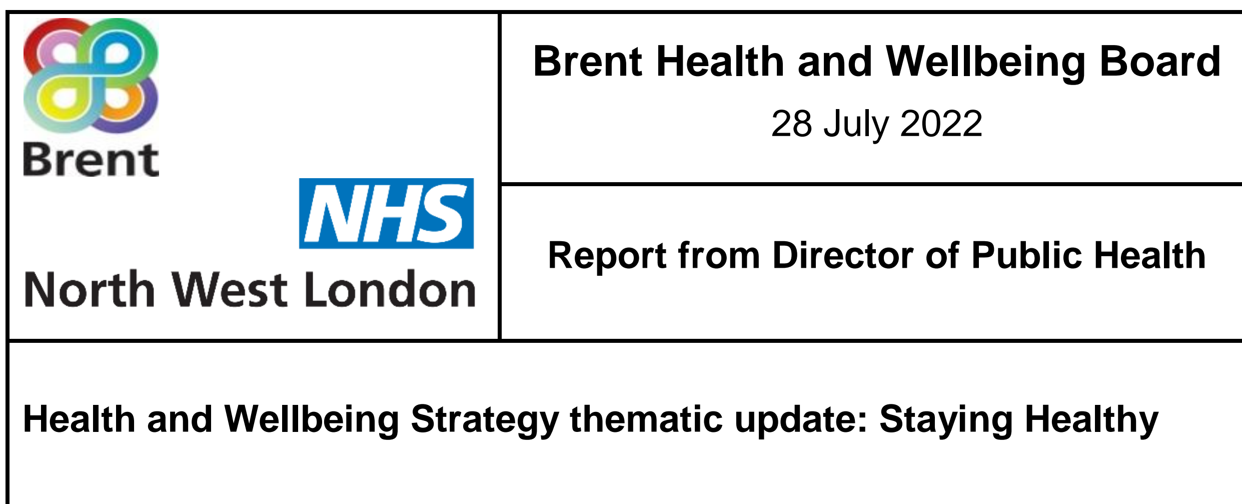

Brent Health and Wellbeing Board

28 July 2022

Report from Director of Public Health

Health and Wellbeing Strategy thematic update: Staying Healthy

Wards Affected:	All
Open or Part/Fully Exempt:	Open
No. of Appendices:	None
Background Papers	None
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1.0 Purpose of the Report

1.1 The purpose of this report is to provide an update to Brent Health and Wellbeing Board (BHWB) on the delivery plan for the Health and Wellbeing Strategy. The Health and Wellbeing Strategy was ratified by BHWB on 16 March 2022, and it was agreed that regular updates would be provided, each update focusing on one of the five themes: Healthy Lives; Healthy Places; Staying Healthy; Understanding, Listening, and Improving; and Healthy Ways of Working. This report provides an update focusing on the theme: Staying Healthy.

2.0 Recommendations

2.1 That Brent Health and Wellbeing Board note the contents of this report.

3.0 Detail

3.1 The Health and Wellbeing Strategy was developed in partnership with our residents and was agreed by the board on 16 March 2022. The strategy has five main themes:

- Healthy Lives
- Healthy Places
- Staying Healthy
- Understanding, Listening and Improving
- Healthy Ways of Working

3.2 Regular updates will be provided to the board, focusing on one theme at a time. The focus for this paper is Staying Healthy.

3.3 The overall outcome for Staying Healthy is: *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.*

3.4 There are 11 commitments in the delivery plan under the Staying Healthy theme, and an update for each commitment is contained below.

<u>We will develop a strategic approach to children and young people with mental health worries and services that meet all needs</u>

3.5 Building on the pilot service, the Council and Central and North West London NHS Foundation Trust (CNWL) have jointly agreed the service specification for a Targeted Mental Health and Emotional Wellbeing Service for Children and Young People in Identified Vulnerable Groups. The approach is in line with the Thrive model that has been adopted in Brent and will be part of a continuum of support for children and young people delivered by the health economy. An innovative peripatetic delivery model aimed at dealing with gaps in current provision will be tested as part of the new specification (partly funded by CNWL). The service will be procured to commence in February 2023 (for two years with the option to extend for a further 12 months). This will allow for further collaborative work with the North West London Integrated Care System/Brent Integrated Care Partnership Board as part of system developments.

<u>We will work across partners to increase awareness of services, including of the Voluntary and Community Sector (VCS) offer, to ensure support for individuals with mental illness to get the right support at the right time</u>

3.6 Brent Health Matters have provided £250,000 grant funding for the VCS. Projects must aim to reduce health inequalities. This funding is distributed through a participatory budgeting process, in which local residents vote for the programmes that will most benefit the community. This ensures both take-up of services and locally tailored initiatives

<u>We will ensure all can access their GP when they need to, and practice variations are reduced</u>

3.7 A number of initiatives aimed at increasing capacity in general practice are being implemented. These include increasing the workforce within general

practice and working with Community Pharmacies to ensure patients with appropriate condition receive the care and intervention required.

Additional Roles Reimbursement (ARR)

3.8 This is a national initiative aimed at increasing the staff skill mix at practice level. GPs are supported to recruit a range of staff disciplines to support patients in community settings. PCNs have been supported to maximise on the multidisciplinary team members they are able to recruit.

3.9 These additional roles will create capacity in general practice and free up GP/ Nurse time to focus on those patients with the highest need.

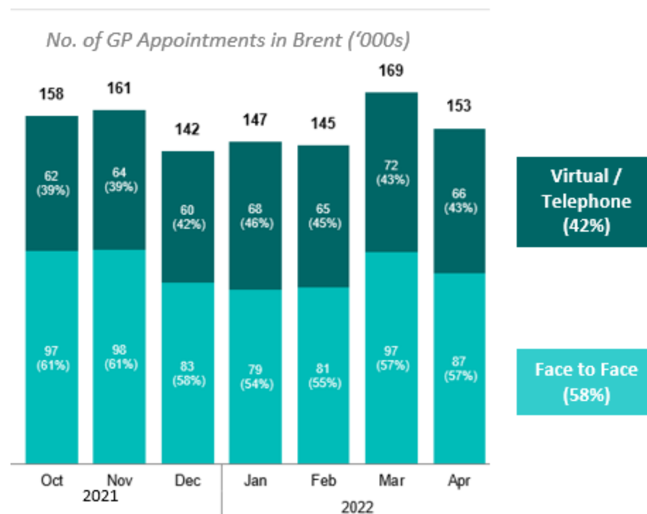
Community Pharmacy Consultation Scheme (CPCS)

3.10 There are 74 Community Pharmacies in Brent and 51 GP practices. Pharmacists training spans a period of five years. NHS England Community Pharmacy Consultation Scheme (CPCS) draws upon the training of local pharmacists and offers patients same day minor illness consultation with a community pharmacist. The scheme enables local GP practices to refer appropriate patients to community pharmacists for same day consultation with clinical advice and where required purchase of over the counter medication. The scheme can support general practice to ensure patients are seen by the right healthcare professional in the right place and will help make more GP appointments availability for those with higher acuity needs.

3.11 Of the 74 Community pharmacists in Brent (plus eight distant selling pharmacies) 65 high street pharmacies are signed up to providing the Community Pharmacy Consultation Scheme. GP practices and pharmacies are working together to develop a clear referral pathway to ensure a seamless service between the two service providers. While IT challenges and data reporting issues have been highlighted during implementation, local GPs and community pharmacies are working in close liaison to ensure the development and imbedding of this integrated pathway. NHS England continues to monitor the scheme nationally.

Appointment activity

3.12 NW London service specification aimed at setting standards for general practice is due for release in October 2022. This will aim to assess appointment offered by the multi-disciplinary team and agree a standard for practices. The current focus has been to ensure standardisation of appointment recording and ensure that practices are routinely recording all patient contact. The number of GP appointments is set out in the graph below. These data exclude appointments offered by Nurses, Pharmacists or other healthcare professionals. The appointments offered through Access Hubs, WSIC service, phlebotomy etc are also excluded.



Investment in Access Hubs and extended access provision to improve on the day access

3.13 From 01 October 2022 Primary Care Networks (PCNs) are required to deliver 60 minutes of extended hours' provision per 1,000 weighted patients. This is double the current requirement for GP Access Hub provision. The Hubs will be required to provide enhanced access between the hours of 6.30pm to 8pm Monday to Friday and between 9am and 5pm on Saturday (known as the Network Standard Hours). The Hubs will provide both advance bookable appointments and on the day booking. During the Network Standard Hours appointments will be offered both face to face and remote (telephone, video or online). The PCNs remit is to ensure the mixture of appointments seeks to minimise inequalities in access across the patient population.

3.14 A NW London survey clearly demonstrated patents preference for Saturday appointments (22%) as opposed to Sunday appointments (4% preference). The continued engagement of patients in developing the Enhanced Access Hub will ensure the Hubs meet the needs of local populations.

3.15 Communication on the hub locations, and the process for booking appointments will be communicated through a range of media including GP websites.

<u>We will reduce the variation of impact from long term conditions between communities, and build on the diabetes model</u>

3.16 The Brent Health Matters (BHM) team is working on reducing the variation of impact from long term conditions and is currently focusing on diabetes. The team has held 12 large scale community Diabetes events, completed between November 2021 and June 2022. Overall there have been 1,409 attendees with 1,170 health checks done. The current plan is to hold at least two community diabetes events a month.

3.17 There are two super diabetes events planned in September, one in the north of the borough, and one in the south. The BHM team will work with PCNs to target

specific cohorts of patients. The BHM clinical team is also working with all PCNs to support patients with Diabetes who don't access services identified by the GP practices. Each GP practice has been asked to identify five patients that don't engage with accessing health care.

3.18 In primary care we are working on improving measuring the nine key care processes for patients with Diabetes. Last year's achievement was 8.6%, and the target for this year was 28.6%, in April we had achieved 44.2%.

We will introduce a mobile health bus, ensuring outreach in areas experiencing health inequalities

3.19 The mobile health bus has been introduced and holds regular roadshows in different areas around the borough. A variety of services are provided on the bus, including mental health; cancer awareness; health checks; healthy eating; physical activity; and smoking cessation.

3.20 From February to June 2022 there have been 23 events, with 1,335 residents engaged.

We will increase community awareness and use of services, and address needs in commissioning processes

3.21 A review of all local advice service contracts was undertaken and contracts were updated to ensure the appropriate advice and guidance is available to the local communities.

3.22 A map of local services is currently being developed, and is expected to be completed by the end of quarter two; this will then be used to identify gaps in service provision. This process will then be refreshed and repeated every couple of years.

We will ensure that children with complex health needs can access the support they need

3.23 The Index of Multiple Deprivation shows that Brent is the fourth most deprived area in comparison with other London Boroughs. For vulnerable people, this results in additional numbers of highly complex cases requiring intensive casework to prevent breakdown.

3.24 There is a dedicated provider collaborative function for CYP inpatient cases which provides Assessment and Treatment, and Safe and Wellbeing reviews.

3.25 The pandemic has resulted in a 40% rise in poorer mental health amongst CYP and in LD/ASD cases this is even higher (one in six cases as opposed to one in nine cases). CYP and Adults with ASD experienced a higher incidence of MH

requiring an inpatient stay – many were negatively affected by lockdowns and restrictions.

3.26 The Dynamic Support Register for Transforming Care, chaired by the Head of Integrated Complex Care, Brent Council is attended by SEND and relevant CNWL CAMHS representatives, and as required attendance by Positive Behaviour Support. The terms of reference were reviewed and updated in October 2021 by all partners.

3.27 As well as this, separate LD/ASD and ASD only meetings are each held monthly.

<u>We will improve your experience of hospital care</u>

3.28 LNWUHT have identified the need to improve patient experience through the expansion of models of care which enable patients to have access to specialist care within their own home and supporting their discharge from hospital.

3.29 This has led to the development and implementation of a virtual ward for patients with Heart Failure with the aim of ensuring access to specialist cardiology care during and following hospital discharge to reduce re-admission. The programme also aims to reduce the need for admission.

3.30 Patients are admitted from both Northwick Park and Ealing Sites.

3.31 So far we have:

- Implemented a Heart Failure Virtual Ward with 103 patients on the pathway
- Developed digital processes to enhance clinical review
- Led on this pathway for the sector in collaboration with other trusts
- Collaborated with Local Community providers and GPs to support the integrated pathway

3.32 The benefits to patients from this model of care include:

- Specialist review of medication and monitoring of side effects
- Information on their condition and how to manage it them selves
- Information on who to contact if there are any worries or issues
- Clear direction for what to do in an emergency
- Specialist Nurse or Doctor discussion during their time on the programme
- Handover to their community teams on discharge

- Use Patient Feedback to improve outcomes
- Decreased admissions and bed days

3.33 We are monitoring equity of access for patients from different ethnicities. We have identified that we need to improve access to patients from Brent and are working with the Heart Failure Task and Finish Group and Community Provider CLCH to develop the integrated pathways. The pathway is at the ratification stage and we are planning to go live in the next month.

3.34 Work will continue on this model of care, and will include setting up access to digital appliances for patients who are unable to afford them, and working with digital providers to develop support structures for patients who are not technologically aware.

3.35 This model is being used as template for other conditions.

We will ensure excellence in our care homes

3.36 The Adult Social Care Commissioning Service has a Residential and Nursing Team that is responsible for the commissioning and quality assurance of care home services and placements. The team carries out statutory safeguarding enquiries in Brent Care Homes and individual placement reviews with Brent service users placed in nursing or residential care (whether those placements are made in borough or out of borough). The team was created when the current Commissioning structure was implemented in 2017. The benefit of creating a team that has oversight of the care home market is that work on quality assurance, placement review and safeguarding is done by one team, helping to form an overall view of quality in the care home sector. Each home has an allocated Placement Relationship Officer (PRO), who is responsible for quality assurance and service user reviews within their allocated portfolio of homes.

3.37 The Residential and Nursing Team is able to bring together the intelligence it gathers from its three areas of work to give a comprehensive picture of residential and nursing services in the borough. As well as information gathered by our own staff, we take into account views of residents, family members and other professionals working in care homes (specialist health staff for example), to build up a picture of quality in Brent services. The team shares information and intelligence on a quarterly basis with the Care Quality Commission, the national regulator of care services, to help inform its view on care home provision in Brent. Each home is given a RAG rating based on their work and this determines the frequency of quality assurance visits. The frequency of visits is based on risk and quality of care; the number of placements the council has with the provider and the size of the care home. Larger homes, with multiple placements, will be visited more frequently than smaller services, unless the risk profile justifies more regular visits to the smaller service.

3.38 Having an allocated Provider Relationship Officer (PRO) is a particularly effective way of working with the care home sector. With nearly 60 homes in the borough, having a good oversight of the sector is crucial. With each PRO managing a portfolio of eight to ten homes each, this becomes more manageable. It also gives care home managers a route through which to contact the council when seeking support, which has been particularly important over the last couple of years as the council and providers have been managing the Covid 19 pandemic.

3.39 The council and partners are engaged in a variety of work with care home providers to improve the quality of the Brent care home sector. Brent runs a monthly care home forum, which is used as a mechanism to communicate and work with homes on good practice developments across the sector. The forum is regularly attended by colleagues from Public Health, the CCG and other partners to help registered managers with initiatives and good practice that can lead to better resident care. The forum is chaired by Basu Lamichhane, manager of Victoria Care Centre. Basu is also a member of the Brent Health and Wellbeing Board, providing a direct link from the care home sector to the Board.

3.40 Brent is running a programme of care home improvement through the Enhanced Health in Care Homes Programme. This programme is jointly funded and commissioned by the council and CCG and delivered with key partners including GPs and CLCH (Brent's community healthcare provider). The main areas of work in the programme include working with providers on key areas of training and development for staff, medication safety in care homes and implementing the Primary Care Network Directed Enhanced Services (DES), which aligns each care home with a GP and multi-disciplinary team to support personalised care and support in Brent's care homes. The programme has also delivered the Covid 19 vaccination role out in Brent Care Homes. Vaccination levels amongst care home residents are very high – 94% of residents have had two doses of the vaccination, and 90% have received their booster.

3.41 The Enhanced Health in Care Homes Programme also includes a Peer Support Programme, which has provided intense, dedicated support to care homes in the borough for that last year. The Peer Support programme is led by Mark Bird, previously registered manager at Birchwood Grange Care Home, Brent's only Outstanding rated care home. Mark Bird has worked with ten care homes during the Peer Support programme, working with managers on improvements that can be made to practice and care provision in their services. Homes have been involved for a variety of reasons – some have welcomed the additional input ahead of a CQC inspection, others because there were concerns about the quality of care and so they have benefited from the bespoke support of a former registered manager. The feedback on the programme has been very positive and three of the homes that were subsequently inspected by CQC have seen their ratings improve from

Requires Improvement to Good, reflecting the work undertaken by the care home managers and staff, and the programme's input. The remaining seven services are still to be inspected by CQC.

We will make sure you have what you need to be safe and well at home

3.42 People who approach the council in need of support from Adult Social Care will have to undertake a Care Act assessment to determine whether they are eligible for formal support from the local authority. Before anyone is assessed they will be offered information and advice to help them seek their own support from friends or family or other networks available to them without relying on commissioned care.

3.43 If, following their Care Act assessment, a person is eligible for support the service's initial aim will be to provide that support to enable the person to continue to live at home. This might be through a short term, time limited reablement care package, where the service user will be helped to regain skills they have lost. Or, the council could commission a homecare package for the person, providing care and support on a regular basis, but also encouraging the person to do as much for themselves as they can. Services can also be provided via a direct payment, where the service user is able to commission their own care using the direct payment budget available to them. Other forms of care, such as residential, nursing or supported living are only considered when it becomes unviable for the service user to remain in their own home.

3.44 The council is in the process of reviewing services for carers and our social isolation service, both of which are aimed at delaying the need for ongoing formal support. These services are currently provided by Brent Gateway, a consortium of providers led by Age UK Brent, Hillingdon and Harrow. The offer delivered via Gateway is being revised in consultation with service users and carers, and will be recommissioned once the Carers Strategy is finalised, which will set out the vision and objectives for these services in the future.

We will increase take up of vaccinations, targeted at those experience health inequalities and disadvantages

3.45 Vaccinations have been offered to residents in different locations, ensuring easy access for all. The locations have been specifically chosen in areas where there are known health inequalities or disadvantages. This year, 1,020 individuals have received their vaccinations on the bus, and a further 381 at pop-up events. The Vaccination Centre at the Civic Centre has also proved successful, vaccinating a total of 11,105 people this year, 5,305 of whom were walk-ins.

4.0 Financial Implications

4.1 In terms of the JHWS development, there are resource implications for Brent Council, and NWL CCG, in terms of officer time and engagement work with the

public. The latter is unlikely to be significant and can depend on getting support from partners in kind.

4.2 It is anticipated that any associated costs will be funded from the existing budgets.

5.0 Legal Implications

5.1 The duty in respect of Joint Health and Wellbeing Strategies (JHWSs) is set out in s116A of the Local Government and Public Involvement in Health Act 2007, as amended. In addition, the Health and Social Care Act 2012 places a duty on local authorities and Clinical Commissioning Groups (CCGs) to develop a Health and Wellbeing Strategy to take account of, and address the, challenges identified in the Joint Strategic Needs Assessment (JSNA). Pursuant to the Care Act 2014, the Council has a duty to ensure a clear framework is developed to meet its wellbeing and prevention obligations under the Care Act.

5.2 The Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (Statutory Guidance) 2013 states "Health and Wellbeing boards will need to decide for themselves when to update or refresh JSNAs and JHWSs or undertake a fresh process to ensure that they are able to inform local commissioning plans over time. They do not need to be undertaken from scratch every year; however, boards will need to assure themselves that their evidence-based priorities are up to date to inform the local commissioning plans".

5.3 In preparing JHWSs and JSNAs, Health and Wellbeing Boards must have regard to the guidance issued by the Secretary of State, and as such, boards have to be able to justify departing from it.

6.0 Equality Implications

6.1 Health and Wellbeing Boards must also meet the Public Sector Equality Duty under the Equality Act 2010. S149 of the Equality Act 2019 provides that the Health and Wellbeing Board must, in the exercise of its functions, have due regard to the need to:

a) Eliminate discrimination, harassment and victimisation

b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

6.2 The Public Sector Equality Duty covers the following nine protected characteristics: age, disability, marriage and civil partnership, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

6.3 The Statutory Guidance states *"this is not just about how the community is involved but includes consideration of the experiences and the needs of people with relevant protected equality characteristics (as well as considering other groups identified as vulnerable in JSNAs) and the effects decisions have, or are likely to have on their health and wellbeing".*

Report sign off:

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