NHS Central London Community Healthcare NHS Trust Brent NHS North West London Clinical Commissioning Group	**Community and Wellbeing Scrutiny Committee** 14 March 2022
	Report from the Borough Director NWL CCG Brent Borough
Transfer of Community Services from LNWHT to CLCH	

Wards Affected:	All
Key or Non-Key Decision:	For Information
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Janet Lewis Director of Operations, Central London Community Healthcare (CLCH) janet.lewis5@nhs.net Steve Vo Assistant Director Integration & Delivery, NWL CCG Brent Borough Steve.vo@nhs.net

1. Purpose of the Report

1.1 The purpose of this report is to:

- Set out the context for the transformation of community services in Brent
- Highlight the reasoning for the transformation programme and the vision for community services in Brent.
- Outline what the priority areas are, how they were identified and how they align with Brent's needs.

2. Details and Background

2.1 The Transfer of Community Services paper was presented to the Committee on 24th January 2022. Whilst the paper described the transfer of Community services to Central London Community Healthcare Trust (CLCH) that took place in August 2021, the Committee requested for an update on the

Recovery Plan for services with long waiting times and the progress of the Transformation programmes supported by the Aging Well Funds.

3. Recovery Plan

3.1 At the Community and Wellbeing Scrutiny Committee meeting on 24 January 2022 requested for the following items:

a) Comparative data on community waiting lists across North West London and action being taken to address long/hidden waiting lists in Brent
b) Information on the community services provided for infants, children and young people

3.2 The following section addresses the queries raised by the Committee by presenting CLCH's Recovery Plan.

3.3 During the Omicron wave of the pandemic, staff were redeployed to support and maintain core services including Discharge to Assess (D2A), Rapid Response, and District Nursing. However, non-core and clinic-based services were reinstated on 1st February 2022 and a review of waiting times for patients was undertaken, with recovery and trajectory plans for all services with long waiting lists developed. The overarching Recovery Plan will be monitored within the Trust and updated to the NWL Integrated Care System (ICS).

3.4 As part of the Recovery Plan, the following details the process of tasks taken:

- Validating waiting time lists
- Calling all patients requiring an appointment with long waits to ascertain they still require the service
- Discharging of inactive patients
- Recording patients that have been seen
- Clinical Triaging
- Reviewing and discussing with all patients waiting for non-urgent interventions of how their needs can be met
- Reviewing the waiting lists weekly by clinicians

3.5 CLCH has been working with their temporary staffing provider to see how they can support filling existing vacancies or providing additional capacity. Each service is in the process of developing and implementing their individual recovery plans.

3.6 In addition, the Trust has identified a process for stratifying large waiting lists to identify patients at greatest risk of harm and has completed Harm Reviews for patients at risk (over 52 weeks), which is a Trust wide process.

3.7 The following tables present services with their current waiting times and CLCH's Recovery Plan.

CBU	Service	Waiting Times				Covid Recovery	
		Longest wait (weeks)	Total waiting list - Current week	No. of Patients over 40 weeks	Waiting List (RAG)	How long to recover with current capacity?	What additional capacity needed to recover by end Q1 2022/23?
Brent & Harrow Specialist Services	Brent Podiatry	49	**964**	1		4 months	1 B6 2 B3 1 month
Brent & Harrow Specialist Services	Brent Nutrition & Dietetics	19	**429**	0		3 months	1 B6
Brent & Harrow Specialist Services	Brent Integrated Diabetes	26	**657**	0		3 months	1 B7
Brent & Harrow Specialist Services	Brent Respiratory Service	33	**90**	0		2 months	1 B6
Brent & Harrow Specialist Services	Brent Cardiology Service	5	**28**	0		5 weeks	

CBU	Service	Waiting Times				Covid Recovery	
		Longest wait (weeks)	Total waiting list - Current week	No. of Patients over 40 weeks	Waiting List (RAG)	How long to recover with current capacity?	What additional capacity needed to recover by end Q1 2022/23?
Brent Planned Care	Brent Adult Community Nursing	16	**470**	0			
Brent Planned Care	Brent Bladder and Bowel	13	**339**	0		Demand exceeds capacity	1 WTE B7
Brent Planned Care	Brent Rehab and Reablement Service	12	**493**	0			2x WTE B6 Physio 1x WTE B7 Physio 0.8 WTE 8a SLT
Brent Planned Care	Brent Falls	9	**114**	0			1 B6
Brent Planned Care	Brent Tissue Viability	1		0			

CBU	Service	Waiting Times					
		Longest wait (weeks)	Total waiting list - Current week	No. of Patients over 40 weeks	Waiting List (RAG)	How long to recover with current capacity?	What additional capacity needed to recover by end Q1 2022/23?
Brent Children's Specialist Services	Brent Paediatric Speech and Language Therapy	25	**209**	0		9 months	2.0 WTE agency for 4 months. Need to fill current vacancies.
Brent Children's Specialist Services	Brent Child Development Service	27	**179**	0		52 weeks+	1.0 WTE 8a AHP for 5 months 0.6 WTE staff grade doctor
Brent Children's Specialist Services	Brent Paediatric Physiotherapy	12	**65**	0		9 months	1.0 WTE agency for 4 months

CBU	Service	Waiting Times				Covid Recovery	
		Longest wait (weeks)	Total waiting list - Current week	No. of Patients over 40 weeks	Waiting List (RAG)	How long to recover with current capacity?	What additional capacity needed to recover by end Q1 2022/23?
Brent Children's Specialist Services	Brent Children's Occupational Therapy	12	**71**	0		9 months	2.0 WTE agency for 3 months. 3WTE B5 Need to fill current vacancies.
Brent Children's Specialist Services	Brent Community Paediatrics	9	**20**	0		na	na
Brent Children's Specialist Services	Brent Children's Community Nursing	7	**5**	0		No recovery. Team meeting KPIs	No additional required, need to fill current vacancies to sustain
Brent Children's Specialist Services	Paediatric Asthma Service	3	**9**	0			No recovery. Team meeting KPIs

3.8 In addition, the following table provide waiting times for some Community services in other boroughs within North West London that we have gathered for comparison. Please note that since community services have been commissioned differently in different boroughs, some KPIs are not directly comparable.

Jan-22					
Service	**Directly Comparable**	**Brent**	**Harrow**	**WL,CL,H&F**	**Comment**
Diabetes	Yes	% of service users offered first appointment within 4 weeks	% of service users offered first appointment within 4 weeks	% of service users offered first appointment within 4 weeks	
		40% (20/50)	100% (84/84)	100% (209/209)	
District Nursing	No	%of non-urgent referrals responded to during the day, twilight or night service periods within 24 hours	%of non-urgent referrals responded to during the day, twilight or night service periods within 5 working days		Note KPIs are not directly comparable
		100% (61/61)	100% (59/59)		
Rapid Response	Yes	% of urgent referrals responded to in 2 hours	% of urgent referrals responded to in 2 hours		
		100% (258/258)	94% (274/291)		
Children Speech and Language Therapy (SALT)	No	% of Children and young people seen within 8 weeks of acceptance of referral		% of Children and young people who enter treatment within 12 weeks of referral	Note KPIs are not directly comparable
		72% (69/96)		99% (155/167)	

4. Transformation of Community Services

4.1 The following section sets out how the progress of the transformation programme will be monitored and evaluated.

4.2 The following table provides the detail of the Transformation Programmes and the key measurables and actions set against these programmes.

I. Scheme	II. Description and Goals	III. KPIs/Targets	IV. Deliverables/Actions to support Implementation	V. Milestone Date
1. Planned Care				
b) Clinical Pathways for LTC Heart Failure (HF) and Respiratory	a. To co-design, co-develop, co-implement and co-evaluate the proposed new Models of Care / Pathways for Brent Heart Failure Services as part of the Community Services Transformation, and present this to the Community Services Executive Group for oversight and approval.	a. Develop/agree outcomes measures and KPI's to be used to measure the success of this transformation	a. Establish HF & Respiratory Task & Finish (T&F) Groups with agreed TOR. Update: Both T&F groups have agreed TOR . HF group meeting on regular basis. Governance structure reviewed and agreed b. Mapping of current service provision and pathways. Update: Completed for HF & gaps identified. c. Develop and agree new pathways and model of care that will improve integration, quality and outcomes for Brent Heart Failure services; such as digital and virtual ward pathways for improvement. Update: LNWH & CLCH have developed virtual ward model, and agreed workforce model to include rotational placements and shared training. Phase I of T&F groups is to develop new pathways & service specs. d. Align Service to NWL CVD Clinical Reference Group and NWL Strategies. Update: HF T&F has representation from NWL CVD CRG e. Co-design Service Specifications that reflect whole system redesign and integration. Update: PCN Clinical Directors sit on the T&F groups and are co-designing the pathways and service specifications with CLCH & LNWHT f. Improve pathways for transition of care between acute and community services to reduce unplanned and avoidable acute activity . E.g Virtual wards and hospital at home. Update: Pathways are being developed in T&F groups and HF	a. November 2021 b. HF - Feb 2022 c. – e April 2022 f. – g. September 2022 Willesden Hublet aims to go live mid-February 2022

			pathway will be integrated working across primary care and secondary care interface g. To develop community respiratory pathways and services including Spirometry Hublets. Update: Spirometry SOP agreed, equipment agreed, staff training in progress. EMIS GP searches are in process of being tested. h. To develop synergies between services and progress towards a cardio-respiratory service model i. CLCH & Brent to review and formalise (service specification) the implementation of Community services, looking at supporting PCNs on Long Covid clinics.	

I. Scheme	II. Description and Goals	III. KPIs/Targets	IV. Deliverables/Actions to support Implementation	V. Milestone Date
2. Unplanned Care				
a) Enhanced care in care homes (framework + DES)	a. To implement the Enhanced care home DES for care homes (and other residential settings), working in partnership with CLCH and PCNs. CLCH to provide the MDT professionals in-reaching to the care homes in Brent, working alongside the PCN GP Practices such as during the MDT meetings. To appropriately implement the use of digital technology to support care home, To include care home residents in any Frailty delivery model	a. To reduce unplanned avoidable admissions to hospitals. b. To improve access to health and social care in care homes.	a. To refresh stakeholders with EHCH aspirations and ambitions in line with the framework (March 2020) ambitions and the Primary Care 'Network DES' targets. Update: Presentation of ECHH Framework to Care Home Forum on 15th December 2021. Stakeholder summit on November 2021 with representation from PCN's, LA, EOL, CLCH, Care Homes, and LAS. b. To Identify gaps / opportunities for improvement through patient-public and wider stakeholders engagement. Update: Stakeholder event August & November 2021, monthly care home forum, Peer support programme to improve CQC ratings c. To work with PCNs to develop and deliver new model. Update: NWL MDT Terms of Reference finalised and sent out to PCN directors and care home lead GPs. d. To monitor progress in achieving EHCH framework aspirations and DES targets and provide support to teams as required. Update: NWL Primary Care DES Gap Analysis was circulated on 12th February 2022 to PCN directors and care home lead GPs. Objective is to establish how care is delivered to care homes across NWL and identify gaps.	November 2021 January 2022 March 2022 March 2022

3. Hospital Discharge & Community Bedded Units				
a) Discharge hubs/pathways	a. Improve timeliness of hospital discharge, increasing referrals into pathways 0-2. through effective MDT working.	a. To reduce hospital aLoS – 21 days and over, <14 days, <7 days, at par with the Pan-London average (currently sits at 12%). b. To monitor Hospital Discharge Pathway tracker.	a. Implement a Discharge Hub model. Update: The model has been implemented. b. To promote seamless transfer of care from hospital back into the community. Update: The Integrated Discharged Team provides a more streamlined approach to discharge. The use of having community providers onsite enables more timely progress for discharges, including therapy reviews with patients on the ward as needed. This provides a better overview of complexities to ensure the risks are understood and can be mitigated against.	October 2021 December 2021
b) Rehab and reablement (inc general and neuro beds)	a. Improve effectiveness of service and pathways from hospital, increasing support at home.	a. To deliver an effective Rehab at home Service.	a. To develop and implement models aligned with NWL ICS standards for Bedded Units. Update: The current community rehab bed provision (Aster Unit – Birchwood Grange Care Home) has been re-contracted in accordance with the NWL ICS standards for bedded units (new contract started Dec-21). A test and learn scheme is due to be initiated in April 22 to develop and prototype an integrated therapy at home and reablement pathway for patients with complex needs as an alternative to bedded rehab provision. This work is aligned with the NWL CCG community rehab bed review b. To develop and implement models aligned with NWL ICS standards for Community-based Rehabilitation. Update: A Discharge to Access (D2A) pilot to test the impact of increased access to physiotherapy as part of an integrated Home First/ reablement pathway (Pathway 1) is on track to be completed in March. The output from the complex (Pathway 2) test and learn will inform the blueprint for new models for integrated community rehab and reablement pathways. A separate test and learn scheme is being developed that will focus on prototyping integrated community rehab and reablement provision as part of the community urgent care pathway. The intention is to run this scheme in April/ May alongside the complex rehab and reablement test and learn scheme. The local authority has taken the decision to commission a new reablement service. The new service is not expected to be in place until Oct-22 at the earliest.	31 October 2022 31 October 2022

4.2.1 EMIS Project

In addition to the programmes above, CLCH committed to the transfer of the patient electronic record from System One (S1) to EMIS and have now set up an operations and IT team to deliver the project.

The work to deliver this has commenced with an anticipated completion date of the 1st June 2022.

The benefits of the transfer are that there will be better communication between the community health services and the GP services. This will enable improved patient care and patients will not need to repeat information between services in primary care and community care.

4.3 Aging Well Funds Updates

In September 2021 the NWL CCG allocated funds to all boroughs, the aim of which was to level up service delivery in identified services.

The value given to each borough was based on population and demographic work completed within NWL.

CLCH was requested as the main community provider to detail out a recruitment plan with partner organisations to obtain best value for this funding and deliver the localised transformation plans.

A detailed plan for funding allocation was developed and signed off through the community services executive group.

Recruitment has been challenging, however transformation for Heart failure, Diabetes and care homes services have been maintained whilst recruiting with the support of bank/agency staff.

The investment into Care Homes is including the development of an integrated, enhanced care home team between CLCH and Central and North West London Foundation Trust (CNWL) to support physical, mental health and learning disabilities needs.

On-going investment for a period spanning three years will occur to enable further investment into community services.

4.4 Patient Engagement - Brent Health Matters (BHM)

4.4.1 Brent Health Matters is a joint partnership between Brent Council, NWL CCG, Central and North West London Trust, London North West University Healthcare Trust, Central London Community Healthcare, and most importantly, the community.

4.4.2 The aim of the programme is to reduce health inequalities in Brent. Council and NHS partners are working with the community to tackle the priority issues (see aims listed below) and those raised by the communities themselves. The initial focus was on Alperton and Church End because of the magnitude of impact of Covid-19 (and health inequalities) on those specific communities, however the programme is engaging with communities across the borough to:

- Reduce impacts of Covid-19 on the community
- Increase uptake of vaccinations and health screening
- Reduce variation in life expectancy and long term health conditions (diabetes, hypertension, obesity, mental health and cardiovascular disease).
- Increase community awareness of existing support/services and improve access to health services.
- Increased engagement with GP Practices including an increase in the number of people registered with a GP
- Work with partners to address the wider determinants of health inequalities

4.4.3 The BHM Clinical service consists of a multidisciplinary team that works closely with 10 GP practices to improve health and wellbeing outcomes of high risk patients. The service takes a proactive and flexible approach to engage with patients who have one or more long-term health condition, to support them to manage their conditions and take up flu and Covid vaccinations. Last year, 2,300 patients were contacted which led to 323 given flu vaccinations, 1865 comprehensive health assessments completed, 187 patients with high blood pressure checked, 685 patient care plans updated and 560 patients receiving bespoke health education.

4.4.4 The Clinical Service also operate an advice line open to anyone living in Brent, so that Brent residents can contact the team to ask about any clinical or social care concerns or queries, and be signposted or referred to the right support. The team also provides one-to-one support to residents who face barriers registering with a GP.

4.4.5 Mental health practitioners from the BHM Central North West London NHS Foundation Trust (CNWL) team are based in GPs, and work closely with the Clinical Service to provide one-to-one support to patients who have a mental health or wellbeing need. The CNWL team is also made up of 5 Community Connectors who work in the community to engage with voluntary and community organisations and faith leaders, to raise awareness about mental health and wellbeing and co-develop solutions that can improve access for communities in the future.

4.4.6 Five Community Coordinators continue to build community networks by engaging with community groups, voluntary and community sector organisations and the wider community through a range of engagement and outreach activities. Currently, 43 volunteer Community Champions work closely with the Community Coordinators to co-develop and implement local action plans for each Brent Connects area and thematic area, based on the

health inequalities issues raised by communities through the engagement activities.

4.4.7 BHM holds the Community Forum on a quarterly basis to engage with the community groups with 2 facilitators for diabetes and mental health discussions. The aim of this forum is to listen to the concerns raised by the community and feedback on the team's progress of addressing those concerns.

4.4.8 The programme has provided two rounds of grant funding to individuals, community and voluntary sector organisations. In April 2021, £250k was awarded to fund projects that aim to reduce health inequalities in Brent. In February 2022, £117k was awarded to 13 organisations towards projects that will promote uptake of the covid vaccine.

4.4.9 Five large-scale Diabetes events have been held in places of worship and other community spaces since November 2021. The events brought together clinical and engagement teams to offer information, awareness, advice, activities and health checks. The events were received well and the health checks were particularly welcomed by residents. BHM has held 5 large scale community Diabetes events with further the details in the table below and is planning for further events in March and April.

Number of people who attended the events	681
Number of people living in Brent	525
Number of people who are registered with Brent GP	489
Number of people who had health checks	422
Number of people who had Diabetes	171

4.4.10 A range of communications and engagement channels are being used to promote key messages and encourage discussions about key topics such as Diabetes, Covid vaccinations, mental health and others. This includes sharing assets and videos on social media including WhatsApp, a regular phone-in shows on the Beat FM, Your Brent magazine articles, monthly BHM newsletter and the vaccine bus.

4.4.11 30 Health Educators (10FTE) work in the community (through workshops, events and street outreach) to raise awareness of Diabetes and signpost people to the relevant services. Together they have engaged with almost 6,000 residents between June and December 2021.

4.4.12 Since January 2022, 4 Health Digital Champions have been delivering Diabetes digital inclusion classes to patients with Diabetes as part of a pilot

project to help patients manage their conditions online using Know Diabetes. The sessions have been well received by participants to date.

4.5 The engagement of service users and key stakeholders will be built in to individual workstream projects as part of the health Inequalities Assessment and Equalities Assessment requirements. This will also include stronger engagement of the voluntary sector and community groups for locality working.

4.6 Health Watch representation is being sought for the Community Services Executive Meeting.

4.7 The Transformation programme aims to use already established Forums such as GP Forums and those through the local authority to access and involve service users at all levels.

5. Strategy & Drivers

5.1 Brent and CLCH's vision for community health services for adults is that care will be delivered, wherever possible:

- ✓ *At the right time* - ensuring that an appropriate level of support is given, enabling early intervention and averting the risk of escalation.
- ✓ *In the right place* - within the community/locality where the child or young person lives
- ✓ Using the *right approach* - applying the latest evidence of best practice and within legislative guidelines
- ✓ *By the right service* - with specialist services supporting universal services to deliver care, wherever possible.

6. Financial implications

6.1 There are no financial implications arising from this report.

7. Legal implications

7.1 There are no financial implications arising from this report.

8. Equality implications

8.1 Brent CCG undertook a review of a number of service specifications for their community services to ensure they are in line with new NHS England standards and are inclusive or quality and safety developments. The expectation is that the new provider will be able to deliver the services as specified. The CCG and CLCH will work with stakeholders to develop and agree a service development plan that will seek to ensure continuous improvement in outcomes for our patients.

8.2 The provider will be required to provide holistic and integrated care that empowers people to be in control of their healthcare outcomes, working seamlessly with the local authority, primary, mental health, acute care services and the voluntary sector.

Report sign off:

Fana Hussain – Borough Director NWL CCG Brent Borough