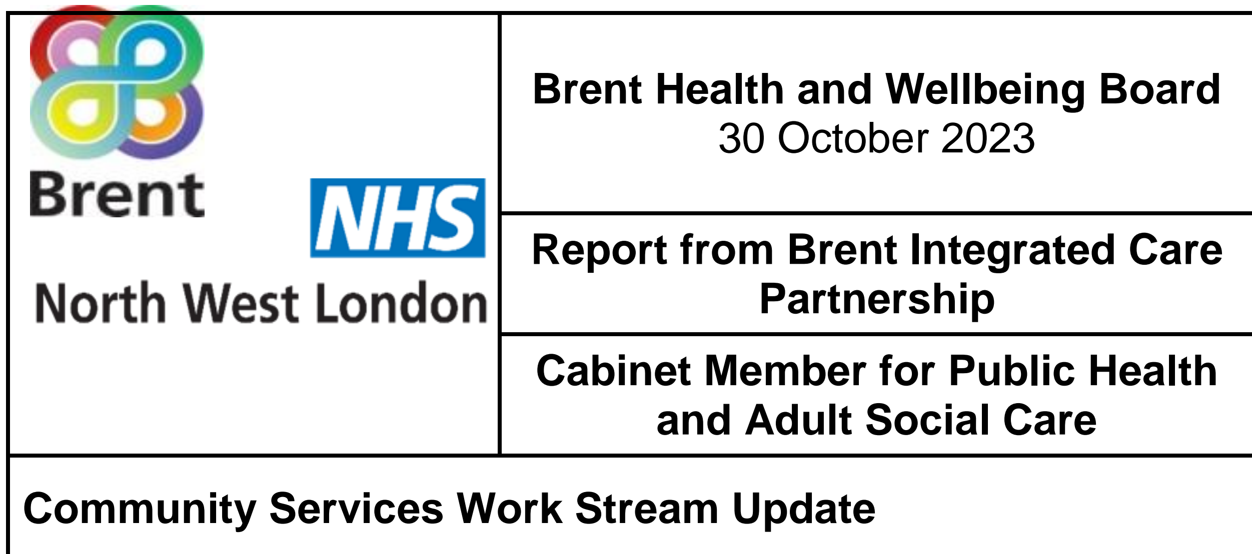

Wards Affected:	All Brent
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	N/A
List of Appendices:	Appendix 1 - Brent Borough Based Partnership Priority Deep Dive – Developing Community Care
Background Papers:	N/A
Contact Officer(s): (Name, Title, Contact Details)	Simon Crawford Deputy Chief Executive, LNWUHT (Co-Chair Community Executive) simon.crawford1@nhs.net Jackie Allain, Director of Operations CLCH (Co-Chair Community Executive) j.allain@nhs.net Tom Shakespeare Brent ICP Managing Director Tom.Shakespeare@brent.gov.uk Steve Vo Assistant Director Integration & Delivery, NHS NW London ICB - Brent Borough stevetruong.vo@nhs.net

1.0 Executive Summary

1.1 This report provides detailed updates on key Community transformation work streams and seeks for steering and advice from Brent ICP Board on areas of Brent residents' needs that are not covered in this report.

2.0 Recommendation(s)

2.1 The 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.

2.2 Given the financial constraints with the NHS, the board is asked to provide steering on key community healthcare services that we should be focusing on.

2.3 Although we have done major comms campaigns for key programme such as Palliative Care, hypertension, and diabetes, there may be other key areas where Health and Social Care can join up to promote our services to our residents in Brent. The Board is asked to provide steering on these key areas.

3.0 Background and Context

3.1 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.

3.2 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.

3.3 This report focuses on Priority 3 – Improve community and intermediate health and care services.

4.0 Detail Community Services Executive Group

4.1 The Community Services Executive Group (CSE), one of the four Executive Groups accountable to the Brent Integrated Care Partnership (ICP) Executive, oversees the integration of the health, social care and voluntary sector services to improve quality of care for Brent residents.

4.2 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. The group is chaired by the Deputy Chief Executive from LNWUHT and Director of Operations from CLCH. The group provides an oversight over key Health and Social Care programmes in Community. The group also provides steering to business cases, issues, and risks.

4.3 The purpose of this group is to facilitate a joint partnership approach to designing, developing and implementing community service transformation.

5.0 Transformation of Community Services

5.1 Below are the key agreed Transformation work streams currently being reported to CSE. Please note that this list only includes key transformation programmes and is not meant to be exhausted of all Community services in Brent as progress of other Community services are reported to CSE.

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

5.2 There is a Task and Finish group for each of the key work stream above 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.

5.3 System partners have worked proactively and collaboratively to bring about wider support in service transformation.

5.4 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 ICP partners.

6.0 Community Respiratory Service

6.1 Aims: The work stream aims 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.

6.2 Deliverables:

- 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

6.3 Progress to Date and Accomplishments:

6.3.1 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. Finalising the ongoing review of adult community service specification and respiratory pathways for transition of care between acute, community and primary care services.

6.3.2 Home oxygen new patient initiation rolled out in Brent.

6.3.3 PR offer increased as new site opened at Willesden Centre, which reduced waiting list significantly.

6.3.4 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.

6.4 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 September for sign-off.
- Future services will provide a seamless and integrated pathway for patients with severe COPD and other respiratory diseases.

7.0 Care Homes Service

7.1 Aims: Our aim is to work collaboratively with Brent Adult Social Care to ensure safe and quality services for our residents in care homes.

7.2 Deliverables:

- 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

7.3 Progress to Date and Accomplishments:

- 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.

7.4 Next Steps:

- The Peer Support Programme continues to provide 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.

8.0 Heart Failure (HF) Service

8.1 Aims: We 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.

8.2 Deliverables:

- 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

8.3 Progress to Date and Accomplishments:

- Our HF Task and Finished group consisted of 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.

8.4 Next Step:

- 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.

9.0 Frailty Service

9.1 Aims: We 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.

9.2 Deliverables:

- 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.

9.3 Progress to Date and Accomplishments:

- 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.

9.4 Next Steps:

- Continue the discussion with the providers to roll out the SPA model.

10.0 Integrated Neighbourhood

10.1 Aims: Our aim 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/ Stonebridge/ Roundwood/ Kensal Green. This would 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.

10.2 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.

10.3 Progress to Date and Accomplishments:

- We completed 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. The directory is hosted online, and refreshed in real time, making them available in the Brent Council and ICP website for the public to access.
- Local Brent Partnership Strategic Estates Group is on-going – 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. This is to help shape the programme going forward.
- Data packs on population demographics, prevalence and characteristics were shared to the 5 neighbourhoods. This forms part of the baseline data to measure future attributions on achievements / lack of development with the programme.

10.4 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.

11.0 Rehab and Reablement Service

11.1 Aim: We aim to build a fully integrated Therapy and reablement service that will flexibly meet the needs of the local population.

11.2 Deliverables:

- 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.

11.3 Progress to Date and Accomplishments:

- 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.

11.4 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.

12.0 Community Services Metrics

12.1 We are actively working with our BI Team to monitor how community services are having an impact on hospitals, keeping our residents safe post hospital discharge and avoiding hospital admissions in the first place.

12.2 Once data has been validated, we will present this at future updates.

13.0 Risk and Issues

13.1 Special School Nursing: Due the additional placements of special school this year onwards, there is an urgent need of NHS investment to special school nursing to fund additional nurses. CLCH has provided their 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. Lack of additional resources means that there are risks to whether children can safely attend school. There is an interim arrangement from Brent ICP to agree funding in the interim but long term funding will still needs to be approved.

13.2 Children Enuresis Service: Currently there is 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.

13.3 Community Frailty: We previously have prepared a Business Case to procure a new Frailty service for Brent. This was not approved by LNW ICB, who requested for a 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.

14.0 Stakeholder and ward member consultation and engagement

14.1 Engagement with Ward Members, system partners, Brent residents, community service users and Voluntary Sector Organisations is on-going. Involvement and inclusion of the Brent population continue to be supported by Brent Health Matters, Community Champions and NW London Residents' Forum.

15.0 Financial Considerations

15.1 Currently, the transformation work is delivered from within the existing core budgets from the NHS and Better Care Fund.

15.2 However, various transformation schemes would require additional funding from NWL ICB with Business Cases being developed at NWL ICB level such as Heart Failure and Integrated Care Neighbourhood.

16.0 Legal Considerations

16.1 There are no legal implications.

17.0 Equality, Diversity & Inclusion (EDI) Considerations

17.1 All substantial changes to service provision for any of the transformation work streams would require an Equality Health Impact Assessment.

17.2 Furthermore more, the following services are specifically focusing on health equality

- Cancer Black Care (CBC): The service has been serving the Brent community for years, offering a range of services including counselling, support groups, education, employment advice, patient navigation, advocacy, befriending, and wellness activities. The programme operates under the premise that cancer care extends beyond medical treatment, encompassing emotional and psychosocial well-being. CBC 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. It is pivotal to delivering holistic and wellbeing cancer services and committed to providing a high-quality and patient-centred service to Brent residents and those from adjoining boroughs registered with Brent GPs.
- Community Diagnostic Hubs (CDH) in Brent: Community Diagnostic Hubs within the Brent Borough play a crucial role in tackling health inequalities by focusing on accessibility, targeted services, education, and collaboration. Accessible Locations, for all users and within travelling distance of 40 minutes in the borough. CDH offers all residents efficient diagnosis and intervention. This helps to reduce health disparities with equitable service provision for all residents, regardless of socioeconomic status, ethnicity, or other demographics, to have equal access to diagnostic services. Brent CDHs contribute effectively in reducing health inequalities and improving the overall health and well-being of residents in boroughs.

18.0 Climate Change and Environmental Considerations

18.1 There are no climate change and environmental implications.

19.0 Human Resources/Property Considerations (if appropriate)

19.1 There are no HR/Property implications.

20.0 Communication Considerations

20.1 For all service change and promotion of heath care services, we work close with the NWL ICB Comms Team as well as Brent Health Matter to reach hard to reach population.

Report sign off:

Helen Coombes
Corporate Director Care, Health and Wellbeing