Brent NHS North West London	**Brent Health and Wellbeing Board** 30 October 2023
	Report from the Integrated Care Partnership (ICP)
	Lead Cabinet Member Councillor Nerva

Winter Planning and Community Resilience

Wards Affected:	All Brent
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	N/A
List of Appendices:	Appendix 1 – Winter Care Planning Presentation
Background Papers:	N/A
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1.0 Executive Summary

1.1 This report aims to update the Health and Wellbeing Board on a comprehensive winter plan with input and engagement across system partners in Brent.

1.2 The severity of the pressure on health and wellbeing systems is due to a combination of factors. There is the known trend of increasing demand and acuity (i.e., Seasonal Flu, sicker and frailer patients), as well as limited capacity (across the ambulance, mental health, community, and acute sectors, all of which contribute to urgent and emergency care performance), workforce shortages (particularly in community nursing), and ongoing capacity challenges in primary and social care.

1.3 The Place Plan for Brent will focus on:

- Taking preventative action to mitigate where possible, the impact of illness of individuals, families and the health and care system, through our flu, and COVID immunisation delivery, particularly amongst groups experiencing the highest levels of health inequalities.
- Communication with local citizens to support them to navigate the local health and care offer, so care can be provided by the right service and/or individual in the right place.
- Support to all residents experiencing homelessness and asylum seekers through on-site vaccination clinics by the Brent Health Matters Teams and / or Find and Treat Team.
- Improving patient flow to free up hospital beds by providing effective, prompt and high impact interventions in and out of hospital care.
- Continuing to strengthen our support and capacity in primary and community teams to prevent admissions to hospital and ensure a robust discharge pathway out of hospital.
- Reducing variation in inpatient care and length of stay for our mental health service users by implementing in hospital efficiencies and bringing forward discharge processes.
- Securing efficient discharge pathways to reduce the length of time our citizens spend in the hospital once medically fit to leave by maximising the use of DHSC funding.

2.0 Recommendation(s)

2.1 It is recommended that the board notes and reviews the local Winter Planning initiatives that have been identified as proactively looking after our residents over the winter period.

2.2 It is recommended that the board provides a steer as to whether they are confident all key areas have been addressed and suggest any areas where system partners can build on schemes or improve on.

3.0 Detail

3.1 Contribution to Borough Plan Priorities & Strategic Context

3.1.1 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. This paper provides details on various schemes that meet the outcomes of strategic priority 5, as well as outcomes within the Health and Wellbeing Strategy throughout the winter period.

3.1.2 It also supports the Council's strategic priority 1 'Prosperity and Stability' to tackle inequality and to provide the best possible support for residents with complex needs. Additionally, it contributes to strategic priority 2, 'A Cleaner,

Greener Future' with the Brent Well and Warm programme, which is outlined below. The Brent Well and Warm programme also seeks to deliver against outcomes in the Climate and Ecological Emergency Strategy 2021 – 2030.

3.1.3 Finally, it supports the outcomes of the Homelessness and Rough Sleeping strategy 2022 – 2025. This paper provides a series of direct and indirect interventions that aim to support homeless people and rough sleepers throughout the winter period.

3.2 Seasonal infections

3.2.1 As at the end of week 40 (12/10/23), COVID 19 rates had shown a slight increase in the UK. As the weather becomes colder and people mix more indoors, COVID 19 infections are expected to further increase. As we are now learning to live safely with COVID, testing is much reduced, and we do not have reliable data on local rates in the community. The new variant BA.2.86 is circulating alongside earlier variants. Data is limited but there is no evidence at present that BA.2.86 infection is more likely to cause serious illness than other circulating variants nor that the protection offered by vaccination will be less. Flu rates and flu admissions remain low and stable. The usual seasonal increase in Respiratory Syncytial Virus (RVS) in young children has begun. RSV is usually mild causing cold like symptoms, but in babies, and the elderly, can be a more serious disease.

3.2.2 Prevention

3.2.2.1 Robust flu and COVID vaccination programme across all cohorts

3.2.2.2 ICB COVID and Vaccination Programme: There is a robust flu and COVID vaccination programme across all cohorts. A new COVID-19 variant, BA.2.86, has been detected with evidence of established community transmission in the UK. The UK Health Security Agency (UKHSA) has advised that the public health intervention with the greatest impact is the vaccination of eligible groups. Accordingly, the autumn COVID vaccination programme has been brought forward, which commenced on 11th September. The aim of this programme is to vaccinate as many eligible people as possible by the end of October. The co-administration of flu vaccination alongside this accelerated delivery of COVID vaccination will have operational and public health benefits. The eligibility for flu and COVID vaccination remains unchanged, although this will be kept under review by Joint Committee on Vaccination and Immunisation (JCVI). There has been no change in advice or action on COVID-19 testing, infection prevention measures, outbreak management measures or treatment.

Alongside several Community Pharmacies, local PCNs are also supporting the acceleration programme for COVID and, where possible, dual vaccination with Influenza. Under the new targeted deployment model, all sites will be initiating a starting amount of vaccine followed by automated replenishment, dependent on weekly bookings using local and national booking systems. Regular reviews with the NWL team and the PCN leads to ensure all eligible

patients are vaccinated on time. Practices can also provide vaccination through local arrangements with their PCN and network. With the Roving Team offering support, PCNs coverage and cohorts are highlighted in the table below:

Network	Covering	Vaccination Site	Offer to	Roving Support
Harness	Harness North & South	Park Royal Medical Centre	Carehome, Housebound & those Eligible	Full PCN coverage, no roving support
K&W	K&W North, South, West & Central	Wembley Centre for Health & Care	Carehome, Housebound & those Eligible	PCN Coverage with additional support provided by Roving team
Kilburn	Kilburn Partnership	Willesden Centre for Health and Care (Confirmation of agreement with NWL Estates?)	Carehome, Housebound & those Eligible	Full PCN coverage, no roving support

There is also outreach work taking place at a Black and Black British event at the Wembley Centre on 21st October which will look to directly tackle health inequalities linked to the community.

3.2.2.3 Of 621 care home residents 382 have accepted a COVID vaccination which equates to 61.5% as at 17 October. All residents have been or will be offered a COVID and flu vaccination by 22 October. Of the 65+ resident group 11,386 of 45,999 have been vaccinated for COVID in a period of 5 weeks.

Brent Civic Vaccination Centre: the COVID19 autumn booster and Flu vaccinations will be available to eligible residents at the Brent Civic Vaccination Centre on the first floor. The centre is open and providing vaccinations on Mondays and Tuesdays between 9:30am – 4:30pm. Residents can book their vaccinations through the NHS UK website.

3.3 Primary Care – GP Delivery Model and enhanced services

3.3.1 GP Surgery services are available during the core hours of Monday – Friday between 8am and 6.30pm. Services are required to be open during these times including Christmas and New Year's Eve. Practices are required to confirm their opening hours with the NW London Primary Care Teams. There is also a redirection service available from NHS 111 back to practices.

3.3.2 Primary care has an enhanced service for carers. The service aims to provide support to carers. The focus of the service is to create an environment where carers are identified and supported to look after their health and wellbeing while caring for their loved one, promoting positive health and wellbeing for carers. The intention is to reduce carer crisis and family breakdown as well as

unwarranted variations in carer support and to tackle health inequalities. There will be work done to identify 'hidden carers' who despite having a caring responsibility, do not recognise themselves as a carer. Carers will be offered on-going advice, information and support.

3.3.3 Primary care also has an enhanced service for under-represented groups providing pro-active health and wellbeing assessment. The groups include those who are:

- Housebound through physical or psychological illness
- Homeless including rough sleepers, those living in accommodation which is unreasonable to occupy, people living in hostels or supported accommodation.
- The hidden homeless such as people in 'squats' or 'sofa surfers' as well as those in Supported Living, Extra Care and Supported Care Services (that are not covered under the Care Home ES).

This service promotes a multi-disciplinary approach with partners to support patients.

3.4 **Brent Well & Warm Programme**

3.4.1 The Brent Well and Warm service offers vital support to vulnerable residents by providing access to practical high quality energy advice and assistance, helping residents to keep bills down and to heat their home more efficiently. The service aims to provide a valuable safety net for those most vulnerable and fuel poor residents, who are suffering hardship through being unable to heat their homes.

3.4.2 Brent commissioned Groundwork to deliver this service. Residents are triaged through existing routes within Brent Council (such as Community Hubs, Family Wellbeing Centres, outreach workers in roles, which make regular day to day contact with residents, such as housing or social care) and through partner organisations, who are well placed to judge if a resident requires support and may be eligible to be signposted to the service.

3.4.3 Groundwork carries out an initial virtual consultation to provide a comprehensive assessment of the residents' energy needs and will identify what (if any) interventions are necessary and suitable. Where suitable, the service provider will also conduct in-home energy advice visits to similarly identify interventions.

3.4.4 The scheme is not designed to be a self-referral scheme for any Brent resident. It is targeted at the most vulnerable to ensure that resources are being deployed efficiently.

3.4.5 To date, Groundwork have undertaken 206 first consultations (49 in person, 157 by phone). The advice provided so far, if residents follow through with the interventions recommended to them, is estimated to have saved Brent residents £44,913 in energy bills, 144,045kg of carbon emissions, and 3,643,963 litres of water. The small measures that have been provided on site

(LED lightbulbs, radiator panels etc.) are estimated to have delivered £2,632 of energy bill savings and 10,298kg of carbon emission savings.

3.4.6 The service has funding until Spring 2024 and scope for up to a further 794 consultations over the course of this winter.

3.5 Communication and engagement campaigns with local communities

3.5.1 There is a programme of communication taking place and plans to support local citizens in navigating the local health and care offer so that the appropriate service and/or individual can provide care in the right place. This will build on the following:

- NW London-wide communications and engagement winter plan to support residents with decisions about their health and the services they use, by providing information and redirecting people at the point of need. The plan uses data from previous winter campaigns and the Whole Systems Integrated Care Dashboard to target and support the right areas and communities.

- Full winter messaging flyers have launched this month. The Flu campaign and Children and young people campaign launched in September. The Self-care messaging will launch in November. All campaigns will continue throughout the winter period, with focus on Urgent and emergency care and Vaccination (flu/Covid booster). All resources are and will be available on a specific communications and engagement resources page on the NW London ICS website. Plans and updates will be discussed regularly at various NW London Health forums. Evaluation began in September and will continue to March 2024. Partners will receive monthly updates on activities and reach.

- Brent Health Citizen Forums that took place in September will also take place in December and March, with a focus on Winter Wellness messaging.

- Greater coordination of communication channels across Borough Based Partnership (BBP) to ensure the efficiency of messaging.

3.5.2 Brent Council Winter Communications Campaign: As in previous years, the NHS in London with UKSHA (UK Health Security Agency) and OHID (Office for Health Improvement and Disparities) will be producing a number of key public messages on keeping well in Winter. These messages and an accompanying tool kit (including imaging and text which will resonate with London's diverse communities as well as translated text) are expected to be released at the end of October. Key messages are likely to include the importance of vaccination but also respiratory and hand hygiene, warmth in the home, keeping active and tips for mental wellbeing. These messages will be amplified through the usual Council communications channels for example the Council's website, e-newsletter and social media.

3.6 **Housing and Asylum Seekers support**

3.6.1 During Winter, the Severe Weather Emergency Protocol (SWEP) is activated by St Mungo's. This is triggered when the weather drops to 0 degrees or below, whereby individuals sleeping rough are prioritised for shelter. They are supported by their connect worker to be registered with a GP practice, if not already, and provided with a proactive health assessment.

In addition, all people experiencing homelessness and asylum seekers housed in the Interim Accommodation Sites are encouraged to have their flu vaccine through attendance at their GP practice and arranging for on-site vaccination clinics by the Brent Health Matters Teams and / or Find and Treat Team.

The Hospital Based Outreach Team for people experiencing homelessness will continue to provide a multi-disciplinary health intervention, social care, housing, advocacy, and practical input so that patients are discharged in an improved situation, reducing hospital re-admittance and homelessness.

3.6.2 Brent Council Housing Needs Preparedness: The Council's commissioned services for single homeless people and rough sleepers will operate as normal throughout the winter months. These include:

- The Turning Point: Drop-in service provided by the Council based at the Design Works building in Harlesden for single homeless people to access support and advice service, including drug and alcohol services.
- Brent Outreach Service: Commissioned service provided by St Mungo's. The Outreach Team are out four nights and one day every week, engaging with rough sleepers in a timely manner.
- VIA New Beginnings Service: Commissioned service that provides drug and alcohol services to local residents including street outreach services, as well as a dedicated 24/7 response line. Once in treatment, service users also have access to a range of practical support, including warm winter clothes and essential items.
- Street Link: Referral service for members of the public to report when they see someone sleeping rough, as well as a dedicated phone number for people to self-refer.
- Winter Shelter: the Council will be providing a Winter shelter, open 7 nights a week for up to 15 rough sleepers throughout the cold weather months. Last year's shelter opened on 7 January and closed on 31 March. The Council work with voluntary sector partners and the Brent Homelessness Forum to ensure a multi-agency effort providing a safe space for rough sleepers during the Winter nights. Specialist support for drug and alcohol services will be provided on site through Via New Beginnings.

3.7 **Trust Provider Plans**

3.7.1 **Central London Community Healthcare**

3.7.1.1 The Brent Rapid Response Team will maintain business as usual levels of activity for winter 2023/24 of over 3,000 patient contacts per month (including follow up visits). The service averaged 450 referrals per month for 2022/23. For 22/23 service performance was 99% against its KPI of a 2-hour response time for all referrals and it is anticipated that this will be maintained in line with performance over winter 2022/23.

3.7.2 London North West University Hospital Trust (LNWUHT) Acute Initiatives to support Winter Resilience

3.7.2.1 For the 2023-24 winter plan, the Trust submitted the following summary plan to the ICB:

- £2,990k (Oct 23 – 31 March 24) for 32 beds at Northwick Park Hospital.
- Additional winter flow schemes £2,000k (1 Oct 23 – 31 March 24).
- LNWUHT has a plan to open up 33 beds pre modular phasing in from this month, then the additional 32 modular from March.
- Additionally, a plan is in progress for 20 additional medical beds at Northwick Park Hospital by reconfiguring surgical bed base (part of step 1)
- There is also plan for additional staffing to support the increase patient demand for the winter months.

3.7.3 CNWL Initiatives to Support Winter Resilience

3.7.3.1 The NWL MHLDA Provider Collaborative ran a joint planning session to share practice, understand and respond to winter challenges in 2023/24. Senior operational leads in Adult, Older Adult and CAMHS services attended, agreeing high impact actions and a shared understanding of challenges facing the system this winter.

3.7.3.2 Operational staff agreed that challenges facing the system mirrored those identified by NHSE, with added local complications including:

- High presentations of patients with drug and alcohol needs, often with no fixed abode.
- Expected impact of new covid waves on older adult admissions and capacity
- London-wide closures of CAMHS private beds, which will impact overall capacity and flow.
- Continued bed pressures since winter 2022/23
- High number of unknown patients presenting at A&E

3.7.3.3 The session focused on learning from major programmes that had supported flow in winter 22-23. These included:

- The introduction of a new MH Crisis Assessment Service, which enabled CNWL to keep MH A&E presentation below August 2022 levels and stabilise 12-hour inappropriate waits and improve admission avoidance rates.
- The use of step-down bed capacity in WLT to improve overall flow.

- Incorporating rehab beds into both Trusts capacity oversight, creating better flow and appropriate lengths of stay in those settings.
- Expanding CAMHS service, including crisis support services as an alternative to crisis admissions.

3.7.3.4 A number of short and long term activities are now being considered by the Provider Collaborative to improve acute pressures further. In the short term, these focus on joint communications to partners – particularly around how to access crisis alternative services - and consistency of processes that are common across both Trusts (such as CRFD definitions). In the longer term, focus included understanding support options for more complex patients (ASD, drug and alcohol etc.), and exploring common assessment processes. Via the local community substance misuse treatment and recovery service is promoting it's 24/7 helpline, duty system and referral process to mental health and acute health professionals. There will be a joint operational planning exercise, including a mid-winter 'check in' to test impact of actions already taken.

3.8 Integrated Care Partnership's Approach to address Winter Pressures

3.8.1 The Winter Planning Programme was initiated by DHSC with a specific focus on strengthening discharge pathways and reducing length-of-stay in the hospital, delivering on the best outcomes for our residents to be better supported at their place of residence.

3.8.2 Since 22/23, Brent has implemented an established Winter Planning process and governance to agree, monitor and assess all winter schemes. Brent ICP Executive requested we develop our plans to mitigate the risks associated with NHS funding for 'Discharge to Assess' ending in NW London on September 22, which potentially posed an additional risk for hospital trusts, particularly for more complex needs.

3.8.3 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 and Council services 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.

3.8.4 There have already been many efforts across the NWL system overall and Brent ICP to ensure an efficient level of beds in both hospitals and Community, best usage of the current capacity, and a reduction in A&E and urgent care demand. In addition, key representatives from each ICP partner met to propose a long list of schemes started in July 2022. The Winter Planning Task and Finish Group is responsible for bringing together all system partners to work up the schemes. 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 detail below. These

schemes were discussed at their respective Executive Groups and ultimately signed off by the ICP Executive.

3.8.5 In addition to existing joint working, the proposed Brent Winter plan builds on a Better Care Fund Plan, which includes several schemes in development with adult social care. This ensures a resilient social care system 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 handyperson service to assist residents at home, housing for residents with homelessness issues, and step-down beds to assist patient flow.

3.8.6 The primary purposes of the proposed schemes are to support the system's resilience in the coming winter months 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 wellbeing.

3.8.7 Total Funding Allocation of Winter Schemes as Part of BCF Discharge Funding is **£3.5m** for 23/24:

- DHSC Direct Local Authority Allocation £1.87m
- NWL ICB DHSC Allocation £1.67m

Fifteen schemes have been included, with most re-instated in 23/24, and they have undergone a rigorous review process at Brent ICP Task and Finish Groups. There has been joint agreement and buy-in from all stakeholders that these schemes should be included in the 23/24 programme.

All schemes stated in **Section 3.9** below meet four main criteria:

- Support flow and discharge, demonstrating an impact across the system.
- Support patients discharged to the best place that meets the requirements of home first and discharges to the usual place of residence.
- Facilitate earlier discharge from acute wards.
- Meet ASC and health benefits.

3.9 Department of Health and Social Care (DHSC) Funded Schemes

The following are the discharge schemes to ensure that hospital discharge flow will continue to be supported as a priority.

3.9.1 Overnight Service – Preventing Avoidable Admissions: The overnight service will support patients in their own homes, reducing the need for repeated hospital visits and admissions, as well as a reduction in nursing homes admissions. The service involves two carers working in pairs, responding to an average of 12 patients a night. The service would enhance our existing services and operate during hours when BAU services are closed.

3.9.2 24-Hour Complex Care: The complex care service provides 24-hour support at home for the most complex care patients discharged from the hospital, who

often require residential placements that can be difficult to secure. Twenty-two people have used this service since January 2023. The service supports quicker discharge as these patients (pathway 2) would often have delayed discharge of 3 weeks or more until an appropriate placement had been found, which is often a care home rather than residential.

3.9.3 Take Home and Settle Service: This is a reactive discharge service that supports the discharge of patients predominantly aged 50 and older across the hospital. The service supports transport to get the patient home and a staff member to settle them back at home and ensure appropriate follow-ups are in place. The patient and their carer are also signposted to relevant third-sector organisations to obtain more comprehensive support for the long term.

3.9.4 Additional Social workers/7-day working: The additional social workers would support post discharges. The team would be able to manage 4-5 clients per week. Ability to manage the increased number of referrals for assessment for patients who have non-complex needs and are discharged through (Home First), as well as those with more complex needs and situations post-discharge.

3.9.5 Step-Down Beds: Provide additional step-down beds in the Community to support more complex patients. Clear referral criteria jointly agreed between CHC, Complex Care and Adult Social Care (ASC). This scheme will ensure there is sufficient support to enable care for complex clients, including Non-Weight Bearing (NWB) and Delirium.

3.9.6 Enhanced Dementia Support Following Discharge: Due to the increasing number of patients placed in care homes due to dementia. The service will support enhanced dementia support following discharge for care in the Community. Non-residential care settings. Dementia specialist workers working with the acute hospital discharge team can provide immediate intervention monitoring and support. Training groups of care workers and informal networks, such as family members, around the management of challenging behaviour. The service model will include enhanced dementia support wrap-around care following discharge.

3.9.7 Trusted Nurse Assessor: As a system, we have identified patients who were experiencing delays to their discharges to care homes, with the assessment process being protracted and confusing. There are significant pressures in the system to improve patient flow across acute hospitals, including accident and emergency, high levels of delayed transfers of care and poor health outcomes for patients.

Delays in patient discharge can harm patients, but most can be avoided, mainly if the delay is caused by waiting for a care provider to assess and accept a patient into their service.

Brent launched a pilot in November 2022, funded by DHSC Discharge funding and ICP Sec 256 from October 2023, with a Trusted Assessor Model. The Trusted Assessor supports patients assessed as needing a care home placement discharge from hospitals to care homes. The pilot has been

developed in collaboration with Care Home Managers, LNWHUT, Brent LA and the Brent Integration and Delivery team. The Trusted Assessor Pilot aims to: (a) improve the discharge and transfer process for patients from the acute (LNWUHT) to an appropriate care home; (b) reduce the time taken to transfer patients successfully; (c) improve relationships and communication for patient transfers.

3.9.8 Bridging Provisional Proposal: Funding of £862k has been allocated from NWL ICB as part of the winter funding to implement a 'Bridging Provision Proposal' replicating/scaling up the Hillingdon model to have a maximum impact on discharge performance. Each borough procures a dedicated care provider to deliver up to 5 days of care to enable any patient to be discharged home within 12 hours from referral. Patients are then assessed at home for either reablement or longer term. The service would be integrated with existing reablement home first services and local authority teams.

3.9.9 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 two 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.

3.9.10 Emergency Support Increase Rapid Response Capacity for Urgent Mental Health Provided: In addition to the Mental Health schemes above, the following scheme will provide preventative holistic support for patients with mental health via Community and Voluntary Sector partners. The Brent Mental Health Crisis Support provides emergency and essential support for patients with Mental Health and Learning Disabilities experiencing emotional distress or crisis. This service also supports people living with dementia in Brent during Winter. 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 experiencing mental health crises.

3.9.11 Community Equipment: Maintaining discharge protocols and delivering an ever-increasing complexity in the products needed to support individuals in their homes has increased demand and faster delivery speeds for community equipment being prescribed. Our program will also support and manage the increased requests for community equipment for patients discharged from the hospital, with the core aim and objective – enabling people to live full, active, and independent lives for as long as possible.

3.10 **Risks to the Place Plan for Brent**

3.10.1 There is a risk that winter demand exceeds acute capacity which would lead to pressures on all unplanned care services. To mitigate the impact of this action will be taken locally to monitor capacity. There will also be a focus on working

with partners across the system to mitigate the risk to unplanned care services and manage capacity.

3.10.2 There is a risk that staffing will be insufficient for winter capacity plans which would lead to poor staff with limited capacity and low morale amongst staff. There is local action planned such as schemes specifically targeted at promoting staff wellbeing, improving recruitment and improving attrition rates. Performance of these schemes will be monitored by staff impact measures.

4.0 Stakeholder and ward member consultation and engagement

4.1 All ICP Winter Planning Schemes have been worked through and agreed upon by all ICP 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 There are no specific financial considerations relating to this paper.

6.0 Legal Considerations

6.1 There are no specific financial considerations relating to this paper.

7.0 Equality, Diversity & Inclusion (EDI) Considerations

7.1 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.

8.0 Climate Change and Environmental Considerations

8.1 The climate change and environmental considerations are covered above in this paper.

9.0 Communication Considerations

9.1 There are no specific communication considerations relating to this paper.

Report sign-off:

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