

Brent Health Matters Programme

Working with communities - protecting people from Covid-19 and tackling health inequalities in Brent



Alignment with NWL ICS Vision and NWL Response to the NHS Long Term Plan

NWL ICS Vision

- Aim of the ICS is to ‘reduce inequalities, increase quality of life and achieve health outcomes on a par with the best of global cities’.
- Care will be integrated within a single system, focused on the needs of the individual and unhindered by organisational boundaries. We will combine our collective resources, clinical expertise and local knowledge to build a fair, effective and accessible health service for all.
- NHS & Local Authorities working together to develop the ICS strategy to reduce inequalities, deliver integrated Borough based care and keep communities safe through joint Covid surveillance

NWL Response to the NHS Long Term Plan

- Intend to build on the past successes of our collaboration and moreover lays clear the public engagement that underpins our vision and clinical strategy.
- Embrace a population health management approach both in understanding inequalities in outcomes for our residents and in our work to reduce those inequalities. Use data key to fully understand the impact of Covid 19 on our population and in planning health and care interventions to reduce inequalities experienced by our residents.



Brent Health Matters Programme

Rationale: The coronavirus arrived early in Brent and the borough has been hit hard during the first wave, the most deprived areas were disproportionately affected.

Aim: Working in collaboration with Health and Social care services, voluntary sector services and voices from our communities to reduce health inequalities in Brent (initially focussing on Alperton and Church End).

Objectives:

- 1) Reduce impacts of Covid-19 on the community
- 2) Increase uptake of vaccinations and health screening
- 3) Proactive management of long term conditions (diabetes, hypertension, obesity, mental health and cardiovascular disease).
- 4) Prevention of long term conditions in high risk population through health education and self care
- 5) Increase community awareness of existing mental health services and improve access to therapeutic interventions for areas impacted by Covid-19.
- 6) Provide a Patient Advice Line for the residents of Brent



Key drivers of health inequality

- High Co-morbidity among Ethnic Minority Groups communities
 - High levels of Diabetes Mellitus, other long-term conditions and poor control of these conditions
- Health Behaviour
 - Covid-19: distrust in safety of hospital, misbelief that primary care is closed, not engaging in alternatives to face-to-face appointments (lack of confidence / digital access)
 - Age (general issue)
 - High exposure among BAME communities
 - Public transport
 - Inter-generational living
 - High attendance to places of worship with large communal activities
 - Less likely to work from home, zero-hours contracts/cash in hand
 - Frontline occupations, less likely to be managers to be able to influence working conditions
 - Socioeconomic deprivation

Who are we working with?

- Brent Council
- Brent Clinical Commissioning Group (NHS Brent CCG)
- Brent GP practices
- Central London Community Healthcare Trust (CLCHT)
- Central and North West London NHS Foundation Trust (CNWL)
- London North West University Healthcare NHS Trust
- Community health service providers
- Other health and social care providers
- Voluntary groups and organisations
- Community and faith leaders
- Community champions
- Patients / Residents



How we deliver our vision?

Objectives	What is the proposed solution?	What resource is available?	How will we measure it? Examples (Short/long term)
<ul style="list-style-type: none"> - Reduce impacts of Covid-19 on the community - Increase uptake of vaccinations and health screening 	<ul style="list-style-type: none"> -Direct promotion of support and targeted communications to communities - Myth busting communications -Engagement through Community Champions to access 'hard-to-reach' communities -Engaging with target audience through community meetings/ community events/ faith leaders 	<ul style="list-style-type: none"> -10 Dedicated Community Champions working with community leads -Communication Task and Finish Group in place 	<ul style="list-style-type: none"> -Flu and Covid vaccination rates by GP practice/Ward (short) -Increase in reported access to healthcare services (Short) -Increase in health screening (Short) -Reduced infection rates/mortalities of Covid 19
<ul style="list-style-type: none"> - Proactive management of long term conditions - Increase community awareness of existing mental health services and improve access to 	<ul style="list-style-type: none"> -Proactive and holistic management of patients -New direct telephone line for communities needing support/ signposting to services -Self care and health education and use of technology e.g. NWL Health apps library -Mental health practitioner working with the GP practices 	<ul style="list-style-type: none"> -Dedicated team of care planners and clinicians -Mental health practitioner assigned to practice 	<ul style="list-style-type: none"> -Increase in referrals for case management (Short) -KPIs for management of LTCs (Long) -Number of queries received through the telephone service - Patient satisfaction surveys
<ul style="list-style-type: none"> - Prevention of long term conditions in high risk population 	<ul style="list-style-type: none"> -Health Educator Champions and Health coordinators in communities, with training provided to take knowledge, messages and support to community groups, including Covid risks, risks of LTC, 	<ul style="list-style-type: none"> -Health Educator (recruitment in progress) 	<ul style="list-style-type: none"> -Reduced rates of LTC -Reduced rates of obesity -Improved health knowledge (surveys)

GP practices included in the first phase

Locality	PCN	Practice Name
Kingsbury	K&W West	Alperton Medical Centre
Harness	Harness South	Brentfield Medical Centre
Harness	Harness South	Church End Medical Centre
Harness	Harness South	Hilltop Medical Practice
Willesden	K&W North	Neasden Medical Centre & Greenhill Park
Harness	Harness South	Park Royal Medical Centre
Willesden	K&W South	St Andrews Medical Centre
Kingsbury	K&W West	Stanley Corner Medical Centre
Harness	Harness South	Stonebridge Medical Practice
Harness	Harness North	Sudbury & Alperton Medical Centre

*The programme will be rolled out to remaining GP practices in the next phase

New Health Service

- We are working with the GP practices within the 2 most affected wards in Brent to understand the health determinants and need for the local population and working together to identify priorities and formulating action plans to support practices to improve health outcomes for the most hard to reach patients.
- We developed a model of care and the Clinical team work flexibly as part of a MDT and have the expertise and capacity to directly address health needs in the community, whilst at the same time building confidence of the community in healthcare services
- Provided a dedicated non –clinical patient advice and support line for the patients and residents of Brent and the 10 practices continues



Brent Health Matters Clinical Service

Health Service	Focus area	Multi Disciplinary Team
<p>A multidisciplinary team of health professionals with condition specific expertise being recruited to provide capacity, case management and to link with wider determinants of health (housing etc.)</p> <p>The health inequalities team will work holistically with people to provide:</p> <ul style="list-style-type: none"> • Health support enhancing the current community, mental health and primary care services • Social care support • Self help 	<p>Flu and Covid uptake continues to be a priority alongside the the following disease groups:</p> <ul style="list-style-type: none"> • Diabetes types 1 and 2 • Cardiovascular conditions • Low grade mental health (anxiety/ depression) • Obesity • Asthma • COPD • Post-COVID sequelae <p>We, the programme leads have met with 10 GP practices and discussed key issues and possible solutions. The practices continue to be supported in identifying their cohort of patients who could benefit from the input from the service. Once identified the clinical team will take the caseload and provide this dedicated support (see GP care model-next slide)</p>	<ul style="list-style-type: none"> • 4 Clinical Team Lead GP's. • Clinical Team Lead. • 2 Admin personnel. • 5 Specialist nurses. • 5 Specialist Health Coordinators. • 2 Dieticians. • 2 Pharmacists. • 4 Mental health practitioners in post working with 10 practices through CNWL

GP MODEL OF CARE

GP Identified Data / Intelligence / EMIS based search

PRIORITY : Flu uptake/immunisations /Diabetes/HF/Breast/Bowel/Cervical screening/LTC/MH/ Covid19

Collection of Data

Formulate Effective Ways to Engage Patient's

Calls or Visit

Call using an identifiable number

Call scripts will include LTC

If Appropriate Make Appointment / Attend

Virtual or Face 2 Face

Holistic Assessment and create a Comprehensive Care Plan

Enables us to assess social needs or any other raised concerns

Highlight Health and Social Care Issues

Discuss with GP the following Week

Individual Case Management

Clinical Testing / Investigations (bloods)/ Provide Care Management / Advice Line / Group Interventions / Health Promotion / Counselling Services / Mental Health /Referrals (DOS)

Follow up on all Referrals made by the service

Specified Timely Reviews

Registering with GP

Why it's important to register with a GP

Once registered, your local GP can help you with many health related issues, including:

- General health advice
- Contraception and maternity services
- Vaccinations
- Preventing Long term conditions
- Prescriptions and managing long term conditions
- Addressing your concerns about your own, or your children's health
- Arranging for tests and screenings to protect you (e.g cervical screening, breast screening)
- Support you with your mental health and wellbeing

GPs are also able to refer you on to hospital, specialist or community services if you need further tests or treatment.



How to register with a GP

It's quick and easy to register with a GP. Call Primary Care Support England on 0333 014 2884 (option 1) for advice, or pop into a practice near your home and ask about becoming a patient.

asylum seekers, refugees, overseas visitors, students, people on work visas and those who are homeless are still entitled to register with a GP

Registering without proof of identity or address

- You do not need evidence of identity, immigration status or proof of address to register with a GP.
- Patients are entitled to register with a GP using a temporary address, which may be a friend's address or a day centre. The practice address may also be used to register them

Temporary registration

- Even if you are an overseas visitor, here longer than 24 hours but less than 3 months, you can still register temporarily with a GP.

Please encourage those around you to register with GP if they have not done so, If someone needs support with registering with a GP please call Brent advice line on 020 3114 71 85 or

BRENT HEALTH MATTERS



**DON'T KNOW WHERE TO TURN
FOR HELP WITH YOUR HEALTH
OR WELLBEING NEEDS?**

Call the new Advice Line on

020 3114 7185

10am-3pm, Monday-Friday

The Advice Line is open to any resident of Brent.

You can ask any non-clinical questions about health and social care and you will be signposted and supported to access services.

You can also receive advice to better manage your health conditions.

London North West Healthcare  NHS Trust Central and North West London  NHS Foundation Trust  NHS Brent Clinical Commissioning Group 

SUPPORTING RESIDENTS TO LIVE HEALTHIER LIVES

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