Brent Health and Wellbeing Board
13 October 2022

Report from
Brent Integrated Care Partnership (ICP)

Winter Planning

Wards Affected:	All Brent
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt:	N/A
No. of Appendices:	Appendix 1 - NWL ICB Winter Planning Allocation
Background Papers	N/A
Contact Officer(s): (Name, Title, Contact Details)	Claudia Brown Operational Director Adult Services (DASS) Claudia.Brown@brent.gov.uk Steve Vo Assistant Director of Integration and Delivery, NWL ICB – Brent Borough stevetruong.vo@nhs.net

1.0 Purpose of the Report

1.1 The purpose of the report is to inform the board of Brent's plan and preparedness to manage the anticipated winter pressures to the local health and social care system.

2.0 Recommendation(s)

2.1 It is recommended that the group notes and comments on our local Winter Planning initiatives, which have been identified to proactively look after our residents over the winter period.

3.0 Detail

3.1 Key stakeholders from Brent Integrated Care Partnership (ICP) have come together as a single Borough team to jointly establish various schemes to support pressures on the hospital system during Winter. Partners on the ICP include Brent Council, London North West University Hospital NHS Trust (LNWUHT), Central and North West London NHS Foundation Trust (CNWL),

and Central London Community Healthcare NHS Trust (CLCH) have come together via multiple Task and Finish Groups.

3.2 The schemes that have been developed build on strong existing joint working, including multiple initiatives which are in place as part of business as usual working to reduce hospital delays, including a dedicated hospital discharge team, Home First and other services

3.3 In addition to existing joint working, the proposed Brent Winter plan builds on a Better Care Fund Plan, which includes within it number of schemes in development with adult social care to ensure a resilient social care system and to support further integration between health and social care. The BCF schemes include provision for additional Social Workers to assist with flow and hospital discharge, a handyman service to assist residents at home, housing for residents with homelessness issues, and step-down beds to assist patient flow.

3.4 These primary purposes of the proposed schemes are to support the system's resilience in the coming winter months with the aims to reduce avoidable unplanned admissions to hospitals and other Urgent Emergency Care services, improve pro-active care, improve access to community (out of hospital) services and promote self-care and well-being.

3.5 The Winter Schemes were also developed to mitigate the risks associated with NHS funding for 'Discharge to Assess' coming to an end in NW London in September 22, which potentially posed an additional risk for hospital trusts, in particular for more complex needs.

3.6 The joint partnership has received buy-in and support from all Brent ICP partners and it is proposed that locally lodged NHS funds are used to fund these schemes, pending any allocations of Winter funding from NW London. The total cost for these schemes is £927k.

3.7 It should also be noted that NHS England has now confirmed £15.54 million Winter funding allocation to NWL ICB for to NHS hospitals, primary care, social care and NHS Community providers across North West London. At the time of writing, it is not clear what proportion of this allocation will be available to support Brent schemes. Further detail on the high level allocations is included in Appendix 1.

3.8 There has already been much effort across the NWL system overall and Brent ICP to ensure efficient level of beds in both hospitals and Community, best usage of the current capacity, and reduction in A&E and urgent care demand. In addition, key representatives from each ICP partner have met to propose a long list of schemes started in July 2022. This led to further meetings to refine the schemes with clear objectives, finance, plans and key deliverables. As a result, the long list has been prioritised to create the following local schemes as depicted in the table below.

Area	Funding
Primary Care	£150k
Supporting Mental Health Service Users	230k
Holistic Support MH and Wellbeing	£80k
Overnight Service	£100k
D2A Mitigation Plan (due to discontinuation of D2A funding)	£367k
Total Funding Required	**£927k**

3.9 Primary Care Schemes: The following are the Primary Care schemes with the aim to prove Access to Primary Care

3.9.1 Primary Care Network - Primary Care Network - Enhanced Access Hubs Pilot: Additional capacity on Bank Holiday/Sundays for re-direction from Northwick Park. The suggestions are to establish one site across Brent/Harrow and have additional GP appointment slots on Sundays and Bank Holidays for re-direction of patients away from UTC. The model would operate alongside the LNWUT re-direction pilot. Patients attending Urgent Treatment Centres (UTC) for primary care conditions are booked into appointments at Wembley Centre for Health and Care. This will be in core hours when GP surgeries are open Monday to Friday. The remaining hours will be covered by Enhanced Access Directed Enhanced Services (DES) funded by NHS England which operates Monday to Friday 6.30pm to 8pm and on Saturday 9am to 5pm.

3.9.2 GP Surgeries – Health Inequalities Clinics: Practice level dedicated clinics operating on weekend focused on high risk patients at risk of admission and supporting pro-active care. This is delivering Saturday morning clinics for patients unable to access services in core hours such as housebound patients, zero-hour contract workers, carers, etc.

3.10 Supporting Mental Health Service Users: The following are schemes dedicated to support Mental Health service users.

3.10.1 Northwick Park Hospital Adult Mental Health Emergency Centre (7-day working): The Mental Health Emergency Centre will be funded on a 7-day working basis, staffed by 3 MH workers and 2 outreach workers who will work to offer contact at the point of admission. The outcome of this scheme is to reduce avoidable admission to general acute or mental health and facilitate earlier discharge from A&E. The joint team would work to support and divert people to settings that better meet their needs while improving patients' experience.

3.10.2 Additional Hospital Discharge Support: This scheme is to support earlier discharge from general acute and mental health wards, working from admission through to discharge. Hospital discharge support workers based in in patient wards, working alongside the acute team to facilitate early discharge for patient who are deemed clinically appropriate.

3.10.3 Community Places for People with Mental Health Issues and at Risk of Homelessness: This scheme is to provide stabilisation for patients in step-down beds, working closely with the community outreach workers, and supporting patients towards living as independently as possible. The aim is to prevent patients from using A&E as the only place of safety, preventing avoidable Urgent and Emergency Care (UEC) admissions.

3.11 Holistic support for Mental Health and Wellbeing: In addition to the Mental Health schemes above, the following are schemes to provide a preventative holistic support for patients with mental health via Community and Voluntary Sector partners.

3.11.1 Emergency Support Increase Rapid Response Capacity for Urgent Mental Health provided: The Brent Mental Health Crisis Support is to provide emergency and essential support for patients with Mental Health and Learning Disabilities experiencing emotional distress or crisis. This service is also to support people living with dementia in Brent during the winter period. The aim is to provide quality support to patients and avoid unnecessary avoidable A&E attendance by providing early intervention for patients at higher risk of experience mental health crisis.

3.11.2 Bereavement Support: This service provides one-to-one counselling to Brent residents affected by loss. This will aid in their recovery due to loss and bereavement. The scheme is aimed at patients who are at high risk of suicide, high anxiety, depression and other mental health conditions. This would prevent patients from using A&E or UEC services as well as lowering the number of visits to their GPs.

3.12 Overnight Service – Preventing Avoidable Admissions: The overnight service will support patients in their own homes, thereby reducing the need to repeated hospital visits and admissions, in addition to reducing admission to nursing homes. The service is to be piloted for 3-4 months; this would involve

2 carers working in pairs responding to an average of 3-4 patients a night. The service would enhance our existing services and operate during hours when BAU services are closed.

3.13 Discharge to Assess (D2A) Mitigation Plans: Due to the recent discontinuation of D2A funding, we have developed local plans to ensure that hospital discharge flow will continue to be supported as a priority, including possible mitigating arrangements where potential delays could occur.

3.13.1 Hospital Discharge Hub: Improve referral process from the hospital into ASC and community teams by:

- Using standard forms for all Boroughs
- Working through the hubs to ensure that early referrals are sent for patients with identified social care needs to enable early MDT discharge planning
- Working through the hub with Wards to ensure that forms are completed with all of the necessary information to enable effective discharge planning
- Working with hub, including ensuring strong social work presence to support discharge home is the preferred discharge route

3.13.2 Home First: Develop Home First offer to ensure that home is the preferred discharge pathway by:

- Ensuring timely and safe support is in place to support people at home
- Exploring potential of extended hours' provision
- Exploring potential for expanded home based health support (rehab, community health etc.)

3.13.3 Step-Down Beds: Provide additional step down beds in the community capable of supporting more complex patients, ensuring:

- Clear referral criteria jointly agreed between CHC, Complex care and ASC
- Sufficient support to enable support for complex clients including Non-Weight Bearing (NWB) and Delirium

3.13.4 Joint Commissioning Approach: Improved working between CHC and Adult Social Care, including:

- Agreement on communications to patients on admissions
- Agreement on lead commissioner arrangements and potential for more joined up approach

4.0 Financial Implications

4.1 Total funding request for the Winter Planning schemes is £927k using Borough based NHS lodged funds, which has been approved by the Brent ICP Board and ICP Executive.

In addition, as stated above, there is £15.54 million allocated to NHS hospitals, primary care, social care and NHS Community providers across North West London. However, Brent ICP has not been notified of the respective share of this funding that is allocated to the local schemes.

5.0 Legal Implications

5.1 N/A

6.0 Equality Implications

6.1 The Health and Equality clinics are dedicated clinics operating over the weekends to support the needs of our vulnerable patients including housebound residents who would not be able to access healthcare otherwise.

6.2. In addition, we are working closely with Brent Health Matters to ensure extend the Advice Line to weekends and bank holidays so that we can reach and redirect vulnerable patients to appropriate health and social services.

7.0 Consultation with Ward Members and Stakeholders

7.1 All Winter Planning Schemes have been worked through and agreed by all ICP stakeholders.

8.0 Human Resources/Property Implications (if appropriate)

8.1 N/A

<u>Report sign off:</u>

Phil Porter
Corporate Director - Adult Social Care and Health