of our workforce strategy, we have summarised. |
| **Duty as to climate change** | Each ICB must have regard to the need to: (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets) and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008. | NW London ICB is committed to NHS England's net zero targets. In 2022 we published the NW London ICS Green Plan http://www.nwlondonics.nhs.uk/download_file/view/329, which outlines how we aim to deliver our commitments on sustainability and climate change. |
| **Addressing the particular needs of victims of abuse** | The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions. | Addressing the needs of victims of abuse is covered within the safeguarding section of the JFP. NW London ICB safeguarding policy covers the provisions of the Domestic Abuse Act 2021, accompanying Serious Violence Duty Statutory Guidance, and relevant safeguarding provisions. |
| **Addressing the particular needs of children and young persons** | The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25. | Our commitment to the particular needs of children and young people is key and outlined in *Priority 2.* |

# Section 7: Glossary of key terms and acronyms

# Glossary of key terms and acronyms (i)

| Acronym | Description |
|---|---|
| **Acronym** | |
| **BCYP** | **Babies, children and young people** |
| **BI** | **Business Intelligence** |
| **CHC** | **Continuing Healthcare:** a package of care for adults aged 18+ who have complex, long-term needs. |
| **CQC** | **Care Quality Commission:** the independent regulator of health and adult social that make sure services provide people with safe, effective, high-quality care. |
| **DAB** | **Co-design Advisory Body:** a group of representatives of community groups, voluntary groups and watchdogs who share their views to support the development of local healthcare and NHS services |
| **EPR** | **Electronic patient record:** all staff involved in a patient's care have access to their health record, giving them a complete overview of patients' care needs. |
| **FDP** | **Federated Data Platform:** Software that will bring together data from across different NHS organisations – currently stored in separate systems – so that staff can access the information they need in one safe and secure place. |
| **GP** | **General Practice:** A clinic made up of medical professionals, including doctors, who treat all common medical conditions or refer patients to services that can help |
| **ICP** | **Integrated Care Partnership:** A joint committee run by NHS organisations and local authorities to improve local health, care and wellbeing. |
| **INT** | **Integrated neighbourhood team:** Teams made up of health and care workers, volunteers and wider partners who will work together to deliver services that respond to local residents' needs. |
| **LAC** | **Looked after children:** any child / young person who needs support with emotional wellbeing |
| **MECC** | **Making every contact count:** A national initiative encouraging public-facing workers to make contact with patients and the public as an opportunity to support or enable them to consider healthy behaviour changes |
| **ODG** | **Operational Delivery Group** |
| **OPTICA** | **Optimised patient tracking and intelligent choices application:** Software that provides clear visibility of all tasks needed before a patient is safely able to leave hospital |
| **PGD** | **Patient group directions:** a legal framework that allows some registered health professionals to supply or administer specified medicines to certain patients |

| Acronym | Description |
|---|---|
| **PHM** | **Population health management:** The analysis and representation of data in an understandable way |
| **RAT** | **Rapid assessment and treatment:** The process of quickly assessing and determining what immediate response is needed for patients initially attending an emergency department. |
| **SDEC** | **Same day emergency care: c**ertain emergency patients can be rapidly assessed, diagnosed and treated without being admitted to a hospital ward. |
| **SEND** | **Special educational needs and disabilities:** a child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support. |
| **UEC** | **Urgent emergency care:** services that provide care for patients who need urgent care. This ranges from life-threatening emergencies to illnesses or injuries that requires immediate attention |
| **VCSE** | **Voluntary and community sector organisations** |
| **WSIC** | **Whole System Integrated Care:** a database providing a summary of patient's health and social care data to help build a better understanding of need across our communities |

| Organisations, teams and groups |
|---|
| **Anchor institution**: large organisations that are unlikely to relocate and have a significant stake in their local area, such as trusts and local authorities |
| **Borough/place based partnership**: partnership between local authorities, primary care, community care, mental health, acute trusts and the voluntary sector to tackle local challenges and improve health and wellbeing |
| **Local authority**: the organisation responsible for public services and facilities in a borough, often referred to as councils |
| **Mental Health Support Teams**: increase access to early intervention for common mental health problems such as anxiety and low mood in schools |
| **Multidisciplinary team**: teams that bring together a range of expertise with a common goal to improve health outcomes |
| **Provider collaborative**: partnership that brings together two or more NHS trusts |
| **Task and finish group:** a group that focuses on an existing issue to identify what concerns there are, if any, with a certain project and resolve these |
| **Trust**: an NHS organisation that provides services to patients, : e.g. hospital treatment, mental health care, ambulance service |

# Glossary of key terms and acronyms (ii)

## Schemes, programmes and platforms

**Additional Roles Reimbursement Scheme**: initiative to grow capacity through new roles in general practice and by doing so, helping to solve the workforce shortage

**Cancer faster diagnostic standard**: national target is that you should not wait more than 28 days from referral to finding out whether you have cancer or not

**Foundry**: a solution that helps doctors, nurses and other NHS professionals by organising information that trusts hold on different databases in one place.

**Health equity programme:** working to tailor services to the level of need in our communities, rather than providing a one-size-fits-all approach.

**High intensity use programme**: making contact with the most frequent attenders of the local A&E to find out how the local health and social care system could better meet their needs

**NHS single delivery plan:** a plan for maternity and neonatal services intended to provide support to services in achieving safer, more personalised care

**Paediatric transformation programme**: a collaboration of organisations working to improve health outcomes for babies, children and young people in London

**Population Health Management and Health Equity Academy**: population health management resources and case studies for health and care professionals (see PHM above for information on population health management)

## Frameworks and approaches

**Anchor Charter**: sets out the ways which our partners aim to have a positive impact on their local communities through their role as employers, land and asset owners and in the way they impact the environment

**Core20PLUS5:**

*Core 20:* the most deprived 20% of the population
*PLUS:* Population with protected characteristics as defined by the Equality Act 2010
*5:* five areas of focus which require accelerated improvement: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

**Operational process of discharge to assess (pathway 1, 2 or 3):** ensures that patients are able to leave hospital safely by directing them to the right next step in their care:

*Pathway 1:* discharged to their home or to a usual place of residence with new or additional health and/or social care needs
*Pathway 2:* discharged to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover
*Pathway 3:* discharged to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care.

## NHS initiatives

**Transfer of care hubs**: Different services such as social care, housing and voluntary services are linked to coordinate support for patients who need it

**Virtual wards**: also known as hospital at home, patients can be cared for at home safely and in familiar surroundings, helping speed up recovery while freeing up hospital beds for patients that need them most

## Additional terminology

**Acute care**: patients treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery

**Capital**: the money used to build, run, or grow an organisation

**Care pathway**: a plan for patient care that is comprehensive and may include care from multiple services

**Co-production (or co-design):** a way of working that involves people who use health and care services, carers and communities in equal partnership

**Elective care**: non-urgent services, usually delivered in a hospital setting

**Estates**: NHS buildings and the grounds they are on, or around them.

**Health equity**: everyone has a fair and just opportunity to attain their highest level of health

**Health outcomes**: broadly agreed, measurable changes in health or quality of life that result from delivery of care

**Hospital discharge**: when patients formally leave a hospital after review that it is safe for them to do so

**Inpatient:** a person who stays one or more nights in a hospital in order to receive medical care

**Outpatient:** a person who visits a hospital for diagnosis or treatment without staying overnight

**Patient flow**: The movement of patients across the healthcare system, including how they interact with and between services and the systems needed to get them from the first point of contact to being discharged.

**Primary care**: the first point of contact in the healthcare system, including general practice, community pharmacy, dental and eye health services

**Protected characteristics**: it is against the law to discriminate because of: age, disability, gender reassignment, pregnancy, race, religious beliefs, sex and sexual orientation

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| Brent<br>NHS<br>North West London | **Brent Health and Wellbeing Board**<br>23 July 2024 |
| | **Report from the Corporate Director of Community Health and Wellbeing – Rachel Crossley** |
| | **Lead Cabinet Member for Community Health and Wellbeing - Councillor Nerva** |

# Better Care Fund - End of Year 2023-24 Reporting

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | None |
| **Background Papers:** | N/A |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Steve Vo<br>Assistant Director – Integration & Delivery (Brent Borough), Brent ICP<br>Email: stevetruong.vo@nhs.net<br>Telephone: 07584 387505<br><br>Eleanor Maxwell<br>Senior Programme Officer<br>Better Care Fund Lead for Brent Borough<br>Email: eleanor.maxwell@brent.gov.uk<br>Telephone: 020 8937 2195 |

## 1.0 Executive Summary

1.1 The purpose of this report is to present the end of year report for the Better Care Fund (BCF) 23/24 which was submitted to the BCF national team on 23rd May 2024.

1.2 This report seeks formal ratification from the Health and Wellbeing Board (HWBB) on the End of Year report. It should be noted that it has been signed off, pending formal HWBB approval, by Rachel Crossley, Corporate Director for Community Health and Wellbeing by way of delegated authority, in order to meet the necessary submission deadlines.

1.3 It was also signed off by Brent's Chief Finance Officer and NWL ICB, and reviewed by Borough based Health and ASC colleagues, NWL ICB and the BCF London team prior to submission.

## 2.0 Recommendation(s)

2.1 For the Health and Wellbeing Board to ratify the 2023/24 Better Care Fund End of Year reporting for 2023/24.

## 3.0 Detail

3.1 This paper contributes to a number of strategic priorities within Brent Council's Borough Plan 2023 – 2027 and the Health and Wellbeing Strategy 2022 - 2027. The central priority it relates to is strategic priority 5 'A Healthier Brent' and looks to tackle health inequalities and provide localised services for local needs around health and wellbeing. The BCF delivers schemes that meet the outcomes of strategic priority 5, as well as outcomes within the Health and Wellbeing Strategy.

3.2 Key points to note:

- 3.2.1 Brent Borough plan met all National Conditions including having a signed S75 agreement in place.
- 3.2.2 Agreement was reached on a new S75 agreement by key partners NWL ICB and Brent LA on 10th February 2024.
- 3.2.3 Expenditure on schemes was reported in line with plan, with the exception of community equipment approved by NWL ICB.
- 3.2.4 For 2023/24 the reporting format changed with spend and activity reported only for the schemes required by Central BCF team, a total of 20 from 76.

## 4.0 Stakeholder and ward member consultation and engagement

4.1 All BCF EoY reporting has been worked through and agreed upon by all stakeholders.

4.2 There are no further stakeholder and ward member consultation and engagement comments specific to this paper.

## Financial Considerations

5.1 The table below details the values included in the End of Year reporting. The only line with an overspend is related to the supply of Community Equipment and arose due to the level of need. The overspend whilst reported was re-imbursed to the LA by NWL ICB

| | 2023 - 2024 End of Year reporting | | | |
|---|---|---|---|---|
| **Category** | **Income** | **Planned Spend (A)** | **Actual Spend (B)** | **Difference (B) - (A)** |
| Disabled Facilities Grant (DFG) | £5,780,850 | £5,780,850 | £5,780,850 | £0 |
| iBCF Contribution | £13,344,692 | £13,344,692 | £13,344,692 | £0 |
| NHS Minimum Contribution to LA | £9,572,333 | £9,572,333 | £9,572,333 | £0 |
| NHS Minimum Contribution to Health Spend | £17,726,564 | £17,726,564 | £18,136,581 | £410,017 |
| Additional North-West London (NWL) ICB Contribution | £1,486,000 | £1,486,000 | £1,486,000 | £0 |
| LA Discharge Funding (1) | £1,870,905 | £1,870,905 | £1,870,905 | £0 |
| NWL ICB Discharge Funding (2) | £1,670,080 | £1,670,080 | £1,670,080 | £0 |
| Total | £51,451,424 | £51,451,424 | £51,861,441 | £410,017 |
| | | | | |
| Total Discharge Funding (1) + (2) | £3,540,985 | £3,540,985 | £3,540,985 | £0 |

## 5.0 Legal Considerations

6.1 None – S75 for 2023-24 is signed to provide shared funding agreement.

## 6.0 Equality, Diversity & Inclusion (EDI) Considerations

7.1 None, as all the existing and new programmes will be delivered to all qualifying patients across Brent.

## 7.0 Climate Change and Environmental Considerations

8.1 There are no specific climate and environmental considerations relating to this paper.

## 8.0 Human Resources/Property Considerations (if appropriate)

9.1 There are no specific Human Resources / Property considerations relating to this paper.

## 9.0 Communication Considerations

10.1 There are no specific communication considerations relating to this paper.

***Report sign off:***

**Rachel Crossley**
**Corporate Director of Community Health and Wellbeing**

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| Brent<br>NHS<br>North West London | **Brent Health and Wellbeing Board**<br>23 July 2024 |
| | **Report from Rachel Crossley Corporate Director of Community Health and Wellbeing** |
| | **Lead Cabinet Member for Community Health and Wellbeing - Councillor Nerva** |

# Better Care Fund 2024-25 Plan Submission

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|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | N/A |
| **List of Appendices:** | None |
| **Background Papers:** | N/A |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Steve Vo<br>Assistant Director – Integration & Delivery (Brent Borough), Brent ICP<br>Email: stevetruong.vo@nhs.net<br>Telephone: 07584 387505<br><br>Eleanor Maxwell<br>Senior Programme Officer<br>Better Care Fund Lead for Brent Borough<br>Email: eleanor.maxwell@brent.gov.uk<br>Telephone: 020 8937 2195 |

## 1.0 Executive Summary

1.1 This report is to provide high level view and seek sign off for the BCF 24/25 plan which was submitted on 18th June 2024.

1.2 This report seeks formal ratification from the Health and Wellbeing Board (HWBB) on the 24/25 plan, it should be noted that it has been signed off pending formal HWBB approval, by Rachel Crossley, the Corporate Director for Community Health and Wellbeing by way of delegated authority, in order to meet the necessary submission deadlines.

1.3 The plan was signed off by Brent Councils Chief Executive, Chief Finance Officer (S151) and NWL ICB.

1.4 The 24/25 BCF plan provides details of how the second year of a two-year plan will be spent in line with the principals of BCF. The £55.5m annual BCF funding for 24/25 will contribute to achieving a number of the Councils strategic priorities, including priorities set out in the Health and Wellbeing Strategy.

1.5 In essence, the 24/25 BCF spend remains in line with the original two-year plan.

1.6 There are a number of fundamental changes to how the BCF plan has been presented. The detail of these changes is set out in the body of this report. The plan awaits formal sign off from National Better Care Team

1.7 It should be noted that the delegated authority to sign the S75 by LA Corporate Director was approved by the HWBB in October 2023 and remains in place for 5 years.

## 2.0 Recommendation(s)

2.1 We ask that the HWBB formally approves the proposed metrics and spend of £55.5m for 24/25 BCF plan.

## 3.0 Detail

### 3.1 Contribution to Brough Plan Priorities and Strategic Context

3.1.1 The BCF plan contributes to a number of strategic priorities within Brent Council's Borough Plan 2023 – 2027 and the Health and Wellbeing Strategy 2022 - 2027. The central priority it relates to is strategic priority 5 'A Healthier Brent' and looks to tackle health inequalities and provide localised services for local needs around health and wellbeing. The BCF plan provides details on various schemes that meet the outcomes of strategic priority 5, as well as outcomes within the Health and Wellbeing Strategy.

### 3.2 2024-25 Plan Change Rationale

3.2.1 The 2023-25 plan was approved in August 2023 and was intended to cover a 2-year period. This 2024-25 plan is an update of existing funded schemes and infrastructure in the 2023-25 plan, rather than a full re-plan. However, it has provided Brent with the opportunity to assess the value of existing schemes as well as repurpose some funding to incorporate new transformational services and ensure current priorities are supported.

3.2.2 The plan has been consolidated so that it is presented in a more logical and structured way, which also delivers the Internal audit recommendations made.

3.2.3 The key changes in the 24/25 plan are:

3.2.3.1 The combining of similar schemes where appropriate to support operational efficiency and improve output metric tracking.

3.2.3.2 The removal of a small number of legacy schemes which were no longer required or where alternative funding streams could be identified.

3.2.3.3 Adjusted funding levels and schemes within LA and ICB discharge funded schemes to deliver best value and adapt to meet the changing needs of the population.

3.2.3.4 Updated contract values for health services commissioned by NWL ICB.

3.2.3.5 The repurpose of a small amount of existing funding as well as use of the annual uplift (NHS minimum) to introduce new schemes that will support local priorities, transformation and winter pressures.

3.2.4 The LA schemes funded by the BCF have been reviewed and some different schemes have been included to ensure the best fit between the schemes identified and the purposes of the BCF i.e.

3.2.4.1 Supporting people to live independently.
3.2.4.2 Prevention of avoidable admissions to hospital.
3.2.4.3 Efficient, safe discharge from hospital

## 3.3 Background

3.3.1 The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

3.3.2 Brent Borough based teams from the ICB, and the LA enjoy very positive working relationships, with joint working practices at all levels contributing to an encouraging year and laying the groundwork for positive future developments. Partnership working with the NWL ICB, health partners including CLCH, LNWH and the charity sector including Ashford Place are also key to delivering positive outcomes.

3.3.3 As the BCF funding has grown the requirement for more detailed programme management has become clear, and as a result a Senior Programme Officer, BCF Lead was appointed in October 2023.

3.3.4 In addition to this, an internal audit of Brent's BCF which had some clear recommendations which the new BCF lead has now gone some way to implementing. The recommendations primarily focus on:

3.3.4.1 Establishing a BCF Board
3.3.4.2 Governance
3.3.4.3 Monitoring
3.3.4.4 Reporting
3.3.4.5 Defining role and responsibilities
3.3.4.6 Improved methodology for financial planning and tracking, and closer partnership working with the LA Finance Teams

## 4.0 Stakeholder and ward member consultation and engagement

4.1. All BCF Planned Schemes have been worked through and agreed upon by all stakeholders.

4.2. There are no further stakeholder and ward member consultation and engagement comments specific to this paper.

## 5.0 Financial Considerations

5.1 The table below details the value of the BCF Pooled Budget for 2024/25. The level of contribution from the NWL ICB has increased as per the specified inflationary increases, which has been uniformly applied to all Health and Wellbeing Boards at 5.66% (* in table below). This is demonstrated further in our BCF Planning Template submission for 2024/25.

| Category | Income 2023/2024 (A) | Income 2024/2025 (B) | Difference (B) - (A) | % Change |
|---|---|---|---|---|
| Disabled Facilities Grant (DFG) | £5,780,850 | £5,799,407 | £18,557 | 0.32% |
| iBCF Contribution | £13,344,692 | £13,344,692 | £0 | 0.00% |
| NHS Minimum Contribution to LA * | £9,572,333 | £10,114,127 | £541,794 | 5.66% |
| NHS Minimum Contribution to Health Spend * | £17,726,564 | £18,729,888 | £1,003,324 | 5.66% |
| Additional North-West London (NWL) ICB Contribution | £1,486,000 | £1,216,000 | -£270,000 | -18.17% |
| LA Discharge Funding (1) | £1,870,905 | £3,118,175 | £1,247,270 | 66.67% |
| NWL ICB Discharge Funding (2) | £1,670,080 | £3,124,905 | £1,454,825 | 87.11% |
| Total | £51,451,424 | £55,447,194 | £3,995,770 | 7.77% |
| | | | | |
| Total Discharge Funding (1) + (2) | £3,540,985 | £6,243,080 | £2,702,095 | 76.31% |

5.2 The Improved Better Care Fund (iBCF) and Disabilities Fund Grant (DFG) will remain broadly the same as in 2023/24 with Brent's allocations remaining at £13.4m and £5.8m respectively.

5.3 Additional ICB Funding for the BCF 2024-25 was proposed to remain except for Scheme 68 - £270,000, Brent ICP Programme Management. NWL ICB has agreed for the funding to still be allocated to Brent and covered within the scope of the S75 shared funding agreement.

5.4 The key change is the substantial increase in the Discharge Funding, recognising the increasing complexity and pressures on all parts of the system to support swift discharge from acute and rehabilitation hospital settings.

5.5 The majority of the additional discharge funding is being used to support the:

- 5.5.1 Bridging service – facilitating quick discharge for patients to return home with appropriate support.
- 5.5.2 Purchase of additional short term residential or nursing home beds - facilitating discharge from acute hospitals inc. complex patients.
- 5.5.3 Contribution to NWL ICB commissioned schemes that Brent patients will have access to including:
  - 5.5.3.1 Furness specialist rehabilitation unit
  - 5.5.3.2 Funding for patients who requirements at discharge fall between existing criteria

5.5.3.3 Contribution to NWL program costs for discharge support services.

## 6.0 Legal Considerations

6.1. Following approval, officers will progress the Section S75 agreement, the legal mechanism to enable the transfer of funding.

## 7.0 Equality, Diversity & Inclusion (EDI) Considerations

7.1. None, as all the existing and new programmes will be delivered to all qualifying patients across Brent.

## 8.0 Climate Change and Environmental Considerations

8.1. There are no specific climate and environmental considerations relating to this paper.

## 9.0 Human Resources/Property Considerations (if appropriate)

9.1. There are no specific Human Resources / Property considerations relating to this paper.

## 10.0 Communication Considerations

10.1. There are no specific communication considerations relating to this paper.

***Report sign off:***

**Rachel Crossley**
**Corporate Director of Community Health and Wellbeing**

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