Brent NHS West and North London	**Brent Health and Wellbeing Board** 9 November 2026
	Report from Brent Integrated Care Partnership

Brent Winter Resilience and Community Flow 2026 27

Wards Affected:	All wards
Report purpose:	For information and discussion
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:	None
Background Papers:	None
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1.0 Executive Summary

1.1 This report updates the Health and Wellbeing Board on Brent's partnership response to winter pressures, including hospital capacity, discharge and the contribution of community, primary care and council services. Partners recognise the pressures facing residents and services and are working together to strengthen timely care, safe discharge and support at home.

1.2 The winter planning position includes a reported 60-bed gap. Rising demand and discharge delays are placing pressure on available hospital beds, particularly where people no longer need an acute hospital bed but require further care or support. Recent review of Brent's discharge information has highlighted Pathway 1 and Pathway 2 as priorities for closer joint attention, alongside longer stays and the concentration of Brent patients at London North West University Healthcare NHS Trust (LNWH).

1.3 The response brings together immediate winter resilience with the longer-term shift towards prevention and care closer to home. A regular ICP place-based flow forum has been proposed to strengthen shared oversight of demand, capacity and discharge, building on existing arrangements and connecting frailty, admission avoidance and

recovery. This report is for information and discussion; no approval of funding or service changes is sought.

2.0 Matters for Board discussion

2.1 The Board is invited to note the winter pressures, the particular focus on Pathways 1 and 2, and the partnership work described in this report.

2.2 Discussion is invited on the connection between immediate winter resilience, partners contributions, and the wider shift towards prevention, independence and community care.

3.0 Detail

3.1 Contribution to Borough Plan priorities and strategic context

3.1.1 The report supports the borough's aims for better health and wellbeing, reduced inequalities and greater independence. It connects NHS winter planning with adult social care, housing and practical support, recognising that residents' ability to remain well or return home depends on the combined contribution of services, families, carers and communities.

3.1.2 Brent ICP's role is to bring partners together around the whole resident journey. The "left shift" means preventing deterioration, identifying need earlier and enabling more care at home or in the community where this is safe and appropriate. Winter learning will inform the 2027/28 ICP strategic plan and the alignment of existing resources, including the Better Care Fund (BCF).

3.2 Background and hospital bed pressures

3.2.1 Brent ICP has brought together available acute and community winter plans, alongside primary care and mental health initiatives and reviewed their connections across admission avoidance and discharge. LNWH describes rising attendance and ambulance demand, continuing flow pressures and the need to sustain additional hospital capacity introduced over the summer. Its prioritisation reflects the immediate requirement to provide safe care within limited resources.

3.2.2 The submission reports a 5.6% increase in attendances in months 1-5 compared with the previous year and a 17.2% increase in Northwick Park Type 3 attendances. It also describes corridor care, length-of-stay pressures and the closure of a 34-bed ward at Ealing for infection control works. These are pressures reported in the winter plan submission, rather than a new live capacity return for this Board meeting.

3.2.3 The reported 60-bed gap is a winter planning position, rather than a verified daily shortage for Brent alone. Joint work is needed to clarify its timing, geographical coverage and assumptions, the contribution of existing services and any residual gap. A shared demand-and-capacity trajectory would help partners target the weeks and pathways where additional support would have the greatest effect.

3.2.4 Recent discussions and local review of data highlight the relationship between people no longer meeting the criteria to reside in an acute bed, extended lengths of stay and onward community capacity. Delays reduce the availability of beds for people requiring admission and can affect recovery and independence. The concentration of Brent patients at LNWH makes close coordination with the Trust and onward care providers particularly important.

3.3 Pathways 1 and 2 and timely discharge

3.3.1 Pathway 1 supports people to return home with additional care, rehabilitation or reablement. The local focus is on understanding the time between readiness for

discharge and the start of support, the availability of care and therapy, and practical barriers such as equipment, housing conditions or home clearance. Earlier joint planning can help identify the support needed for a safe return home.

3.3.2 Pathway 2 provides short-term bed-based rehabilitation, recovery or further assessment where a person cannot immediately return home. Capacity and timely access to suitable provision require joint attention, together with onward arrangements so that temporary care supports recovery and does not become an extended stay. Hospital and community bed capacity need to be considered together.

3.3.3 Further work is also needed for patients without a planned discharge date, people with extended stays and those whose needs span several services. Home First, bridging support and the Transfer of Care Hub (TOCH) provide an important focus for understanding how existing capacity is used and where coordinated intervention could help. More complex discharge pathways, including Pathway 3, remain within the wider oversight of flow.

3.4 Strengthening place based community flow governance

3.4.1 A regular ICP place-based community flow meeting has been proposed to bring LNWH, community health services, primary care, the local authority and other relevant partners together outside the Executive meeting. Its format, frequency and core membership remain to be agreed with partners, with particular attention to winter pressures and avoiding duplication of existing forums.

3.4.2 The proposed forum would develop a shared view of current and anticipated demand and available community capacity; examine Pathway 1 and 2 barriers; and review Home First, bridging services and TOCH coordination. It would connect this work with frailty and proactive care so that admission avoidance, discharge and recovery are considered together.

3.4.3 The intended approach is practical joint problem-solving, with a small number of shared priorities, named action leads and clear outcomes. Operational barriers requiring wider support would be escalated through existing borough and system arrangements. Organisational responsibilities and established clinical and statutory processes would continue to apply.

3.4.4 A shared monitoring view would include people no longer meeting criteria to reside, Pathway 1 and 2 waiting times and delay days, planned discharge dates, longer stays, community capacity and utilisation, and readmissions. Reporting would use dated baselines and common definitions to distinguish improvement in flow from pressure being transferred to another service.

3.5 Prevention and the 1 per cent challenge

3.5.1 Supporting safe hospital care and intervening earlier in the community are complementary parts of the winter response. For people with frailty or wider social needs, proactive reviews, rapid community responses and practical help at home may prevent deterioration or avoid a hospital attendance. Where admission is needed, early discharge planning and timely recovery support remain essential.

3.5.2 The borough's work on the 1% challenge is intended to translate a measurable contribution to reducing hospital demand into practical action across the pathway. The focus is on where collective intervention can reduce avoidable admissions, unnecessary hospital days and discharge delays while improving residents' outcomes. Partners will need to confirm the baseline, denominator and reporting period before expressing the challenge as a quantified Brent delivery commitment.

3.5.3 Potential contributions include targeted frailty reviews, Urgent Community Response (UCR), ambulance referral and diversion, Hospital at Home, and better access to appropriate primary care. Prevention also involves addressing non-clinical risks such

as cold homes and difficulties accessing support. Work on urgent treatment centre attendance should examine residents' clinical and social needs and the availability of alternatives, without assuming that attendance is inappropriate.

3.5.4 Benefits should be assessed through admissions avoided, acute bed-days released, safe return home, readmissions and resident experience, alongside the additional workload in community and social care. Released capacity should be distinguished from cash-releasing savings. This will connect winter resilience with longer-term investment in prevention and care closer to home.

3.6 Brent Council contribution over winter

3.6.1 The council's core adult social care contribution includes assessment and care planning, arranging support for eligible residents, safeguarding and emergency duty arrangements. These functions are central to discharge and to supporting people whose needs increase over winter. Joint attention to assessment, care availability and the practical circumstance at home is particularly relevant to Pathway 1; suitable recovery provision and onward support are important to Pathway 2.

3.6.2 Brent's existing reablement service provides short-term support to regain skills and confidence at home. It can support people leaving hospital and others who may benefit from greater independence. Its role in the winter pathway is to support recovery and reduce reliance on ongoing care where appropriate, with individual goals and subsequent needs reviewed through care planning. (1)

3.6.3 Adult safeguarding and emergency duty arrangements remain part of the council's response when residents are at risk, including outside office hours. The flow work should maintain clear links to these arrangements so that safety concerns and complex circumstances are addressed through the appropriate services. (2)

3.6.4 Alongside statutory services, Brent Well and Warm, delivered with Groundwork, offers eligible households energy advice, home visits where needed and guidance on financial support. Council information also signposts residents to warm spaces and help with energy costs. Connecting residents to this support is relevant to preventing deterioration and addressing the conditions that can make recovery at home more difficult. This is existing support, rather than a newly confirmed winter capacity expansion. [3]

3.6.5 The Public Health team and Brent Health Matters are working hard to promote winter vaccine uptake and winter well health messages. Estimates suggest indicated that, in England, the winter vaccination programme prevented an estimated 104,000 hospital admissions and 7,100 deaths. Public Health has pulled together a multiagency working group to support joint action on improving vaccination uptake. The Public Health team is arranging vaccinations for social care and care workers at a variety of community settings as well as social care and health care workers based at the Council. This includes 6 community Flu and Covid Vaccination sessions in October 2026 and 5 sessions in November 2026. The team has also arranged 3 Flu vaccination sessions for Health and Social Care Workers based at the council. The Public health team is also providing targeted flu vaccination session for the homeless in accordance with the new eligibility guidance. Additional sessions will be facilitated depending on demand, uptake and epidemiology.

3.6.6 The partnership is seeking to bring together a single borough view of existing BCF, adult social care, housing and Public Health activity alongside any additional winter provision. This will clarify available capacity, referral routes, outcomes and dependencies. Scheme-level winter commitments and additional capacity will need confirmation by the responsible leads before they are included as funded delivery assumptions.

3.7 Further opportunities and next steps

3.7.1 Borough planning has identified options including a falls response, stronger ambulance-to-UCR referral, practical home support, additional step-down or flexible care capacity, and primary care appointments bookable from urgent treatment services. Primary care partners have also developed options for respiratory and paediatric access, proactive frailty reviews, care-home support and vaccination outreach.

Option	Indicative cost	Scope and intended contribution
Falls pick-up service	c£230,000	Wider Outer North West London footprint; appropriate response after falls and fewer avoidable conveyances.
Ambulance and UCR diversion pilot	£20,000 per month	Wider footprint; £120,000 assumes six months. Brent share and period require confirmation.
Practical home support	c£50,000	Handyman support linked to community health to address barriers to safe discharge.
Additional step-down or flexible care	c£300,000	Indicative six-month estimate for ten beds or flexible care capacity; model and throughput to be refined.
UTC-bookable primary care appointments	c£350,000	Initial assumption of 20 weeks and 15 daily appointments; operating days and additionality require confirmation.

3.7.2 These remain options for appraisal where resources become available. Any scheme would require confirmation of additionality, capacity, mobilisation dates, delivery responsibility and measurable benefit. Proposals covering a wider geography would need an agreed Brent contribution, and overlapping proposals should be assessed together to avoid counting costs or benefits twice.

3.7.3 The immediate priorities are to develop the proposed community flow arrangements with partners, deepen understanding of Pathway 1 and 2 constraints, and connect existing provision to a shared demand-and-capacity view. Learning will support earlier joint planning for future winters and the wider programme of prevention and care closer to home.

4.0 Stakeholder and ward member consultation and engagement

4.1 The report draws on winter planning discussions involving acute, community, primary care and local authority partners. The proposed governance arrangements are subject to further partner discussion. This is a partnership update rather than a report of formal public or ward member consultation.

4.2 Residents and carers should be involved in individual discharge and recovery planning. Their experience should also inform pathway improvement, including whether support is accessible, culturally appropriate and coordinated around what matters to the person.

5.0 Financial Considerations

5.1 In response to the acute sector's immediate operational position, including increased demand, bed pressures and continuing challenges with patient flow, the Integrated Care Board (ICB) decided to allocate the additional winter funding to acute partners, with the exception of £140,000, allocated to Adult Social Care. This decision was made without borough partnership consideration of the final allocation. Brent partners recognise the rationale for prioritising safe hospital care and maintaining capacity through the winter.

5.2 Borough partners had sought to use this funding opportunity to strengthen admission avoidance and community capacity, reducing demand earlier in the pathway and supporting timely discharge. These proposals remain relevant to the wider winter response. While recognising the immediate acute pressures, the partnership has requested that the priorities and use of any further funding are considered and agreed at partnership level, through the appropriate approval arrangements, so that investment reflects the needs and potential benefits across the whole pathway.

5.3 Alongside the additional winter funding, agreement has now been reached on spend for the £1.1 million neighbourhood investment outlined in Brent's neighbourhood proposal. This supports the borough's response to the 1% challenge and the shift towards prevention, proactive care and support closer to home. The intention is to reduce avoidable hospital demand while improving residents' independence, experience and outcomes.

5.4 With agreement on spend in place, work is now focused on mobilising the neighbourhood model, initially through the Harlesden work on frailty and adults with complex needs, alongside targeted cardiovascular prevention. Mobilisation will bring partners together around the delivery arrangements, workforce and community capacity, cohort identification, referral routes and measures of impact. Brent Health Matters, resident involvement and voluntary and community sector partners are integral to developing support around people's wider needs.

5.5 The £1.1 million provides the investment basis for mobilisation; it should not be described as a realised saving or a guaranteed reduction in acute expenditure. Benefits will be tracked against agreed baselines, including avoidable admissions, hospital bed-days, discharge flow, independence and inequalities, alongside the impact on community and social care services. This will support shared oversight of the 1% ambition and inform future partnership investment decisions.

6.0 Legal Considerations

6.1 No new statutory powers, delegations or service changes are sought through this information report. Delivery continues through the responsibilities of the respective partner organisations. Any subsequent proposals would require appropriate legal and governance consideration, including care and safeguarding responsibilities, equality considerations and lawful information sharing.

7.0 Equity, Diversity and Inclusion Considerations

7.1 Winter pressures can have a greater effect on people with frailty, disability, long-term conditions, limited support networks or difficulty keeping their homes warm. Language, digital access, housing insecurity and cultural needs can affect access to services and timely discharge. Partners should use local data and resident insight to identify and respond to these differences.

7.2 Any subsequent service changes should consider equality impacts through the relevant organisational processes. Monitoring should examine who benefits and whether access or outcomes differ across resident groups. Safe discharge planning should reflect individual needs and the circumstances and capacity of unpaid carers.

8.0 Climate Change and Environmental Considerations

8.1 Support for warmer homes and appropriate care closer to home connects winter resilience with wider environmental objectives. Any change in travel or resource use would require assessment; no quantified environmental saving is claimed in this report.

9.0 Human Resources and Property Considerations

9.1 Community and social care workforce availability, appropriate recovery beds and conditions in residents' homes affect winter delivery. No new staffing establishment or property commitment is sought. Additional schemes would require a deliverable workforce and capacity plan alongside any funding approval.

10.0 Communication Considerations

10.1 Partners should provide clear and consistent information about access to care, discharge support and practical winter assistance. Communications should be accessible and should distinguish existing services from proposed or newly funded provision. Shared reporting through established borough and system arrangements will support oversight of pressures, actions and outcomes.

4 Council service references

[1] Brent Council - Reablement Short-Term Support. https://brent.gov.uk/adult-social-care/staying-independent/reablement
[2] Brent Council - Protecting adults from risk of harm and abuse. https://www.brent.gov.uk/adult-social-care/protecting-adults-from-risk-of-abuse
[3] Brent Council - Electricity gas and water bills including Brent Well and Warm. https://brent.gov.uk/cost-of-living-help-and-advice/electricity-gas-and-water-bills
Council service information checked on 20 October 2026. Winter planning figures are attributed to the October submission and are not a live Board-date position.