Brent NHS North West London	**Brent Health and Wellbeing Board** 20 November 2025
	Report from the Corporate Director Service Reform and Strategy and Managing Director Brent Integrated Care Partnership
	Lead Cabinet Member for Adult Social Care, Public Health and Schools - Councillor Neil Nerva

Winter Plan 2025/26

Wards Affected:	All Brent wards
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)	Open
List of Appendices:	N/A
Background Papers:	N/A
Contact Officer(s): (Name, Title, Contact Details)	Steve Vo Assistant Director of Place Brent Borough, NWL ICB stevetruong.vo@nhs.net Jasvinder Kaur Perihar Programme Manager- Intermediate Care, Brent ICP J.perihar2@nhs.net

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 Winter Plan for Brent will focus on:

- Acknowledging the uncertainty around NHS reforms, although core services will not be adversely affected.
- Securing efficient discharge pathways to reduce the length of time our residents spend in the hospital once medically fit to leave by maximising the use Department of Health and Social Care (DHSC) funded schemes to manage system pressures and keep residents well this winter.
- Taking preventative action to mitigate where possible, the impact of illness on 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 and priority target groups.
- 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, including strengthening the community frailty service using a neighbourhood MDT approach.
- Enabling continued access to primary care services during the winter period.
- Improving patient flow to free up hospital beds by providing effective, prompt and high impact interventions in and out of hospital care.
- Communication with local residents 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, housing problems and related social issues to access timely support.
- Reducing variation in inpatient care and length of stay for our mental health service users by bringing forward discharge processes.

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

https://www.brent.gov.uk/the-council-and-democracy/strategies-priorites-and-policies

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.

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 Background

3.2.1 This report provides an update on the challenges and responses related to winter pressures as faced by local healthcare partners. It consolidates insights and actions from Brent Adult Social Care (ASC) and Brent Integrated Care Partnership (ICP) / Brent Borough Based Partnership Team, London North West University Healthcare NHS Trust (LNWHT). Central London Community Healthcare NHS Trust (CLCH) and Primary Care, Central North West London Healthcare trust (CNWL) to ensure safety for our residents whilst overcoming challenges.

3.2.2 **Recognition of uncertainty around NHS Reforms**

- In March 2025, NHS England confirmed that Integrated Care Boards (ICBs) would face **around 50% reductions in operating costs for 2025/26**.
- This significant restructuring aims to refocus funding on frontline care under the **10-Year Health Plan**, emphasising prevention, community-based care, and digital transformation.
- This restructure is likely to impact on central and strategic capacity, and increase pressure on frontline and partner organisations. However core services will not be adversely affected.
- To mitigate this impact a Joint Winter planning sub-group was established across the partnership. Use of shared analytical and operational resources were explored. Borough capacity is being strengthened for proactive prevention and admission avoidance work and a focus on the three shifts (prevention, community care, digital enablement) to mitigate demand on acute services through better self-management and early intervention.

3.2.3 **Admission and Discharge Planning**

Current challenges

- Supporting for patients in care home deemed as having complex needs and or challenging behaviours, including dementia.
- Knowledge and confident of care home and home care staff to support people with complex needs.
- Bridging service provided for 7 days instead of 14days.
- On going work to develop guidance on Section 22 Care Act for NWL to determine health and care responsibilities for cohorts where commissioning pathways are unclear.
- Community Equipment provider is not yet fully mobilised and the impact through winter is unknown.
- High demand for Adult Social Care Urgent Response services and bottleneck with some people remaining in the scheme for nearly 2 years.
- Limited step-down beds in Brent.
- Frailty cohort are high users of health services due to complex health and care needs and are high users in winter surge periods.
- Brent has one of the highest numbers of individuals within the frail cohort and experiences high levels of deprivation. Deprivation correlates with higher frailty-related hospital admissions.

Mitigation

- The Brent Integrated Care Partnership (ICP) and Brent Council, known as The Partnership, were granted approximately £6.2 million in funding to address discharges and winter pressures.

- A number of schemes have been funded to collectively improve patient flow, reduce delays, and enable people to recover closer to home. Working together these schemes aim to manage system pressures and keep residents well this winter.

DHSC funded schemes:

1. **P3 - Trusted Nurse Assessor (TNA)** – Streamline discharge from acute to care homes and reduce assessment delays. TNA is responsible for conducting all assessments, overseeing discharge processes to ensure ward readiness, making regular visits to care homes, and serving as the primary liaison between the care home, hospital, and the Enhanced Care Home Support Team.
2. **Dementia Behaviour Specialist Scheme (DBS)** This is an initiative designed to undertake assessments and interventions for patients with behaviours that challenge and are referred to either a care home or community settings, using appropriate evidence-based practice.
3. **P1 Bridging services** Provide short-term, intensive support for patients post-discharge for up to 7 days.

4. **P3 Complex patient beds /Residential package** Provides additional 1:1 hours for complex P3 patients to support discharge into residential care. Patients with dementia and delirium (until a DST is completed).

5. **P1 Complex Care community packages** Specialist complex support provided following discharge. Care in the community specialist worker works with the acute hospital discharge team, providing immediate intervention, monitoring and support. 1:1 hours will be for up to 6 weeks initially allowing patients to settle at home with individual guidance.

6. **P1 Urgent Response Service** (extended night-time care and support) Home care packages to support individuals at risk of falls, wandering, or requiring night-time assistance**.**

7. **P2- Short term step down bed** – **Dawpool Road** 4 Step down beds support people with some complex care needs to be discharged until appropriate accommodation is available for them.

8. **Ashford Place Hospital Discharge** Assists mental health, learning disability, and dementia patients with safe, early discharges. Liaising and working with hospital discharge leads to co-ordinate safe and effective discharge for patients with complex care needs who would benefit from practical and emotional support at the time of discharge.

- Discharge performance has been moving in the right direction. Using data from the Optica Discharge Dashboard (Foundry) (Sept 2025) , Brent is performing slightly below target on key delay metrics, with consistent month-on-month improvement.

  Metric Current | Target

  - P1 Average Delay Days | 2.31 | 2.00
  - P2 Average Delay Days | 4.90 | 5.00
  - P3 Average Delay Days | 7.80 | 7.00

- Bridging service incorporated additional quality assurance processes and further screening step.

  Frailty Service :

- There is a new service model and clinical pathway for Brent aligned to the NWL Community Frailty Common Core Offer (CFCCO).
- The new model strengthens the Community Frailty service which is to provide proactive, holistic care for frail patients and coordinate health and social care across Brent's five neighbourhoods thereby improving integration, reduced fragmentation, and delivering efficiency savings reinvested to increase coverage and quality. The aim is to move from three to one provider.
- The integration of multidisciplinary teams (MDTs) and social care ensures that residents receive timely falls assessments, home adaptations, and personalised support. This proactive, community-based approach plays a key role in preventing falls and supporting older adults to live safely at home and prevent avoidable admissions.

- By proactively managing moderate frailty in the community, this service reduces demand on GP appointments and urgent care pathways, especially during winter surge periods.

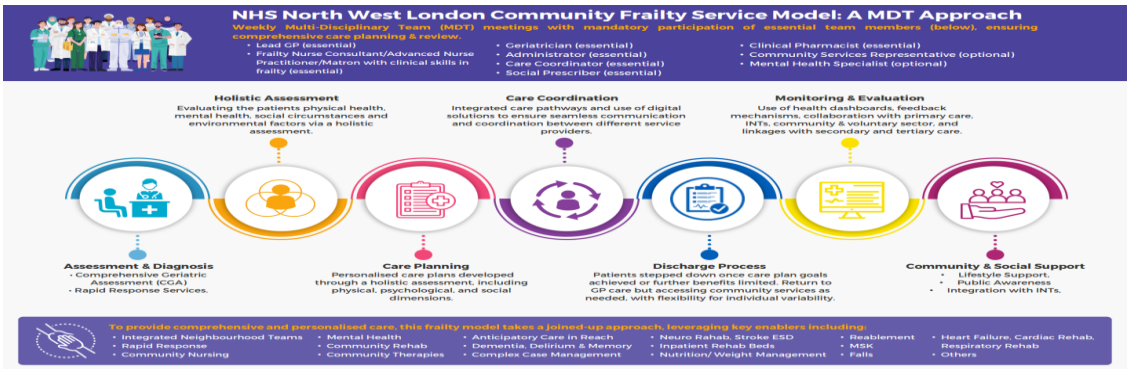
Priority areas of focus

- Develop Section 22 Care Act guidance for NWL for unclear complex patient pathways. to help reduce time to agree and fund care and support GAP and complex patients.
- Trusted Nurse Assessor to continue to work closely with the care homes, hospital and the Enhanced Care Home Support Team (ECHST) to improve communication and preparation for transferring patients; ensuring all patient needs are identified and the necessary support is provided by the ECHST.
- Dementia Behaviour Specialist Team continue to support and deliver training within the care homes and to domiciliary staff in the community on the subject of understanding dementia and managing challenging behaviours.
- Bridging service to continue to stabilise team with right resource and permanent staff.
- Urgent Response Service (extended night-time care and support) to continue to monitor the service and use the data to support assurance.
- Review usage of Dawpool step down beds.
  Frailty Service :
- Development of an integrated approach is to contribute to reducing falls and avoidable hospital admissions. Better focus on the moderate cohort to improve these admission rates.
- Complement Community Integrated Care Management (ICM) (medical focus) and Primary Care (identification and referral) by addressing broader frailty needs across the community and social domains, bringing key health and social care partners together to holistically manage patients' needs.

Next Steps

- Develop section 22 Care Act NWL guidance ensuring a consistent approach across NWL and equity for residents.
- Develop a SOP for the Urgent Response Service to ensure the service is being used appropriately.
- Funding for DHSC funded schemes to be confirmed for 2026/27.
  Frailty service:
- Expanded referral pathways into social care, VCSE, and secondary care.
- Re-procure a single-provider model covering all five Brent neighbourhoods.
- Deliver care through integrated neighbourhood MDTs (frailty nurses, social workers, reablement, VCSE).
- Operate a central Single Point of Access (SPA) for triage, care coordination, anticipatory care planning, and UCR delivery.
- Accept referrals from multiple pathways, including primary care, secondary care, social care, VCSE, and care homes.
- Awaiting funding for Frailty virtual ward, as NWL ICB has commissioned a frailty virtual ward, which once mobilised will provide targeted interventions in patients' homes. This initiative will provide additional capacity to support

patients who would otherwise be in an acute bed due to the acuity and complexity of their clinical needs.



3.2.4 Flu vaccinations and immunisation

Current Challenge

- Raise awareness of the National booking systems for Covid 19 vaccinations.
- Take up of flu and vaccinations particular focus on vulnerable groups and children's flu and vaccinations during pregnancy.
- Winter infections reducing inpatient capacity.

Key Mitigation

- Winter seasonal communication campaigns for residents in NWL.
- All children from Reception to Year 11 (ages 4–16), as well as those attending SEN schools up to age 25, are being offered the nasal or intramuscular influenza vaccine as part of the school vaccination programme.

Priority areas of focus

- Vaccination campaign September – November 2025.
- Winter communication campaign focus on Children's flu/pregnancy vaccinations.
- Launch of national booking system for COVID-19.

Actions Taken

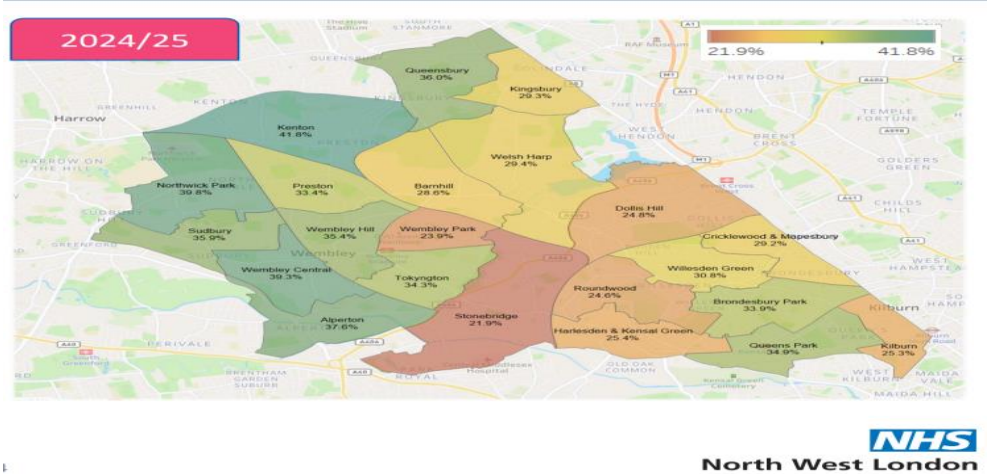
- LNWHT have implemented a flu frontline staff vaccination programme to safeguard healthcare professionals and ensure workforce resilience by reducing staff absences in the winter period. Target: 4,712 to achieve 5% additional staff vaccinated.
- CLCH are creating vaccine sites across the boroughs to increase vaccination take up in staff and peer vaccination will be available on bedded units to increase access.
- Primary care are delivering the seasonal flu and COVID vaccination campaigns ensuring sufficient spread and provision for the most vulnerable.
- Primary care continuing to work with Brent Partners to increase vaccine uptake for Brent residents.
- Designated pharmacies in Brent can offer children's flu vaccinations.

- All scheduled schools in Brent are visited twice- once for the initial vaccination session and a second time for a mop-up session to ensure all eligible students are offered the vaccine.
- Community catch-up clinics are being held on Saturdays, during half-term, and on weekday evenings at 3 locations in Brent.
- Conducting a pilot programme offering the nasal or intramuscular influenza vaccine to nursery-aged children at three nurseries in Brent
- NWL Winter Communication campaign includes resources for staff - Communications resources for staff :: North West London ICS

Next steps

- The NWL Winter Seasonal Campaign to increase vaccination take up launched in September 2025. The purpose of this campaign is to support local residents with decisions about their health and the services they use, by providing information and redirecting people at the point of need.
- Communication methods to include magazine articles in Council newsletter, videos, flyers in 13 languages and NWL ICB website.
- The plan will use data from previous winter campaigns and the Whole Systems Integrated Care (WSIC) Dashboard to target and support the right areas and communities, where take up has been low.

Chart 1: Brent – Vaccination take up (Source: WSIC dashboard) 2024/25



3.2.5 **Access to healthcare during winter period: primary and community care**

Current Challenges: Primary care :

- The appointments that are reserved are not taken up by NHS 111 and UTC team (1 appointment per 3,000 patients) resulting in some appointments remaining unused at some Enhanced Access Hubs.
- Practices enabling access for Pharmacies to view up to date patient records.

Key Mitigations

- Continue to review appointment timings with partners to ensure suitability for NHS 111/UTC bookings and interchangeability between NHS 111/UTC on a first come first serve basis.
- Patients are reminded of the appointment on the day to reduce DNA

- Awareness campaigns to promote Pharmacy First.
- Practices encouraged to enable NHS Connect, giving pharmacies secure access to patient records.

Priority areas of focus

- Deliver timely, equitable and responsive care with a focus on reducing delays for urgent concerns and improving patient satisfaction.
- Promote the 24/7 urgent dental care service and increasingly over Christmas period to patient organisations and GP Practices.
- Check Care Homes are OK in advance of peak winter period.
- Continue Access Programme improvement for winter readiness and call response times.

Action Taken - Access for Primary care

- Brent GP surgeries – all will open, core hours from 8am to 6.30pm with doors and telephone open during these core hours, including Christmas and New Year's Eve.
- Enhanced Access Hub -The Hubs are a continuation of the GP practices and they offer evening and weekend appointments on Monday-Friday 6.30pm–8.00pm and Saturday 9.00am-5.00pm for patients registered with Brent practices.
- NWL Access Service - PCNs/Practices enhance on-the-day appointment availability during core hours and continually review appointment types and balance of on the day proactive capacity to ensure the appropriate mix of appointments both at practice and at scale. They work in collaboration with partner organisations to flexibly adjust capacity to meet demand and support redirections to appropriate care pathways
- Pharmacy First Service The service helps with capacity in practices, so practice appointments can be used for patients who really need them. Patients are encouraged to use community pharmacies for minor illness and medicines advice. This will free up GP appointments for patients with more complex needs, improving access and efficiency.
- Dental health – 2 new dental pilots launching in October 2025 to improve access, support, oral health and embed prevention across health, education and community settings – focus on children and young people 0-16 in CORE 20+ area and those identified as having higher oral health needs. Other pilot focuses on people living in temporary/ emergency accommodation.
- Emergency appointments are available for NWL residents via NHS Dentistry pathway.
- Neighbourhood MDTS coordinating proactive care for population cohorts with complex health and social needs
- Community capacity. CLCH make effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC cohorts where it is effective and appropriate to do so.
- CLCH active member of the NWL bed review and will support identifying any issues as they may arise.

Next Steps

- Continue to monitor appointment uptake and utilisation across practices and hubs to maximise uptake.
- Work with partner organisations to align appointment availability with demand.
- Communications with PCNs re Access Hub opening over the bank holidays.
- Promote awareness of the full range of available services (GP core hours, Enhanced Access, Pharmacy First, NHS 111, UTC)
- NWL ICB Winter Communication Plan will support system issues and support residents with decisions about their health and the services they use, by providing information and redirecting people at the point of need. It includes magazine articles in Council newsletter, videos and flyers in 13 languages, NWL ICB website.

3.2.6 **Access to healthcare during winter period: Acute**

Current Challenges

- LNWHT demand modelling has indicated attendances and admissions predicted to increase by 4% compared to last year as per Trust submitted operating plan.
- External discharge delays have been predicted to increase by 2% compared to last year based on the various external risks i.e. social care allocations and community equipment
- Capacity modelling - Based on 97% occupancy, the modelling suggests the Trust requires 26 more beds
- High volume of attendances and London Ambulance Service (LAS) conveyances.
- Winter infections reducing inpatient capacity.

Mitigations

- Increase in demand aims to be off set via pathway changes described throughout LNWHT Winter plans summarised to:
    - LAS demand management vis the sector commissioned model.
    - Increased redirection from NHS 111 and UTCs into primary care.
    - Increased streaming to ambulatory pathways i.e. ED SDEC, surgical assessment unit, gynae SDEC.
    - Development of the Discharge Ready Unit (DRU) and Older Peoples Short Stay Assessment Unit (OPSSU).
    - Actions on planned flow and discharge.
    - LNWHT new digital front door at Northwick.

Priority area of focus

- Winter approach refocus on:
    - ED gatekeeping with LAS and Sector ICC Hub.
    - Expansion of ED front door streaming.
    - Expansion and redesign of ambulatory pathways.
    - Increase inpatients and SDEC capacity.
    - Developing new flow models across 2025/26 ready for winter pressure.

    - Planned Winter Budget supporting escalation capacity as needed - £2.0m

- Improve access: ongoing engagement shapes 2026/27 commissioning priorities and ensures the patient voice drives changes, with a focus on: Strengthening continuity of care for complex needs.
- Improvement in winter readiness and call response times
- In 2025/25 PCNs have developed Access Improvement Plans against targets to improve access and health outcomes.
- Deliver timely, equitable and responsive care with a focus on reducing delays for urgent concerns and improving patient satisfaction.
- Strengthen collaboration with partner organisations to ensure maximum use of all available appointments.

Actions Taken

- Organisational leadership and process in place for winter period.
- Surveillance mechanisms in place including the use of Federated Data Platform (FDP) real-time data and forecasting tools to better manage demand.
- The Plan has been discussed with partners Brent, Harrow and Ealing Borough and LA Teams, CLCH, CNWL, WLNT and LAS.
- Daily discharge tracking updated at ward level.
- Proactive identification of P1 bridging pathway patients.
- Nurse Trusted Assessor to liaise with care home management re care planning and expectations.
- Redesigned capacity at NPH :
    - NPH Darwin C bay +4 beds (the daytime frailty assessment bay) to use as 4 OPSSU beds staffed 24hrs a day.
    - NPH Darwin +2 beds per bay, across B and C Bays.
    - NPH Dickens DRU overnight 4 beds to use 24/7 across the weekend for DRU criteria patients.
    - NPH AMU L5 consider additional escalation beds subject to discussion with EAC Division.
    - SDEC capacity expanded at NPH.

Next Steps

- Developing new flow models across 2025/26 ready for winter pressure.
- Continued development of gate keeping pathways, initially via REACH and ED SPA. Now developing as part of a sector wide approach to further strengthen the call before convey approach.
- NWL ICB have commissioned a frailty virtual ward, which once mobilised will provide targeted interventions in patients' homes. This initiative aims to reduce emergency admissions by offering care within the community. Furthermore, we have addressed gaps in community and neuro-navigators, which support both discharge and admission avoidance.

3.2.7 **Cost of Living and well-being support**

Challenges

- Challenges for people struggling with rising costs or just about getting by, there is a risk of homelessness and mounting debt.

Mitigations

- Brent council has in place services to support people that are struggling with rising costs and debts: https://www.brent.gov.uk/cost-of-living-help-and-advice
- Brent Hubs have been set up to work with residents who find it difficult to access the support they need through mainstream services: https://www.brenthubs.com/
- Community Wellbeing service - The project provides preventative support for local families and enables members to access a wide range of support under one roof, in order to build financial and personal resilience: https://www.sufra-nwlondon.org.uk/our-services/community-wellbeing-service/
- Support with anxiety and depression is provided by Brent Talking Therapies. This is a free, confidential NHS service for people registered with a Brent GP who are over 16 and can support with a range of concerns. It can be accessed via CNWL website: Brent NHS Talking Therapies, Email: cnw-tr.brent.iapt@nhs.net Telephone: 020 8206 3924
- Support with damp and mould and prevention can be obtained via https://www.mecclink.co.uk/london/housing-damp-and-mould-advice/

Priority areas of focus

- Provide timely advice and support via website links.
- Brent Hub focused on supporting people to help themselves and each other, working with them to solve their problems and build knowledge, understanding and resilience.
- Community well-being service-for just £4/week, service members have access to a range of support including a Community Shop, Community Café and Advice and Guidance through an extensive timetable of partners in the space.
- Evening Community Kitchen, where non-members can also enjoy a free delicious two or three course meal.

Next Steps

- Community Wellbeing service has been operating from the newly renovated New Horizons Centre since January 2025 and will soon expand into a full-time service**.**

3.2.8 **Cold weather, rough sleepers and housing**

Challenges

- Potential deaths or serious harm from exposure to extreme cold. This is usually when the temperature is zero degrees or below for several nights.
- For rough sleepers, there are not enough Severe Weather Emergency Protocol (SWEP) bed spaces, requiring the use of multiple locations and additional staffing during activations.
- There are no single-occupancy bed spaces and no dedicated funding to provide B&B for rough sleepers who are not eligible for statutory assistance.
- The Winter Night Shelter operates only from January to March and currently supports low-need males only, leaving limited options for others earlier in the winter season.
- For hospital discharges, there is insufficient supported accommodation for patients with complex mental health needs and a shortage of suitable housing

for those with significant physical health issues, including a lack of wheelchair-accessible accommodation.

- Patients who require care packages cannot have these arranged until an address is confirmed, creating additional pressure on the Council to identify suitable accommodation quickly.
- In addition, there are interim accommodation pressures from hospitals where discharge dates are not provided in advance. This limits the Council's ability to plan and can result in bed blocking when suitable accommodation cannot be sourced immediately.
- Damp and mould in the home can lead to respiratory and other health issues and is particularly sensitive for babies, children, older people and people with specific health conditions, such as asthma.

Mitigations

- Severe Weather Emergency Protocol (SWEP) in place and can be activated when the weather is very cold.
- For rough sleeping, work is underway to identify additional mitigation measures ahead of the winter season. This includes exploring options to increase bed capacity, reviewing available funding for temporary placements and working with voluntary sector partners to strengthen referral and outreach arrangements during SWEP activations.
- For hospital discharges, pathway to move inpatients from wards into suitable accommodation before discharge, reducing the need for interim accommodation and preventing avoidable delays to hospital flow.
- The London Damp and Mould Checklist designed by London's public health system partners, for use by health and social care professionals who visit residential properties as part of their management and care of patients.

Priority areas of focus

- Works with local partners to make emergency spaces available for anyone sleeping on the streets, so that no one has to remain outside in dangerous weather, and a 15-bed Winter Night Shelter are currently in place to support rough sleepers during periods of extreme cold.
- For hospital discharges, depending on the patient's medical needs, individuals are discharged into supported accommodation or suitable private rented sector housing, if they do not have a home to return to. Where these options are unavailable and the individual is assessed as having a priority need, interim accommodation is provided to ensure that no one is discharged from hospital without a safe place to stay.
- For rough sleeping, to take as many people off the streets as possible during Severe Weather Emergency Protocol (SWEP) activations by maximising the use of available bed spaces. This includes making regular referrals to the Winter Night Shelter and maintaining high churn throughout the three-month period so that as many rough sleepers as possible can be supported.
- For hospital discharges, a new dedicated Hospital Discharge Housing Team has been established, with a daily physical presence at Northwick Park Hospital. The newly appointed Team Leader has access to NHS systems, allowing officers to identify and assess patients from the point of admission rather than waiting until they are declared fit for discharge. This early involvement helps to prevent avoidable delays, improve planning, and reduce bed blocking.

- The damp and mould checklist and guidance in place for health and social care professionals to sign post and use to support the identification of internal damp and mould, as well as people at risk of poor health due to damp and mould exposure in their home. There is also an emphasis on prevention of damp and mould for all residents.

Next Steps

- Activate SWEP protocol if weather is very cold.
- For rough sleeping, to develop and agree the 2025/26 SWEP protocol, ensuring early planning, clear activation criteria and improved coordination with partners across the borough.
- For hospital discharges, to build a more efficient streamlined process that enables homeless inpatients to be identified and supported early now there is a new team in place, ensuring they can move into suitable accommodation with the right level of support before a request for interim accommodation is made by hospitals. This will help reduce last-minute pressures and support timely, safe discharges.
- Promote use of housing damp and mould advice - https://www.mecclink.co.uk/london/housing-damp-and-mould-advice/

3.2.9 **Mental Health**

Challenges

- Adults and older adults with physical health, mental health, learning disabilities and those living with dementia staying in hospital for longer than necessary can reduce independence, result in them losing muscle strength and can lead to more risks of infection.

Mitigations

- Reducing inpatient length of stay by supporting and bringing forward discharge processes.
- Assisting and supporting adults and older adults with physical health, mental health, learning disabilities and those living with dementia with safe and early discharges.
- Regular meetings with hospital discharge co-ordinators and with patients and their families to communicate the advantages of recovery out of hospital.
- Leaving hospital as soon as patients are clinically ready, with timely and appropriate recovery support will benefit their recovery.

Priority areas of focus

- Early discharges home with no additional support.
- Early discharges home with informal support from voluntary organisations
- Early discharges home with additional support from the Adult social care, NHS community teams: occupational therapists, physiotherapists, community nursing
- Early discharges home with a care package
- Early discharges to somewhere other than your home such as:

    - Extra care sheltered accommodation
    - Residential care home
    - Supported living
    - Nursing home
- Early discharges through NHS Continuing Healthcare
- Early discharges through NHS-Funded Nursing Care

Next steps

- Continue the work to support the hospital multidisciplinary teams with discharge plans that address the patient's specific needs and considers their medical condition, support system, and living situation.

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. As hospital discharges increase, Adult Social Care services will be required to assume additional costs associated with care packages, reablement, and home care provision. Furthermore, as we support a higher volume of discharges involving more complex patients, this will exacerbate existing financial pressures within Adult Social Care budgets.

5.2. Winter schemes supporting discharge and admission listed in 3.2.3 are funded through the Department of Health and Social Care fund. In 2025/26, Brent ICP was granted £6.2 million in funding to address discharges and winter pressures. No additional funding will be provided above that. Assurance of the schemes has been undertaken, and they have been approved to continue subject to on-going funding. There is some risk to partnership working to manage system pressures if this funding is not continued.

6.0 Legal Considerations

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

7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 Residents from deprived areas, facing health inequalities and from specific ethnic groups and residents that are frail over 65+ are more likely to be at higher risk of ill health and using health care services during the winter period.

7.2 Flu vaccinations and immunisations are to target priority groups which include children, pregnant residents and people with long term conditions.

7.3 The NWL ICB Winter communication campaigns is to target areas with low take up of vaccinations in previous years.

7.4 Support for residents to access health and community services is provided by Community Well-being services and other community organisations.

8.0 Climate Change and Environmental Considerations

8.1 There are not specific climate change and environmental considerations relating to this paper.

9.0 Human Resources/Property Considerations (if appropriate)

9.1 There are no specific human resources/ property considerations relating to this paper.

10.0 Communication Considerations

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

Report sign off:

Rachel Crossley
Corporate Director of Reform and Strategy

Tom Shakespeare
Managing Director Brent Integrated Care Partnership