Brent Borough Based Partnership Priority Deep Dive – Developing Community Care

Health & Wellbeing Board Report

Introduction & Overview

This is a **high level report** for the Health & Wellbeing Board about the current collaborative working undertaken by all system partners in regards to the development and progress to date of key community transformation workstreams.

The Health & Wellbeing Board is asked to:

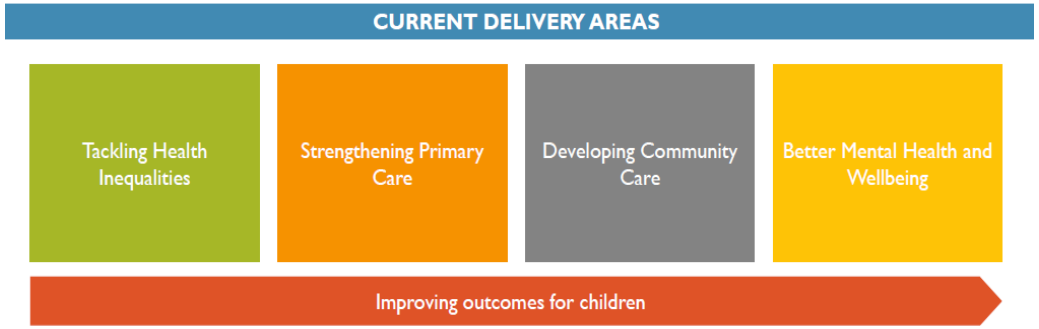
- Note and comment on the contents of this report and the work undertaken so far to improve Community services in Brent.
- Provide steering on key community healthcare services that we should be focusing on.
- Provide steering on future comms campaign for key areas where we should be focusing on to promote our services to our residents in Brent.

Background & Context

Brent's Borough Based Partnership (BBBP) brings together commissioning and provider organisations to support the improvement of local health and wellbeing outcomes and reduce inequalities across Brent's communities and residents.

The Partnership has 4 priorities:

- Priority 1 - Reduce health inequalities.
- Priority 2 - PCN Development and reduction in practice variation.
- **Priority 3 - Improve community and intermediate health and care services.**
- Priority 4 - Improve mental health and wellbeing.



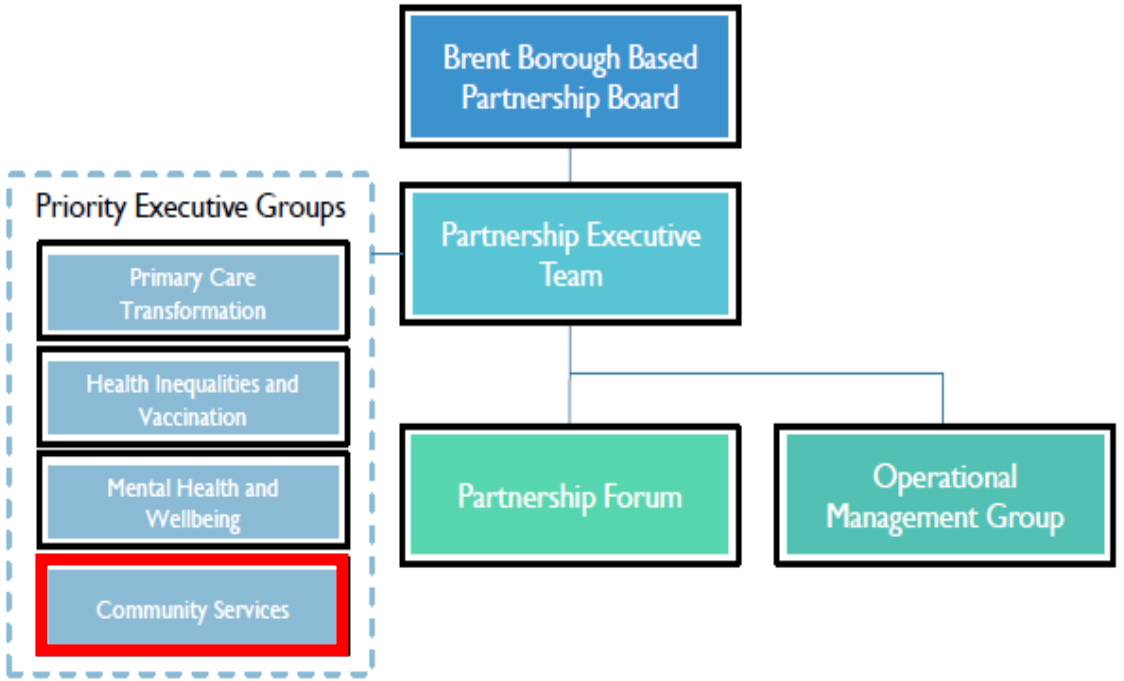
Brent ICP Integrated Care Partnership
North West London Integrated Care System

Community Services Executive Group

The **Community Services Executive Group (CSE)** oversees the integration of the health, social care and voluntary sector services to improve quality of care for Brent residents.

The group provides an oversight over key Health and Social Care programmes in Community, and steer to business cases, issues, and risks.

The group facilitates a joint partnership approach to designing, developing and implementing community service transformation.



Brent ICP Integrated Care Partnership

North West London Integrated Care System

Community Services Executive Group

The CSE has representation from London North West University Healthcare NHS Trust (LNWUHT), Central London Community Health Care Trust (CLCH), NWL ICB Brent Borough team, Brent Local Authority, GPs, Voluntary Sector Organisations (CVS) and Healthwatch.

Partnership priority:	**Delivering Community Care** **Improving outcomes for children**
Partnership Chairs:	**Simon Crawford (LNWUHT) and Jackie Allain (CLCH)**
SRO:	**Steve Vo** **Assistant Director Integration and Delivery**
Clinical Leads:	**Dr Lyndsey Williams** **Dr Anne Murphy (Children and Young People Clinical Lead)** **Hasmita Patel (Professional Lead)**
Key Projects:	**Transformation of Community Services** **Community Neighbourhood Teams & Super Hubs**

Transformation of Community Services

The agreed transformation workstreams are currently being reported to CSE, as well as the rest of the services operating as BAU Transformation/BAU.

A Task and Finish Group is set up for each key workstream to ensure progress and accountability. These Task and finish groups meet regularly to agree on the proposed phasing of priorities, new models of care and pathways for these services.

The Borough Team's programme leads provide assurance on the delivery of the transformation work streams to CSE on a monthly basis, which enables effective oversight of the programme to all partners.

- Respiratory
- Care Home
- Heart Failure
- Frailty
- Rehab and Reablement
- Integrated Neighborhood

Respiratory

Transformation Workstream Aim:

To provide a high quality community respiratory service to adults with long-term respiratory conditions, enabling them to reach their maximum potential empowered by clear, locally agreed integrated care pathways.

Deliverables	**Progress to date and Accomplishments**
• Reducing NEL admissions for acute exacerbations of COPD. • Meeting the Pulmonary Rehab (PR) waiting time of 90 days from referral to enrolment (class start date). • Contacting and assessing all patients referred into service within 7 working days of their discharge date.	• The Chronic obstructive pulmonary disease (COPD) Exacerbation Case Management Pilot was concluded after 4 months with an evaluation produced in August showing 18% reduction of non-elective activity for COPD patients in hospitals from the same period last year. The evaluation also shows positive impact on patients' personal life, Dyspnoea, Anxiety levels, Depression levels, and patient information needs. • Community service specification and respiratory pathways finalised. • Home oxygen new patient initiation rolled out in Brent. • PR offer increased as new site opened at Willesden Centre, which reduced waiting list significantly. • Imperial College Healthcare NHS Trust opened the new Willesden Community Diagnostic Centre (CDC) on 19th June. Although spirometry test was not in scope, we have managed to work with the CDC to take on spirometry testing to assist Brent GPs with the spirometry backlog.

Next steps

- Draft specification has been finalised by Respiratory Task and Finish group and oxygen new assessments are now included as part of the service provision. The expectation is to present the final spec to CSE in November for sign-off.
- Future services will provide a seamless and integrated pathway for patients with severe COPD and other respiratory diseases.

Care Homes

Transformation Workstream Aim:

To work collaboratively with Brent Adult Social Care to ensure safe and quality services for our residents in care homes.

Deliverables	**Progress to date and Accomplishments**
• Improving care home CQC rating. • Reducing A&E attendances from care homes. • Improving community and intermediate health and care service. • Supporting care home with workforce retention and recruitment via facilitating training.	• Peer Support Programme, a 12- week intensive programme to support care home with improving their processes and CQC rating. The programme has supported 16 care homes in Brent. All care homes that had their CQC inspection post peer support have improved their CQC rating. • The Brent Care Home Dashboard has been developed by the NHS Brent Borough Team to provide a comprehensive dataset and assist system partners with monitoring our key care home metrics including LAS call-outs, A&E and non-elective activity, CQC rating and Vaccination. • The team has worked proactively and collaboratively with NWL ICB and NHSE to promote and improve uptake on COVID vaccination in the Spring COVID vaccination booster campaign.

Next steps

- The Peer Support Programme continues to provides support for the 2 care homes currently on the programme and work with Brent Adult Social Team to invite additional care homes to the programme.
- The Borough Team will be focusing on the COVID vaccine Autumn campaign.

Heart Failure (HF)

Transformation Workstream aim:

To provide a patient-centred model of care closer to home using a case management approach, supporting HF patients manage their long term condition.

Deliverables	**Progress to date and Accomplishments**
• Meeting the target of managing 100% of patients post 2-week discharge pathway. • Treating and seeing patients within 2 weeks of referrals. • Reducing HF preventative admissions and activity in hospital.	• Our HF Task and Finished group had representation from clinicians and managers from NWL ICB Borough Team, CLCH, LNWUHT and Primary Care developed a gold-standard service specification, tailored for the local needs in Brent. The specification requires additional resources which is recognised by NWL ICB who is reviewing HF services across the sector. A Business Case is being developed at NWL level with input from Brent to request for further funding and implement the new service specification. • The CLCH HF Team has improved its service provision whilst taking on feedback from GPs and clinical consultants from hospitals. • End of Life Heart Failure pathway is being led by our clinical lead in Brent which is to be implemented across NWL. • Lead HF clinicians including HF nurse consultant in primary care, our GP HF Lead, and HF consultant at LNWUHT, in Brent have come together to prepare and provide an educational presentation to Brent GPs at this month's GP Forum.

Next steps

- We will continue working with our colleagues at NWL ICB to advocate for Brent and ensure that our residents' needs are met with the right level of funding and resources.

Frailty

Transformation Workstream aim:

To provide an integrated Frailty service for Brent patients, focusing on patients' needs aligned to the Integrated Neighbourhood Model. We aim to optimise our resources and improve patients' journey through seamless and integrated Frailty pathways managed by Primary and Community clinicians alongside Brent Adult Social Care.

Deliverables	**Progress to date and Accomplishments**
• Creating an integrated and seamless model of care to improve patient journey and quality of care with streamlined resources across different services in Community. • Meeting the 75% target on hospital admission avoidance for patients who have gone through the Community Frailty service.	• Clinicians across primary, community and acute have jointly worked with managers from the Brent Borough Team and Brent LA to devise a new model of care for Frailty and Complex Care patients. • This new model of care is in discussion to be implemented with the providers, creating a Single Point of Access (SPA) for patients with frailty and complex healthcare needs.
Next steps • Continue the discussion with the providers to roll out the SPA model.	

Rehab and Reablement

Transformation Workstream aim:

To build a fully integrated therapy and reablement service that will flexibly meet the needs of the local population.

Deliverables	**Progress to date and Accomplishments**
• Full achievement of outcomes and goals following 6-week rehabilitation treatment. • Full achievement of outcomes and goals following 6-week reablement service. • Overall reduction in ongoing care such as homecare following the 6-weeks of rehab and reablement for at least 3 months.	• Three models of care have been established including bronze, silver and gold, with the bronze model has already made progress with the aim of achieving the gold in the future years with appropriate funding.
Next steps • To continue with implementing the bronze model of integrated rehab and reablement services that are currently commissioned separately between the NHS and Brent Local Authority.	

Integrated Neighbourhood

The aim of the programme is to deliver health, social, and care services that are tailored to the local neighbourhood needs in Brent, which are aligned to the 5 Connect Areas – Kilburn, Kenton & Kingsbury, Wembley, Willesden and Harlesden/Stoenbridge/Roundwood/Kensal Green. This will allow our residents to access care health and well-being services closer to home at a single space / campus of premises, allowing stronger and sustained integration amongst health, social and care services.

Deliverables

- Create a resilient multidisciplinary workforce, who are motivated, engaged and flexible.
- Establish integrated and closer-to-home care, health and social hubs across the 5 Connect Areas in Brent.
- Create inter-operable Information Systems across provider partners, allowing real-time information/data sharing.

Progress to date and Accomplishments

- Completion of a directory for Brent care, health and social services with 130 service lines commissioned by the NHS, Council, Voluntary Sector and Public Health in Brent.
- Local Brent Partnership Strategic Estates Group is ongoing. This is a platform for partners to discuss estates /premises queries, escalations and innovations.
- Pipeline developments underway: Wembley Park – aim to 'go live' Feb. 2024. South Kilburn and Alperton – to follow in the near future. Local Brent Estates Strategy will be available sometime in October/November '23.
- Local Brent Strategic Integrated Care Team (ICT), Data & Digitalisation has been ongoing. Mapping exercise with partners has been completed. On-going frontline staff deep dive on connectivity aspirations and priorities to establish working group on ICT connectivity/data sharing.
- "Have your say" survey has been completed with 85+ responses from stakeholders and wider Brent residents.
- Data packs on population demographics, prevalence and characteristics shared with the 5 neighbourhoods. This forms part of the baseline data to measure future attributions on achievements / lack of development with the programme.

Next steps

- Create a Brent Borough Strategic Workforce and Organisational Development steering group – planned for the 19th of Sept. (inaugural meeting).
- On-going specification development of integrated health and care hubs, looking at the synergies of existing hubs in Brent.
- ICT, Data & Digitalisation – continue to identify quick wins, short/medium/long term priorities, and testing system connectivity with neighbourhood teams.
- Develop Neighbourhood dashboard that has Health and Care Inequalities demographics and determinants. This will help our local neighbourhood teams to near real-time access to population health characteristics, better understand them so they can tailor their services to local needs.

Key Children Work Streams Reported to Community Executive Group

- Neurodiversity Pathway
- Speech and Language Therapies
- Special School Nursing
- Children Enuresis and Continence

Top Programmes Issues & Risks

Special School Nursing

Current position	Mitigations
There is an urgent need of NHS investment to special school nursing to fund additional nurses due to the additional placements of special school this year. Lack of additional resources means that there are risks to whether children can safely attend school.	CLCH has provided a paper detailing the demand and capacity, indicating a 2.5 WTE to their nursing team by September 2023. This has been escalated to NWL ICB but we have yet to receive a response. In the interim, there is an interim arrangement from Brent ICP to agree funding in the short-term but long term funding will still need to be approved.

Children Enuresis Service

Current position	Mitigations
Lack of Community Children Enuresis Service in Brent. There is risk of increase of emotional, psychology mental health issues for both children and parents as a result of this. Previously, we have submitted a business case for Brent but was not approved.	Brent and Harrow are working on a joint Business Case to get the appropriate funding to establish this service in the two boroughs.

Top Programmes Issues & Risks

Community Frailty

Current position	Mitigations
Business Case developed to procure a new Frailty service for Brent. It was taken to NWL ICB however it was not approved.	NWL Frailty Wide review to understand the core offer across the sector prior to agreeing to the procurement. Currently, we are having to make appropriate changes, moving towards the new Frailty model within the existing contractual constraints. Brent has been nominated to lead on the NWL wide Frailty review work.

Top Delivery Areas to Promote Health Equality

Cancer Black Care	Community Diagnostic Centre (CDC)
Cancer Black Care has been serving the Brent community for over 21 years, offering a range of services including counselling, support groups, education, employment advice, patient navigation, advocacy, befriending, and wellness activities. The service aims to reduce health inequalities and improve health outcomes by addressing the cultural and emotional needs of people affected by cancer and family, friends, and carers by providing a comprehensive support service to all members of the community affected by cancer.	Two of the three CDC in NW London will be based in Brent. The Willesden Facility opened on 19/06 and the Wembley Facility due to open by November this year. The CDCs are focused on helping combat health inequalities, by locating them in areas where there is most need, closer to home and to speed up diagnosis for a range of conditions so that patients can get their treatment faster. The CDCs will provide access for all users and with travelling distance of 40 minutes within the borough, reducing health disparities with equitable service provision for all residents, regardless of socioeconomic status, ethnicity, or other demographics.