Public Document Pack

Community and Wellbeing Scrutiny Committee

Tuesday 9 July 2019 at 6.00 pm
Boardrooms 3-5 - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members	**Substitute Members**
Councillors:	Councillors:
Ketan Sheth (Chair) Colwill (Vice-Chair) Afzal Ethapemi Hector Knight Shahzad Stephens Thakkar	Aden, S Butt, Gbajumo, Gill, Johnson, Kabir, Kelcher, Mashari and Nerva Councillors: Kansagra and Maurice

Co-opted Members
Helen Askwith, Church of England Schools
Dinah Walker, Parent Governor Representative
Simon Goulden, Jewish Faith Schools
Sayed Jaffar Milani, Muslim Faith Schools
Alloysius Frederick, Roman Catholic Diocese Schools

Observers
Ms Sotira Michael, Brent Teachers' Association
Lesley Gouldbourne, Brent Teachers' Association
Jean Roberts, Brent Teachers' Association
Brent Youth Parliament, Brent Youth Parliament

For further information contact: Bryony Gibbs, Governance Officer
bryony.gibbs@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:

www.brent.gov.uk/committees

The press and public are welcome to attend this meeting

Notes for Members - Declarations of Interest:

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also significant enough to affect your judgement of a public interest and either it affects a financial position or relates to a regulatory matter then after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.
(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.
(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.
(d) **Land -** Any beneficial interest in land which is within the council's area.
(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.
(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.
(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:
- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:

- You yourself;

a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest

Agenda

Introductions, if appropriate.

Item		Page
1	**Apologies for absence and clarification of alternate members** Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 64.	
2	**Declarations of interests** Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.	
3	**Deputations (if any)** To hear any deputations received from members of the public in accordance with Standing Order 67.	
4	**Minutes of the previous meeting** To approve the minutes of the previous meetings held on 17 April 2019 and 9 May 2019 as a correct record.	1 - 12
5	**Matters arising (if any)**	
6	**Substance Misuse Service** This report provides an account of substance misuse services in Brent. It covers the Integrated Treatment, Recovery, Wellbeing and Substance Misuse service model and the commissioning arrangements by Brent Council Public Health. The performance of the provider, Westminster Drugs Project (WDP) with Central North West London (CNWL) NHS Foundation Trust as the clinical partner, is described. The work of B3, the service user council for Brent entirely run for and by local residents who have been directly affected by problematic drug and alcohol misuse, is described.	13 - 24

7 Childhood Obesity: Members' Scrutiny Task Group 25 - 34

To enable members of the Community and Wellbeing Scrutiny Committee to set up a members' scrutiny task group to review childhood obesity in Brent.

8 Central Middlesex Hospital - Urgent Care Centre Changes in Operating Hours 35 - 80

This paper from NHS Brent CCG looks at the urgent care provision in Central Middlesex Hospital (CMH) and report on the findings on its utilisation, impact on equality, health inequalities and overall quality of CMH UCC. Included in this case for change report are the alternative options that Brent CCG has taken into consideration to ensure the access to services are providing best use of public money and better use of resources. The paper shows current usage of the urgent care centre (UCC) as well as the public and stakeholder engagement plans.

9 Palliative and End of Life Care in Brent 81 - 90

This report provides an update for the Overview and Scrutiny Committee on Community Palliative and End of Life Care (EOLC) services in Brent. The report describes demographic data and activity, the current range of local acute and community specialist palliative care services and the CCG's strategy and commissioning intentions that address some of the challenges in the delivery of EOLC services in Brent

10 Community and Wellbeing Scrutiny Committee Work Programme 2019/20 Update 91 - 98

The report updates Members on the Committee's Work Programme for 2019/20 and captures scrutiny activity which has taken place outside of its formal meetings.

11 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 60.

Date of the next meeting: Wednesday 4 September 2019

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

This page is intentionally left blank

Brent

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Wednesday 17 April 2019 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor and Councillors Afzal, Conneely, Hector, Knight, Thakkar, and Co-opted Members Reverend H Askwith and Mr A Frederick

Also Present: Councillors Farah

1. **Apologies for absence and clarification of alternate members**

   Apologies for absence were received from Councillors Colwill and Shahzad and from appointed observer Jean Roberts.

2. **Declarations of interests**

   Councillor Sheth declared a personal interest as Lead Governor of the Central and North West London NHS Trust.

3. **Deputations (if any)**

   There were no deputations received.

4. **Minutes of the previous meeting**

   RESOLVED:-

   that the minutes of the previous meeting held on 18 March 2019 be approved as an accurate record of the meeting.

5. **Matters arising (if any)**

   There were no matters arising.

6. **Update on Transforming Care Programme: Learning Disabilities**

   Councillor Farah (Lead Member Adult Social Care) introduced the report and advised that Helen Woodland (Operational Director Social Care) and Helen Duncan-Turnbull (Head of Service, Complex Care) were present to help address members' queries. Helen Duncan-Turnbull highlighted that the report updated the committee on the progress achieved with respect to the delivery of the transforming care plan (TCP). It was explained that the TCP aimed to reduce inpatient admissions for people with learning disabilities, ensuring that there was sufficient support available in community settings, with the ultimate aim of improving quality of care and quality of life. The report outlined Brent's progress against the national

and regional requirements and set out the priorities for the current year as agreed at the Brent Health and Wellbeing Board in January 2019.

To achieve the national TCP, Brent had four work streams in place: Market Development; Reduction in the number of NHSE and CCG in-patients; Integration of the Health and Social Care Learning Disability teams; and, Transitions. Drawing the committee's attention to the progress made against the key milestones for each of these priorities, Helen Duncan-Turnbull advised that all of these had been met and were being monitored both by the North West London Steering Group and at a local level. Furthermore, Brent had exceeded the milestone relating to accommodation for people with Learning Disabilities due to the council's New Accommodation for Independent Living (NAIL) project. A key area of challenge related to the support for those individuals with complex needs. Brent currently had ten people in specialist commissioned beds and currently, forensic support was lacking across North West London, with particular concern for outlying boroughs such as Brent. A further area of challenge was the potential financial pressures relating to individuals with complex needs who had been in-patients for less than five years. The NHSE provided funding for those who had been in-patients for five years or more to support discharge plans and community provision; however, seven of the ten individuals were not eligible for such funding, representing a financial pressure for the CCG or local authority going forward.

In concluding her introduction, Helen Duncan-Turnbull highlighted next steps and priorities for the coming year, which included the establishment of an Autism Board and the further development of specialist accommodation via the NAIL project, with a particular focus on the complex support needs of the ten individuals previously referred to. It was noted that the 0-25 Disabilities Team and the Integrated Health and Social Care Team had now been established. With regard to the later work would focus on improving the cohesion of the team, with a service review due later in the year to monitor progress.

Duncan Ambrose (Assistant Director, Brent CCG) outlined the practical monitoring arrangements supporting the work of the TCP. The committee was advised that a weekly monitoring call was held to discuss each in-patient with Learning Disabilities and consideration given to how their discharge could be accelerated. A risk register was maintained for those at risk of becoming in-patients, with consideration given to what support could be put in place to prevent escalation.

The Chair thanked colleagues for the introduction to the report and invited questions from members of the committee.

The committee questioned what actions were taken to mitigate the challenges highlighted in the report. Further details were sought regarding the monitoring arrangements for providers and it was questioned how the council and CCG was ensured that the needs of individuals within these provisions were being met. Members subsequently sought particular comment on the operational challenges posed by the integration of Health and Social Care Learning Disabilities teams and the creation of the 0-25 Disabilities Team. Concern was expressed that the lack of funding transfer agreements for seven individuals in specially commissioned in-patient provision could act as a disincentive in supporting their discharge to community based services. Several queries were raised regarding workforce development, with members seeking assurance that the training programmes

detailed in the report had been successful in addressing the issues raised via the Winterbourne View scandal, and questioning the breadth of coverage across the workforce. Members subsequently questioned how the council and CCG ensured that independence was promoted and that a hospital environment was not simply being recreated in the community.

Discussing the success of the NAIL programme, members questioned whether this would support the return of the 84 individuals placed in provision outside of the borough. Further information was sought with respect to the timeframes for the delivery of the NAIL schemes aimed at meeting the needs of people with a learning disability with complex needs. Clarification was sought with regard to the additional beds provided via de-registration or spot-purchase and the role of specialist commissioning was queried. Members sought comment on other housing options which could be considered for this cohort and questioned what support was provided to those cared for within their family homes. With reference to Direct Payments, the committee questioned whether officers were confident that the council had sufficient oversight of the provision being directly commissioned to prevent poor quality provision or financial abuse of those using Direct Payments.

It was noted that the Outcome Based Learning Disabilities team service specification was due to be ratified and the committee questioned who had devised this specification and who had been consulted during its development. Members further questioned how the voice of vulnerable adults was captured with the TCP and commented that future reports should include feedback from those affected. The committee asked when advocates were used to support individuals in making their voices heard. In concluding their questioning, Members sought comment on whether there was any concern amongst officers that there were individuals with unidentified needs who remained unsupported by the council.

Responding to the queries raised, Helen Woodland (Operational Director Social Care) emphasised that the intent behind the transforming care agenda was to move people into community settings where there could be a greater assurance with regard to safeguarding and the quality of care received. Every individual with a social care package of support had an annual review to ensure that the care they received remained appropriate for their needs. In addition, contract monitoring with providers, safeguarding visits and close working with the CCG and Integrated Health and Social Care team all contributed to the safeguarding structures in place.

Helen Woodland advised that integrated teams provided better outcomes for service users. Commenting on the integration of the Health and Social Care Learning Disability Teams, Helen Woodland advised that the challenges had been both practical and cultural: the former included issues such as where the team should be located and how the different IT systems worked together; the latter, the understanding the different eligibility criteria for services and the different risk structures in place. It had been important to invest time to allow a protected learning environment to develop and to support techniques such as reflective practice sessions to encourage different perspectives to be shared. A service review was scheduled for later in the year to ensure that the work that had been undertaken had been effective and that the expected outcomes were being achieved. Duncan Ambrose emphasised that prior to the integration of the services, it had been the service user who had experienced these tensions between the services.

Helen Duncan-Turnbull outlined the challenges experienced in the creation of the 0-25 Disabilities Team, which combined the children's team and the transitions team. It was highlighted that there were different legislative requirements for children and adults and the approach taken had been to 'buddy up' workers from the respective teams to ensure the necessary mix of experience and knowledge. This approach helped to build supportive relationships between team members and was reinforced by a programme of formal learning and quarterly reviews.

The committee was assured by Helen Duncan-Turnbull that the lack of a funding transfer agreement did not act as a disincentive for the council or CCG in supporting the discharge of a patient – this would be unlawful. Rather it would be necessary to assess the support needs of the individual being discharged from inpatient care, determine which of these fell within health or social care services and to arrange for funding to be agreed between the council and CCG as necessary. Duncan Ambrose added that the transfer funding agreements provided by NHSE were to aid in the acceleration of inpatient discharge for those who had been in-patients for a long time and would not be a disincentive for normal processes.

Addressing Members' queries on workforce development, Helen Duncan-Turnbull advised that a number of the staff training programmes referred to in the report had been identified as necessary to implement the Transforming Care agenda, both at a North West London and local level. Many of these programmes were therefore, specifically targeted to address particular issues of concern. A range of training around positive behaviours support had for example, been commissioned to help staff better support people with complex needs and challenging behaviours. The contract monitoring teams also created workforce development plans for the local authority and providers. These plans were reviewed annually to account for emerging needs or issues identified via contract monitoring. It was confirmed that not all staff would have received the training to date and that this could take approximately 18 months. Helen Woodland emphasised the importance of the workforce development plans established via contract monitoring, noting that as a commissioner of these services, the council had a responsibility to ensure that ongoing training needs were being addressed. This was particularly important given continual changes in the provider market and staff turnover for individual providers. The council had to work continually to ensure that provision that had been rated as good, remained so. The work of the Safeguarding Concerns Sub Group was particularly important in this process, allowing the council to identify issues early on and target support as needed.

The committee was further informed by Helen Woodland that outcome frameworks were being built into the annual reviews of individuals' support needs to better capture people's perceptions of their care and wellbeing. Developing a better service user led view of services also helped ensure independence was being promoted and the NAIL programme meant that individuals were less likely to be placed in residential or nursing care. Furthermore, the council was reviewing the procurement of its home care services to ensure that all providers had an enablement or reablement focus. This was not something that was currently present in the provider market and the council was working with those companies to support their staff to achieve this focus. There was currently a lot more work to be done before this goal was achieved for home care, though many residential

providers and supported living providers were very good at promoting independence.

Helen Woodland further advised that part of the approach of the NAIL programme was to create accommodation around cohorts, for example those with similar interests or age, and designing those developments with input from those who would be living there and their network of family and friends. With regard to the 84 individuals currently placed out of borough, it would depend on the individual circumstances as to whether it was appropriate or beneficial to change their existing arrangements. The number of out of borough placements was likely to fall over time as circumstances were reviewed but members were advised that sometimes it was entirely appropriate to place someone out-of-borough. It was clarified that the NAIL schemes listed in the report were Learning Disabilities specific. There was an ongoing forward plan to develop NAIL accommodation in line with future need. Helen Woodland clarified that the provision of additional beds via de-registration meant that the council worked with an existing care home to convert their registration to a supported living provider, requiring de-registration with the Care Quality Commission. With regard to spot purchasing, this was a method of purchasing using a West London Alliance framework of rates for which a bed was only paid for when used. Spot purchasing had been used for specialist provision and in some cases the package of care was very expensive due to the complexity of needs.

Helen Woodland highlighted to the committee that not all Brent residents with a Learning Disability would qualify for housing support, but strong links were maintained with the housing team to provide support where appropriate. It was further clarified that if an individual was cared for in a family setting, the carer would be entitled to an assessment and where needed support could be provided to aid independence, identify housing solutions, or provide respite care. Addressing concerns expressed regarding direct payments, Helen Woodland advised that there was an element of risk with direct payments but it was suitable to allow those adults the freedom to commission their own services. The council had monthly contact with individuals using direct payments and had oversight of the services being received. A peer review would be held in Brent in June 2019 and this was one amongst a number of safeguarding mechanisms that contributed to the council's safeguarding framework.

Helen Duncan-Turnbull advised that the Outcome Based Learning Disabilities team service specification had been developed at a North West London Level in line with best practice and agreed for use across all partners including the local authority and CCG. It was confirmed that the voice of adults with learning disabilities was fed into the Transforming Care Programme via the Learning Disabilities Partnership Board, which was co-chaired by a service user. This group and the Health Sub-Group were good at engaging their peers and representing those views to the council and partners. Helen Woodland clarified that advocacy would only be used for individuals who were unable to speak for themselves, support in all other cases would be provided by a social worker. Family members were engaged wherever possible.

Helen Woodland advised that the council was likely to know of individuals who needed support, often via the health service. The eligibility criteria for social care support was more stringent than it had been and there were no longer as many services for people to access. A key issue for those who were not supported by the

council was safeguarding. A lot of work had been undertaken with partner agencies to raise the profile of reporting safeguarding concerns and positively, Brent had a significantly higher rate of reporting than other boroughs.

At the invitation of the Chair, Ian Niven (Brent Healthwatch) advised that Brent Healthwatch had been closely involved in the TCP and the process had been very positive. Ian Niven explained that he had been struck by the genuine commitment and professional approach taken to solving complex problems. Commenting on the voice of service users, Ian Niven highlighted that the CCG had commissioned an advocate which worked with relevant groups around this and helped to ensure engagement in the decision making processes regarding the Integrated Health and Social Care Team.

The Chair thanked everyone for their contribution to the meeting.

RECOMMENDED:

i) That the measures already in place to support the TCP cohort in the borough and the further actions planned as part of the TCP programme be noted;
ii) That the progress made against key milestones and the areas that require further development be noted.
iii) That future reports on the TCP include the voice of the service user;
iv) That a further report on the progress made in relation to the TCP be presented to the committee at an appropriate time, following the service review;

7. **Community and Wellbeing Scrutiny Committee Work Plan 2018 - 2019 Update**

RESOLVED: that the contents of the Update on the Committee's Work Programme 2017-18 report, be noted.

8. **Any other urgent business**

None.

The meeting closed at 7.30 pm

COUNCILLOR KETAN SHETH
Chair

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Thursday 9 May 2019 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Afzal, Ethapemi, Hector, Knight, Shahzad, Thakkar, Co-opted Member Ms Dina Walker and appointed observers, Mrs Lesley Gouldbourne and Ms J Roberts

Also Present: Councillors M Patel, Chan, Chappell, Choudhary, Hylton, McLennan and Tatler

1. **Chair's Opening Remarks**

The Chair opened the meeting, welcomed those present and outlined the protocol to be followed for the meeting.

2. **Apologies for absence and clarification of alternate members**

Apologies were received from Councillor Stephens and co-opted members Mr Simon Goulden, Reverend Helen Askwith and Mr Aloysius Fredericks.

3. **Declarations of interests**

The following interests were declared for transparency:

- Councillor Ketan Sheth – Director of Daniel's Den Ltd
- Councillor Colwill – Governor of St Gregory's RC Science College
- Councillors Hector and Chan –Councillors for Kensal Green Ward

4. **Deputations (if any)**

Deputations were considered under the item 'Call-In of Executive Decision - Approval to Establish an Alternative Provision Free School with Integrated Youth Offer from the Roundwood Youth Centre'

5. **Call-In of Executive Decision - Approval to Establish an Alternative Provision Free School with Integrated Youth Offer from the Roundwood Youth Centre**

Having received the report from the Director of Performance, Policy & Partnerships detailing the background to the call-in referred to the Scrutiny Committee for consideration, the Chair began by inviting Councillor Chan to outline the reasons for the call-in and alternative action being sought as a result.

Councillor Chan advised that the call-in detailed a number of concerns regarding the Cabinet decision to establish an alternative provision free school with integrated youth offer from the Roundwood Youth Centre. Councillor Chan asserted that the decision lacked policy imagination and failed to fully address alternative options to

establishing a free school. The Cabinet had not provided sufficient evidence that local authority schools in the area had been approached to discuss delivering the alternative provision under their management.

Addressing aspects of the Cabinet decision in further detail, Councillor Chan advised that the call-in also highlighted concerns regarding a potential lack of accountability and strategic oversight in the intended arrangements. With reference to paragraph 6.2 of the Cabinet report (attached as Appendix B to the papers before the committee), Councillor Chan noted the financial implications of commissioning places at the proposed new alternative provision free school and highlighted that no detail had been provided of how this financial relationship would be overseen. Members' attention was further drawn to resolution iii) of the Cabinet decision which delegated authority to the Strategic Director of Children and Young People, in consultation with the Lead Member for Children's Safeguarding, Early Help and Social Care, to identify the Council's preferred provider of the Alternative Provision Free School with integrated youth provision. Councillor Chan asserted that this decision should sit with the appropriate Lead Member(s) to ensure accountability. It was further noted that there was an expectation that the governance arrangements include a senior council officer acting as a trustee of the new alternative provision. Councillor Chan emphasised that with this amounting to just less than 20 per cent of the trustees, there lacked assurance that there would be sufficient strategic oversight of the new arrangements. In concluding his introduction to the call-in, Councillor Chan expressed agreement with the intention to provide more youth services at Roundwood Youth Centre but stated that he was wary about how the council had characterised the lack of provision at the venue.

The Committee then moved on to consider representations from members of the public and other stakeholders who had requested to speak in relation to the call-in. Comments made were as follows:

Gherie Weldeyesus (Brent National Education Union) expressed his concern that, under the new arrangements the youth club at Roundwood Youth Centre would be discontinued, despite reassurances to the contrary. He stated that the council should fully fund the youth centre to ensure that children and young people had somewhere to go after school and in the holidays.

Mary Adossides (Chair, Brent Trades Councils and former Head Teacher of Manor School) emphasised that there was a crisis in Special Educational Needs and Disabilities (SEND) provision due to cuts in government funding. Therefore, the decision to open alternative provision for vulnerable pupils was welcome. However, the difficulties placed on the local authority in establishing this new provision were not understood and it was felt that the council should both retain the local asset of Roundwood Youth Centre and develop this new provision in conjunction with existing Brent schools. Support was expressed for an alternative proposal to establish the new alternative provision on the Roe Green Strathcona site as part of the Brent family of schools.

Sandra White (Sector Development Director, Young Brent Foundation) stated that she supported the Cabinet decision. She advised that the Young Brent Foundation (YBF) supported 122 youth groups in Brent and that the YBF would be working very closely with the daytime provider at Roundwood Youth Centre. The expectation was

that these groups would use the facilities at the Centre to provide quality youth services for the afternoons and evenings.

Chris Murray (CEO, Young Brent Foundation) advised that under the proposed arrangements, the YBF would aim to dovetail provision in the evening to achieve better synergy with the needs of the pupils of the free school. The YBF would be a key stakeholder in ensuring that the facility was used to provide quality youth services in the evening and expressed that the proposals represented a real opportunity to provide young people with a place to go and enjoy.

Jennifer Ogole (CEO, Bang Edutainment and founding Chair of Young Brent Foundation) advised that the Cabinet decision envisaged a partnership between the alternative provision free school and the voluntary sector to deliver the youth offer at the Roundwood Youth Centre. Bang Edutainment would be included in this partnership and had an established record of delivering youth services. Bang Edutainment had actively pushed for this decision and had worked with officers in the council to secure an option that would ensure sustainable funding for a youth offer.

Martin Francis (speaking on behalf of Simone Aspis, Director of Advocacy, Changing Perspectives) stated that greater investment was needed in mainstream provision to enable vulnerable pupils to be supported to remain in an inclusive setting. Pupils educated in alternative provision settings often had undiagnosed needs and experienced poorer outcomes than their mainstream peers.

The Chair thanked all members of the public and stakeholders for their contributions and then invited Councillor Patel, as Lead Member for Children's Safeguarding, Early Help and Social Care, to respond to the reasons provided for the call-in and public representations made at the meeting.

Councillor Patel began by outlining the benefits of the proposed decision which included: increasing the provision of youth services in Brent, including the services on offer to key target groups; securing the long term future of the Roundwood Youth Centre; and, enabling excluded pupils to access alternative education provision in-borough. Members heard that the Roundwood Youth Centre was currently chronically underused and the council did not have the resources to extend the offer at the venue without partner organisations. With regard to establishing the alternative provision as a Free School, it was confirmed that all secondary schools in Brent had been asked if they would consider delivering the provision under their management, but none had expressed an interest. Under the 2011 Education Act, any new school must be established as a Free School. Councillor Patel advised that she opposed this legislation but the council had to operate within the law. The proposed governance arrangements envisaged that the trustees include a senior officer and an existing Brent Secondary Head Teacher to support strong collaborative working. Members were urged to consider all that could be achieved with the Cabinet decision to establish an alternative provision free school with the integrated youth offer at Roundwood Youth Centre.

The Chair thanked Councillor Patel for her response and then invited questions/comments from the Committee, with the following issues raised:

a) Councillor Chan was asked to clarify what additional information was required to adequately determine whether the possibility of the provision being managed by an existing Brent school had been fully explored and to further explain what alternative action the call-in suggested. Councillor Chan suggested that a list of all the schools approached and details of the outcomes of the discussions should be provided. Any subsequent report should fully detail why alternative options had not been pursued and should address the issues of accountability and oversight previously referred to.

Gail Tolley (Strategic Director, Children and Young People) advised that there were 15 Secondary Schools in Brent – two were voluntary aided and the remainder were all academies. In February 2017, the Brent Secondary Head Teachers discussed the idea of developing alternative provision at the Roundwood Youth Centre site. As there were no community secondary schools in Brent, it was acknowledged that a free school would need to be established with a DfE approved academy sponsor. The Department for Education maintained a list of approved academy sponsors and a number of schools in Brent were on that list. Discussions were held with Brent's secondary school providers as to whether any wished to take the lead as the approved sponsor but none wished to. Newman Catholic College had again been approached as recently as 25 April 2019 to see if they wished to consult with the Roman Catholic Diocese with regard to the potential of running the alternative provision and they confirmed that they did not. Brent's secondary schools had supported the approach being taken by the council.

b) The committee noted that Brent did not have any Secondary Schools under Local Authority control and questioned whether the call-in members considered that the alternative provision could be delivered under a primary school infrastructure. Councillor Chan asserted that the possibility should be explored. This proposal was supported by Mrs Jean Roberts (appointed observer) who further expressed concern that the local authority would have little control over the selection of a free school provider. Gail Tolley clarified that the Cabinet decision referred to the free school presumption process, one of two possible routes to establishing a new free school. In contrast to the free school application process, the presumption process allowed the local authority to develop a specification against which DfE approved academy sponsors could apply. It was noted that there were a number of primary schools on the DfE list who could apply if they wished. The council's selected provider would be required to be approved by the Regional Schools Commissioner on behalf of the Secretary of State.

c) Responding to the committee's queries regarding the alternative options considered, Councillor Patel advised that Roundwood Youth Centre was chronically underused and it had been necessary to consider how the centre could remain open to deliver youth services. The decision taken by the Cabinet would ensure that there would be an expansion of youth services at the centre, whilst also providing the much needed additional alternative provision places required in the borough.

d) Members queried whether the existing users of the Roundwood Youth Centre had been consulted about the proposals. Councillor Patel emphasised that there was no threat to the existing provision at Roundwood

Youth Centre. There were currently no tenants of the centre and the evening youth services were run by the council. The centre was hired out by various groups for other activities. Discussions would be held with the with the free school provider to advise that the current offer must be supported going forward.

e) Further details were sought regarding the youth provision that would be available for children and young people using the centre under the proposed arrangements. Councillor Patel explained that the new provider would be required to deliver the MyPlace grant agreement outcomes which included: more young people, parents and communities feeling that young people have attractive and safe places to go in their leisure time; more young people, particularly the most disadvantaged, participating in positive leisure time activities that support their personal and social development; and, more young people having access to information, advice and support services from within places they feel comfortable.

f) Members questioned what powers the council would have to ensure that the existing youth offer was continued at the centre after the Free School was established. Nigel Chapman (Operational Director, Integration and Improved Outcomes) explained that the MyPlace outcomes would be part of the lease for the site, requiring the provider to ensure the outcomes were achieved. The council could terminate the lease if these outcomes were not being met. Councillor Patel reiterated that the proposed governance arrangements envisaged that the trustees for the new Free School include a senior council officer and an existing Brent Secondary Head Teacher, allowing the local authority and Brent's secondary schools to influence the delivery of the offer at the centre.

g) In response to further queries regarding consultation undertaken on the proposals, Nigel Chapman explained that the staff employed at the Roundwood Youth Centre had been informed of the intentions of the council, but a formal consultation would not be conducted until a confirmed Cabinet decision was in place.

As no further issues were raised, the Chair thanked everyone for their contributions and then invited the committee to consider the recommendations set out in the report in relation to the outcome of the call-in.

As a result of the discussion that followed the Committee **RESOLVED** by a majority decision:

- that the Committee did not wish to refer the matter back to the decision maker or to Council, and therefore the decision was deemed to be confirmed and would take effect immediately following the meeting.

The meeting closed at 7.25 pm

COUNCILLOR KETAN SHETH
Chair

This page is intentionally left blank

Brent	**Community and Wellbeing Scrutiny Committee** 9 July 2019
	Report from the Director of Public Health

Substance Misuse Service

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt:	Open
No. of Appendices:	0
Background Papers:	0
Contact Officer:	Andy Brown, Head of Substance Misuse, andy.brown@brent.gov.uk 020 8937 6234

1.0 Purpose of the Report

1.1 This report provides an account of substance misuse services in Brent. It covers the Integrated Treatment, Recovery, Wellbeing and Substance Misuse service model and the commissioning arrangements by Brent Council Public Health. The performance of the provider, Westminster Drugs Project (WDP) with Central North West London (CNWL) NHS Foundation Trust as the clinical partner, is described. The work of B3, the service user council for Brent entirely run for and by local residents who have been directly affected by problematic drug and alcohol misuse, is described.

2.0 Recommendation(s)

2.1 Members of the Scrutiny Committee are recommended to note the treatment and recovery services available to residents with problems of drug and alcohol.

3.0 Detail

3.1 **Background:** Specialist drug and alcohol treatment and recovery services offer a wide range of interventions to support people to recover from drug and alcohol

dependence. These include referral to inpatient detoxification and residential rehabilitation (where appropriate); opiate substitute prescribing (often referred to as secondary prescribing); Employment, Training and Education (ETE) support; peer mentoring and peer led support; and access to Mutual Aid / Fellowship groups such as Alcoholics Anonymous and Narcotic Anonymous.

3.2 The responsibility for commissioning substance misuse services transferred from the NHS to local authorities on 1st April 2013 as a result of the Health and Social Care Act (2012). Services are commissioned by the Public Health team and funded by the Council's public health grant. Inpatient detoxification and residential rehabilitation are agreed on a case by case basis by the Head of Service working with New Beginnings. These services are funded through the grant but are not provided locally; clients are referred to a range of external providers such as Brook Drive, Passmore House and Streetscene. Mutual Aid Groups (Alcohol Anonymous etc.) meet regularly in Brent and form part of the local recovery system but are not commissioned.

3.3 Year on year reductions have been made in the public health grant which has reduced by 7.5% (£1.685 million) since 2015. Drug and alcohol services are not mandated, unlike sexual health or 0-5 services which authorities have a statutory duty to ensure are provided. This, combined with the continued reductions in the public health grant, has led, some local authorities, particularly outside London, to make significant cuts in drug and alcohol services. In Brent service redesign, close working with providers, service user's engagement and robust commissioning has meant to date we have been able to preserve services while reducing cost.

3.4 Increasingly, with the introduction of Universal Credit, access to welfare rights and advocacy has become a key element in maintaining well-being and recovery and now forms an important component of services.

3.5 The National Drug Strategy (2017) estimates that 45% of all acquisitive crime is committed by people dependent on opiates and/or crack (the two drugs which cause the most damage to local communities). An estimated 40% of all violent crimes nationally are alcohol related. Drug and alcohol misuse are also directly related to child protection, abuse of vulnerable adults, anti-social behaviour and domestic abuse

3.6 There is evidence that being in treatment has marked impacts on the wider health and social care economy, as well as on levels of offending. The National Drug Strategy (2017) emphasises that evidence based drug and alcohol services support improvements in health, reduced drug and alcohol related deaths, reductions in blood borne viruses, improved relationships and reduced wider social harms. The National Modern Crime Prevention Strategy (2016) focused on the need for effective treatment, early intervention and prevention alongside enforcement strategies in order to mitigate the impact of drug related crime and related anti-social behaviour. Substance misuse services in Brent have always been required to demonstrate to Public Health commissioners how they contribute to these wider societal agendas.

3.7 **Local patterns of drug and alcohol use:** Local substance misuse services are required to participate on the National Drug Treatment Monitoring System (NDTMS). This provides anonymised reports to commissioners which enable us to monitor and benchmark the performance of local services, as well as providing some insight into local patterns of drug and alcohol misuse. NDTMS gives a clear picture of who is in the treatment system locally and also estimates the numbers of substance misusers outside of the treatment system who are yet to enter services, often referred to as the 'treatment naïve' population.

3.8 NDTMS categorises services users according to their primary substance(s) of misuse, there being four categories:

- Opiates
- Non opiates (crack cocaine, cocaine)
- Alcohol
- Alcohol and non-opiate

Public Health England (PHE), who analyse the NDTMS returns, estimate that there are:

- 2,310 opiate and/or crack users in Brent
- 1,752 opiate users
- 1,331 crack users
- and 3,169 problem alcohol users.

These are mid-range figures based on lower and higher confidence intervals and suggest that approximately only a third of active drug users are engaged with treatment service and only a fifth of problematic alcohol users according to data provided through NDTMS.

National figures for 2017/18 would suggest that the percentage of unmet need is as follows

- Opiates 64% locally against a national average of 59%
- Non opiates (crack cocaine, cocaine) 65% against a national average of 62%
- Alcohol 80% against a national average of 82%

There are many barriers to substance misusers accessing treatment, not least an individual's willingness to recognise they have a problem and need help. Locally we endeavour to minimise these barriers, for example there are no waiting times to access treatment in Brent.

The most recent local NDTMS data available is for Q4 2018/19. This showed that:

- 1090 local residents were engaged in structured treatment services of which

- 274 (25%) were primary alcohol users
- 152 (13.9%) were alcohol and non-opiate users
- 557 (51%) were opiate users and
- 107 (9%) were non opiate users.

The most recent national figures for comparison are for 2017/18 and show the breakdown of those in structured treatment is as follows:

- 28% were primary alcohol users
- 10% were alcohol and non-opiate users
- 53% were opiate users and
- 9% were non opiate users.

There were 485 new presentations to structured treatment services in 2018/18 of which:

- 178 (36.7%) were primary alcohol users
- 83 (33.3%) were alcohol and non-opiate users
- 167 (34.4%) were opiate users and
- 57 (11.7%) were non opiate users.

This means 1.3 residents per day in Brent enter into structured treatment intervention for their problematic substance misuse behaviour.

National 2017/18 figures show the breakdown of new presentations to structured treatment is:

- 40% were primary alcohol users
- 15% were alcohol and non-opiate users
- 32% were opiate users and
- 13% were non opiate users

3.9 **The development of the New Beginnings Service:** Following the transfer of responsibility for public health to the Council, the inherited substance misuse services were recommissioned in 2014. Six contracts - for Treatment and Recovery Services, Outreach & Engagement, Counselling and Day Programme, Criminal Justice Services and a Young People's Integrated Service - were awarded through a competitive tender on a two plus one plus one basis commencing 1st April 2015. At that stage, the individual components of the treatment and recovery system were commissioned and contracted for separately. This allowed individual provider organisations with different specialisms to provide different elements. The Clinical Prescribing contract was awarded to CNWL, an NHS Foundation Trust, all other contracts were awarded to third sector organisations.

3.10 Contracts were extended for 2017/18 following strong performance by the providers. In response to the reduction in the public health grant, the contract value was re-negotiated and commissioners secured a 10% cash releasing saving from the contract extension with the third sector providers.

3.11 During 2017/18 the substance misuse services were recommissioned. The new service model was developed in conjunction with B3 and with regard to local need. The objectives for the new Integrated Treatment, Recovery, Wellbeing and Substance Misuse Service were specified as:

- To provide high quality evidence-based community based addiction treatment for adults with drug and alcohol dependence (and other co-morbidity issues),
- To reduce substance misuse related harm and enable clients to tackle their dependence on drugs and alcohol and promote pathways to abstinence and recovery
- To promote health, well-being and recovery amongst clients and their families
- To enable heroin and crack users to become drug free from these substances.

3.12 The new specification responded to areas of local new or under meet need, for example services specifically for older users and for women and extended opening hours (10.00 am to 7.00 pm from Monday to Friday backed by 24/7 helpline). The new service model Included an improved “health and wellbeing” offer which includes clinical prescribing but also includes smoking cessation, opt out HIV testing and screening for / vaccination against blood born viruses. alongside a treatment and recovery model aimed at supporting people from addiction through to abstinence based recovery pathways.

3.13 Extensive market engagement took place during 2017/18 as a result of which commissioners had confidence that the market could respond to a tender for a single contract for an integrated service to replace the previous 6 separate contracts. Commissioners preferred this model as having the potential to introduce efficiencies through the sharing of “back office” functions while retaining client facing services.

3.14 The new service model also rebalanced the spilt between the more expensive clinical services and non-clinical elements (for example outreach, criminal justice services and recovery support).

Service users were fully involved in the development of the new service specification.

3.15 The contract for the redesigned Integrated Treatment, Recovery and Wellbeing Substance Misuse Service was tendered using the Competitive Procedure with Negotiations arrangements and awarded to WDP. Bids were evaluated on quality (40% weighting), social value (10% weighting) and price (50%). WDP partnered with CWNL NHS Foundation Trust to deliver the clinical elements of the new service. A four-year contract was awarded with the potential to extend for 2 further years, until 31st March 2024. Savings of 17.5% were achieved through negotiation on contract extension and through the procurement exercise, this equates to an average of £500k per annum on the original budget. The total value of the contract including any options to extend is £21,067,007.

3.16 B3 were involved in the design workshops to look at how services were to be bought together into a single service. This informed the service specification which included a section on how the new service would develop the "service users view" entirely written by B3 members. Members of B3 were involved in the evaluation of bids. Their involvement contributed to a more robust evaluation. However, it did require a significant commitment by B3 members and required both commissioners and the Council's procurement team to be able to provide support and training which needed to be factored into the procurement timeline.

3.17 The commissioning process resulted in a service specification which better met need and delivered savings. It also resulted in a change from the previous five providers to a single lead third sector provider subcontracting with a clinical NHS service. Any change in service provider and in service design can be unsettling for service users. Therefore, following contract award, commissioners and WDP worked with B3 on the mobilisation of the new contract and the transition of clients to a new provider. This was an intensive process over several months.

3.18 WDP consulted B3 members of the branding of the new "Integrated Treatment, Recovery and Well Being Substance Misuse Service" with the result that the service is now "New Beginnings".

3.19 New Beginnings Service covers two sites: Cobbold Road, which is the community hub, and Willesden Centre for Health and Care, where the majority of clinical services are provided, (although there is clinical outreach at Cobbold Road). The service is open 10am to 7pm Mondays to Fridays with staff in the Wembley custody suite 7 days a week and outreach work in the early morning and late evenings. The service is also supported by a 24/7 helpline (**0800 107 1754**) which is available to any Brent resident directly or indirectly affected by substance misuse.

3.20 The service includes a shared care scheme where clients receive the majority of their care from primary care with clinical support and advice from New Beginnings. Clients on this scheme will usually be on stable substitute prescribing and often have other chronic conditions which are suited to primary care management. It is anticipated that more clients will be supported across primary care in future through the development of outreach, pop up clinics and satellite provision over the next year which will support an aging cohort of substance misusers.

Services provided by New Beginnings include;

- Information, advice, support, assessment and drop-in
- One-to-one key working
- Needle exchange and harm reduction services
- Substitute prescribing
- Group work programmes (including abstinence and evening groups)
- Access to inpatient detoxification and residential rehabilitation

- Women-only groups
- Health assessments and blood born virus screening & vaccination
- Counselling and psychology
- Self-help and mutual aid groups
- Aftercare services
- A health and wellbeing service for people who use substances at lower levels, including alcohol, club drugs, cannabis and cocaine
- Education, training and employment (ETE) support
- Family and carer's support and advice
- Reducing offending and gang affiliation
- Sexual health advice
- Integrated Offender Management (IOM)
- Restrictions on Bail (RoB)
- Prison, Probation and Court Link Work

3.21 While many features of the new service model have been specified by commissioners, the provider has also introduced innovations in service delivery, notably WDP's Capital Card. This is a reward card for service users, families and carers of WDP services which incentivises service users' engagement through a simple earn-spend points system, akin to a Tesco Club card or a Boots Advantage Card. Clients can earn points by accessing services that support improved health and wellbeing, they can then spend these points on products and services such as gym sessions, cinema and theatre visits, hair and beauty salons, cafés and coffee shops. WDP also provide regular points-based services, such as day-trips, weekend retreats, classes and groups.

3.22 Public Health and WDP had recently been successful in a bid to Public Health England for £188k of capital funding. This will be used to renovate the communal and reception areas across both the Cobbold Road and Willesden sites (a priority for B3 members), an app for those in employment, and for a Fibro Scanning Machine which detects early liver damage caused by alcohol.

3.23 **B3: be heard, be motivated, be free:** B3 is the service user council for Brent. It was formed in 2009 by people using local drug and alcohol treatment services who wanted to help themselves and others facing the same day to issues around addiction and recovery. B3 is an entirely peer led service, run for and by local residents with approximately 120 - 130 members and an expanding volunteer base.

B3 aims to:

- raise awareness of drug and alcohol issues through information and education
- provide a voice and support for service users in Brent
- improve services in Brent through community feedback, partnership work, training and service user involvement.

3.24 B3 run the BSAFE weekend service at Cobbold Road - at weekends, B3 are the custodians and key holders for the building. "BSAFE" stands for safe

access for everyone and is a volunteer run out of hours' weekend service for individuals with substance misuse problems and/or engaged with recovery services. Weekends are a period where people can feel particularly isolated and BSAFE offers both support to maintain recovery and a route into treatment, a number of service users have accessed treatment after using the weekend service. The service operates on both Saturdays and Sundays and is regularly attended by 50-70 service users. Brent is one of the few London Boroughs that has a weekend service on both Saturday *and* Sunday.

3.25 B3 are also commissioned by Public Health to run a Recovery Champions course. This runs four times a year and participants study for two days a week for 5 weeks focusing on:

- Drugs & alcohol advice, support & consultancy.
- Presentation & communication skills.
- Self-development to build participants' confidence in working and learning together.
- The development of essential skills such as health & safety, confidentiality, personal values, boundaries, safeguarding and communication skills.
- To continue their development on the role of recovery champions and where they can signpost and refer other local residents to help and support services such as New Beginnings.

3.26 In 2018, B3 was recognised in the Brent Council "Pride of Brent" Awards as Community Project of the Year, with Radha Allen, B3's Project Manager being awarded Champion of the Year. The service has also been recognised as a national model of good practice by Public Health England (PHE) for involving service users in the development of treatment and recovery services. B3 sit on the London Service User Council for Drugs and Alcohol chaired by PHE London and regularly appear at national forums to talk about the work they undertake in Brent. In May 2019 B3 celebrated its 10th anniversary and the 8th anniversary of the launch of the BSAFE weekend service.

3.27 B3 are involved in the development and delivery of the contract as members of the Contract Management Board where they have the status of an equal stakeholder alongside public health commissioners and consultants and the service provider.

3.28 Performance 2018/19:

The New Beginnings service was fully mobilised by 1.04.18 as a result of the detailed pre-contract mobilisation work undertaken by Public Health, WDP and CNWL with support from B3.

With the change in service provider there was a transfer of staff, clients and case files from across 5 organisations into a single performance management and reporting system to be led by WDP. As was expected the transfer led to a temporary drop in performance.

However, performance is improving and across a number of areas remains higher than the national average.

Key areas of performance Q4 2018/19 from NDTMS (the most recent figures):

- **Successful completions as a proportion of all in treatment:** (more is better)
- Opiate clients: local performance **9.3%** against national performance **6.0%**
- Non-opiate clients; local performance **37.45%** against national performance **35.2%**
- Alcohol clients: local performance **42%** against national performance **37.8%.**

- **Treatment completed/retained for 12 weeks or more:** (more is better)
- Opiate clients: local performance **94.9%** against national performance **94.5%**
- Non-opiate clients: local performance **94.2%** against national performance **84.7**%
- Alcohol clients: local performance **94.2%** against national performance **86%.**

- **Unplanned Exits:** (fewer is better)
- Opiate clients: local performance **14.6%** against national performance **16.7%**
- Non-opiate clients: local performance against **8.2%** national performance **18.8%**
- Alcohol clients: **4.3 %** local performance against national performance **13.6%**
- Alcohol and non-opiates: local performance **9.2%** against national performance **17.9%**.
- **Waiting times:** There were no recorded waiting times recorded for clients waiting to start first intervention.

Areas for improvement include increasing the numbers engaging with the local system against a national trend of declining numbers engaged in treatment services. Public Health will also be working to support the New Beginnings Service in improving performance on Blood Borne Viruses (BBV) including the Mayor for London's vision to eliminate Hepatitis C in London.

3.29 **Partnership working-** In addition to delivering treatment and recovery services, WDP participate in a range of operational and strategic partnership working with Brent Council and others. These include:

- A co-located social worker working with both CYP and ASC
- A co-located young people's worker in the Youth Offending Service
- The Working with Families programme
- Integrated Offender Management / Reducing offending
- Work to address Gangs and to reduce serious youth violence

- The Multi Agency Risk Assessment Conference (MARAC)
- The Violence against Women and Girls work stream
- Work to address the impact of the sex industry and prostitution
- The Multi Agency Sexual Exploitation Group (MASE)
- The Student Health and Well Being Group
- The Alcohol Pathways Group
- Outcome Based Reviews

3.30 **Final Comment -** The move to an integrated service for substance misuse, the service redesign and successful tender for the New Beginnings service which went live on 1st April 2018 have led to a more seamless treatment journey for those that need help and support with drug and alcohol problems.

3.31 The key challenge in year two of the contract will be to further improve outcomes and KPIs. In particular, given the accessibility of the service and the positive outcomes it achieves we need to increase the numbers of people presenting to or being referred to the service.

3.32 Public health will also be focussing on the performance management of the wider public health outcomes in the contract, such as Blood Born Viruses, particularly Hepatitis C where we need to increase referrals for treatment. Another focus will be the Employment Training and Education opportunities for those engaged in the service, including supporting the work of new NWL Individual Placement and Support (IPS) where WDP are also the main provider.

3.33 The approach that the Council has taken to substance misuse provision in Brent has attracted national and international interest. This has included visits from Kenya, Sweden and the Netherlands in 2017. Duncan Selbie, Public Health England CEO, also visited Cobbold Road Treatment and Recovery Centre in 2017 and was extremely positive in relation to the joint working between local services and service users in improving the treatment System. More recently in June 2019, there was a high profile visit by senior civil servants and advisors to the Cabinet who came to look at the local implementation of the IPS service and how good practice was being developed to enable service users to access support with employment and training. Brent continues to be regarded as a model of good practice nationally in relation to how service users are involved in the development of local services

4.0 Financial Implications

4.1 There are no financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising from this report.

6.0 Equality Implications

6.1 There are no equality implications arising from this report.

7.0 Consultation with Ward Members and Stakeholders

7.1 Ward members who are members of the Community and Wellbeing Scrutiny Committee will be involved in scrutinising this report at committee.

REPORT SIGN-OFF

Dr Melanie Smith
Director of Public Health

This page is intentionally left blank

Brent	**Community and Wellbeing Scrutiny Committee** 9 July 2019
	Report from the Assistant Chief Executive

Childhood Obesity: Members' Scrutiny Task Group

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	1 – Scoping Paper
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	James Diamond, Scrutiny Officer, Strategy and Partnerships, james.diamond@brent.gov.uk 020 8937 1068

1.0 Purpose of the Report

1.1 To enable members of the Community and Wellbeing Scrutiny Committee to set up a members' scrutiny task group to review childhood obesity in Brent.

2.0 Recommendation(s)

2.1 Members of the Community and Wellbeing Scrutiny Committee to discuss and agree the contents of this report and scoping paper attached in the Appendix.

2.2 Members of the Community and Wellbeing Scrutiny Committee agree to set up a task group with the terms of reference and membership in the Appendix.

3.0 Detail

3.1 In 2018 the Community and Wellbeing Scrutiny Committee discussed a report from the Director of Public Health about childhood obesity, which was presented by the Cabinet Member for Public Health, Culture, and Leisure and Director of Public Health. It stated that average levels of childhood obesity in Brent measured by National Child Measurement Programme exceed those of similar boroughs. At the meeting members discussed the wider problems of children achieving a healthy weight, balanced diets and exercising habits in

Brent. The committee decided a task group should be set up to examine the issue in detail.

3.2 The causes, prevention and treatment of childhood obesity are an extremely broad and complex area. Instead of an 'end to end' review the task group has opted to look at four focused areas for its evidence sessions: NHS, local government and public services; external environment; the home environment, and parental engagement.

3.3 A key part of the work of the task group will be to produce a written report with recommendations which the Community and Wellbeing Scrutiny Committee will agree to refer to Cabinet, Full Council, or the NHS and health services. Recommendation-making is a key function of an overview and scrutiny committee. It's considered good practice that recommendations are SMART (specific, measurable, agreed, realistic and timed); limited in number, and rest on a body of evidence which is accumulated during the scrutiny review.

3.4 Evidence-gathering is a key part of the role of the task group. Members will be expected to develop their own lines of questioning to test the evidence they are presented with, and to weigh-up the evidence they are given. It is considered best practice for members to consider different types of qualitative and quantitative information so they have a complete view of a subject. [1]

4.0 Financial Implications

4.1 There are no financial implications arising from this report, but finance implications in the task group's final report will be considered at that stage.

5.0 Legal Implications

5.1 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 a scrutiny committee can ask for health bodies to provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny; attend before a local authority committee to answer questions as necessary and respond to scrutiny reports and recommendations.

6.0 Equality Implications

6.1 There are no equality implications arising from this report, but equality implications in the final report of the task group will be considered at that stage.

7.0 Consultation with Ward Members and Stakeholders

7.1 Non-executive members are involved in this overview and scrutiny task group.

Report sign off:

Peter Gadsdon
Assistant Chief Executive

[1] *The Scrutiny Evaluation Framework*, (Centre for Public Scrutiny, April 2017) pp.7-9

APPENDIX

Childhood Obesity Members' Task Group Scoping Paper

Subject

1. The NHS Long Term Plan identifies obesity as approaching epidemic rates among children, and advocates closer working with local government and other public services so that there can be a combined effort in tackling children's obesity levels. Nationally, the government has pledged to halve childhood obesity and significantly reduce the gap in childhood obesity between the poorest and most affluent areas.

2. The Mayor of London's Health Inequalities Strategy has prioritised the need to help more children achieve a healthy weight, particularly in deprived communities, and cut childhood obesity. Recently, the Mayor has banned advertising of food and drink which is high in fat, salt or sugar, across Transport for London's estate. [1]

3. Childhood obesity is a priority in the prevention work stream of the Brent Health and Care Plan, and the North West London STP Health and Wellbeing Partnership. The National Child Measurement Programme has consistently recorded rates in Brent above the average for London and England. In 2017/18 there was an obesity rate of 14.7% for children in Reception, and a 28.1% rate for children in Year 6. A significant number of the borough's children are already obese at Reception but the problem is worsening with the rate doubling by Year 6. In addition, 14.9% of Reception children and 15.7% of Year 6 children were overweight.

4. Childhood obesity is a major health inequality. Data from the National Child Measurement Programme indicates that obesity rates vary among children in Brent according to their ethnicity, and family's household income. The highest levels of excess weight were recorded in the Black ethnic group while the Asian ethnic group has relatively low levels at Reception but much higher levels at Year 6. There is also a relationship with poverty although it is weaker. Children in Stonebridge, Brent's poorest ward, have among the highest levels of being obese or overweight while children in Kenton, the most affluent ward, the lowest rates. [2]

5. Nationally, the NHS is treating 1,000 children a year who develop severe complications, including diabetes, cardiovascular conditions, and sleep apnoea. Obesity in childhood is linked to obesity in adult life, which increases NHS costs. For some children, obesity is a cause of poor mental health and emotional wellbeing. [3]

Scope

6. The scope of the scrutiny review has been narrowed to four areas: NHS, local government and public services; external environment; home, and parental

[1] *The London Health Inequalities St*rategy, (Greater London Authority, 2018), p11;
[2] *Childhood Obesity*, Community and Wellbeing Scrutiny Committee, 28 February 2018
[3] *NHS Long Term Plan* (NHS England, 2019) pp.37-46

engagement. Task group evidence sessions will explore the reasons for childhood obesity rates in the borough by looking in greater detail at these four areas.

7. Childhood obesity involves a number of services and professionals across the NHS, local government and public services. An evidence session will review how the 'whole system' works with children and parents. This could include how doctors, health and early years professionals in Brent are identifying when a child is overweight or could become obese; what advice and guidance is given to parents about a child's healthy weight, and how professionals initiative conversations with parents, and refer to healthy weight management services. The task group is particularly interested in how the NHS, GPs and local government services such as health visitors and midwives support a parent in the first 1,000 days of a child's life, including in pregnancy, and their advice to parents around breastfeeding and introducing a child to solid foods after a child is born. In addition, it will look at what Public Health information is provided to help parents recognise the signs or symptoms of a child who is in danger of becoming obese. The evidence session could also look at information provided to children up to the age of Year 6 about sugar and diet in schools and early years settings and the promotion of initiatives such as the Daily Mile or Kids Run Free programme. It will also look at the take up of Healthy Schools London among schools in the borough, and the Healthy Early Years Award in Brent.

8. A safe external environment and greater opportunities to be physically active outside the home play a role in preventing obesity. The task group would like to understand what outdoor play spaces exist for children up to Year 6 and how they are being given opportunities to be physically active with their parents. This could include walking to school, sport and games, and physical activity. The task group will also look at the role of programmes such as the Healthy Catering Commitment which create a healthier external environment for children and their parents in the borough's high streets. In addition, the task group will look at particular projects such as Play Streets, which can have a positive effect on children's physical activity.

9. The task group would also like to look at home environment and childhood obesity. Factors causing obesity can include diet and consumption of food and drink which is high in fat, salt or sugar, and the role of food preferences of family members. The task group is considering looking at what opportunities are provided by the NHS, local authority, and the public sector for parents to consider their home environment and the role of diet and food and drink consumption in a child's health. It will also look at the particular problems faced by low-income families, and how different cultural backgrounds may affect the choices made by parents.

10. The members of the task group believe it is important that there is a conversation with parents in Brent about childhood obesity and that they are given an opportunity to input into the scrutiny review. The final meeting will be an 'open mic' forum which provides an opportunity for the task group members to engage with parents and community organisations to find out their views around the issue of childhood obesity. It will also look at parents' engagement with NHS and Public Health and council services in this area.

Appendix A

Task Group Membership:

Councillor Thakkar, Chair

Councillor Knight

Councillor Hassan

Co-opted task group members:

The committee would like to co-opt onto the task group a representative from **Brent Youth Parliament**.

Terms of Reference

a) Understand the causes of childhood obesity among children in Brent up to Reception and Year 6.
b) Examine the trends for obesity rates among Reception children and the increase in obesity by Year 6.
c) Evaluate the impact of NHS, health services and public services in preventing childhood obesity and preventing and responding to excess weight and obesity in childhood.
d) Review the effects of external environment and home environments on children's health, wellbeing and weight, including the impact of household poverty, parents working hours and other family 'stressors' such as insecure housing or employment.
e) Evaluate the role of parents and parenting in preventing childhood obesity with particular reference to adult obesity.
f) Understand how different children may be affected, in particular those with Special Educational Needs and Disabilities, and children who are carers.
g) Review local authority and NHS strategies and Policy Framework as appropriate.
h) Make reports or recommendations to NHS bodies, the council's Cabinet or Full Council on the basis of the evidence it has gathered as part of the review.

Evidence Sessions

Evidence Session 1	Themes/Areas for discussion	Attendees/Organisations Invited
Health services, NHS and public services **16 July 2019**	Breastfeeding, solid foods. How encouragement is given to mothers around breast feeding, and training for health professionals; how health services work with other agencies and work places to encourage and create an environment to support mothers. Signposting by GPs; midwives, paediatricians and consultants in hospitals. GP training in discussing weight management. Understanding what weighing/measuring takes place 0-4 in Brent Collecting data and information systems: GPs, A&E departments, paediatricians, school nurses, children's centres Training for healthcare professionals in identification Healthy weight 'pathways' for 0-5; 5-10 year olds Healthy Early Years (HEY) Award; National Child Measurement Programme in schools	GPs health visitors Brent CCG NHS paediatricians Public Health England Brent Council officers Charities, third sector organisations Midwives Healthwatch Schools Barnardo's Private, voluntary and independent (PVI) early years providers

Evidence Session 2	Themes/Areas for discussion	Attendees/Organisations Invited
External Environment **23 July 2019**	Walking to school, driving to school or pre-school Opportunities for children's physical exercise Helping children who live in unsafe areas or who do not have access to safe walking routes or opportunities to be physically active Brent's parks and playgrounds and encouraging physical activity Wider opportunities to be physically active in a safe environment Creating healthier high streets Play Streets in Brent	Parent group representatives Brent Council Transportation officers Transport for London Private, voluntary and independent (PVI) early years providers Schools Sports organisations Charities, third sector organisations Health visitors, practice nurses

Evidence Session 3	Themes/Areas for discussion	Attendees/Organisations Invited
Home Environment **3 September 2019**	Diet Budgeting Food preferences of family members Family habits and physical activity High sugar food Food growing Fast food and takeaways Culture and diet	Parent group representatives GPs Brent CCG Food growing organisations Charity, third sector organisations

Evidence Session 4: 10 September 2019

The final session will be an engagement event and an 'open mic' for Brent parents and interested residents and organisations. This will be run by the Strategy and Partnerships Team and modelled on It's Time to Talk engagement sessions.

The open mic session will attempt to reflect back what the task group has found in the previous evidence sessions.

Parents and others will be invited to discuss the issues around childhood obesity and meet with the task group members so they can hear their views at the 'open mic' session.

Questions and areas for discussion could include:

- Why do parents engage or not engage with NHS and Public Health services?
- What are the particular challenges for parents with pre-school children who are obese?
- What can parents, residents and community organisations do to help themselves?

This page is intentionally left blank

Brent	**Community Wellbeing Scrutiny Committee** 9 July 2019
	Report from Brent Clinical Commissioning Group

Central Middlesex Hospital – Urgent Care Centre Changes in Operating Hours

Wards Affected:	All
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
No. of Appendices:	7
Background Papers:	
Contact Officer(s): (Name, Title, Contact Details)	Rashesh Mehta – Assistant Director, Integrated Urgent Care, Brent CCG Email- rasheshmehta@nhs.net

1. Summary

This paper from NHS Brent CCG looks at the urgent care provision in Central Middlesex Hospital (CMH) and report on the findings on its utilisation, impact on equality, health inequalities and overall quality of CMH UCC.

Included in this case for change report are the alternative options that Brent CCG has taken into consideration to ensure the access to services are providing best use of public money and better use of resources. The paper shows current usage of the urgent care centre (UCC) as well as the public and stakeholder engagement plans.

The CCG has the statutory responsibility to manage its finances effectively and efficiently which meets local population needs. Likewise, any proposed changes to commissioned services must be evidence-based. It is an opportune time to look at the current capacity and demand for CMH UCC service and to discuss whether savings can be made by reducing services when there is little or no usage from residents.

The purpose of this report is to identify current usage and provide evidence-based case for change so that the Community Wellbeing Scrutiny Committee can be sighted on the plans to close the Urgent Care Centre at Central Middlesex Hospital (CMH) overnight from 12am midnight to 8am, when it has a *low volume* of attendances and need (preferred option)

To date, the CCG has carried out a series of engagement activities on the proposals with the public and other stakeholders, including the Brent Equality Engagement and Self-care (BEES) committee, Healthwatch, CVS Brent, members of the Carers Board and ran a bespoke workshop to include voluntary sector organisations and patients. Summaries of feedback received from this activity are provided in section 3 titled Involvement.
The Governing Body of Brent CCG considered the proposals on 25th June and approved them, subject to receiving confirmation of approval from the LNWHT A&E Delivery Board.

What the Committee is Asked to Do

The Community Wellbeing Scrutiny Committee is asked to scrutinise the proposals, and to confirm that significant public involvement has already taken place in relation to this matter. Since this is not a substantial change to services, Brent CCG does not consider that a full scale public consultation is required and the engagement that has taken place is proportionate to the change in question.

The Committee is asked to support the CCG's approach to informing the public about the changes to the service times. We will develop printed materials and a section on our website for all the information on the engagement. Translations would be available upon request.

Following confirmation from the Committee, and from the A&E Delivery Board, it is Brent CCG's intention to give 3 months' notice to the provider of the UCC (Greenbrook Healthcare) and during this period we will provide information to the public on the reduction in hours, together with information on where they may wish to access alternative services.

1. Introduction

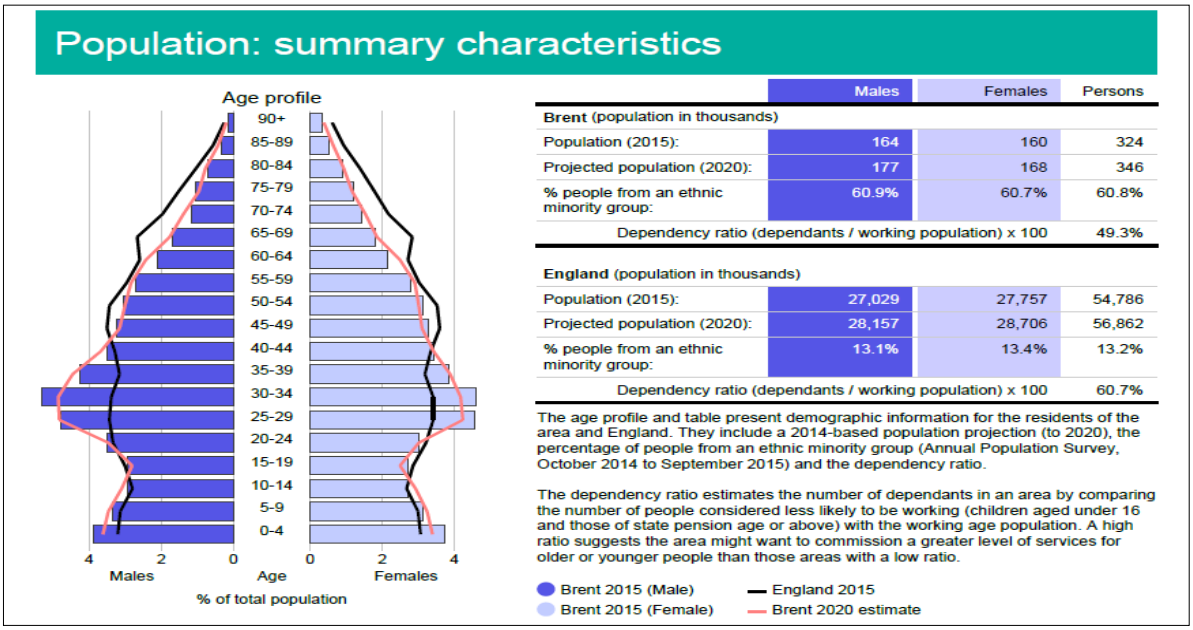
1.1 About the London Borough of Brent

- Brent borders the boroughs of Harrow to the north-west, Barnet to the north-east, Camden to the east, Westminster to the south-east, and Kensington and Chelsea, Hammersmith and Fulham, and Ealing to the south. Brent has a mixture of residential, industrial and commercial land. Brent is home to Wembley Stadium, one of the country's biggest landmarks, as well as Wembley Arena. The local authority is Brent London Borough Council. Covering an area of 4.23 ha, the borough has around 334,700 residents[1] making it the 14th densely populated boroughs in the UK with 75.2 persons per ha. It is part of the NW London Collaboration of CCGs which includes eight London Boroughs and is also part of the NW London Health and Care Partnership (or STP).

- The borough has 81 community pharmacies, 56 GP surgeries with a total GP registered population of 392,892 (as of May 2019), two hospitals – Central

[1] Population Change in Brent – Key Facts https://data.brent.gov.uk/dataset/population-change-in-brent---key-facts

Middlesex Hospital and Northwick Park Hospital (NWPH), both with urgent care centres and one (NWPH) has an emergency department (ED). The two hospitals are 5.5 miles apart or about 16-35 minutes' drive between sites, just over half an hour journey using public transport[2].



Graph 1: Summary Characteristics of the Population of London Borough of Brent (Feb. 2019)

- Brent is a diverse London borough and large proportion of the population are young working age (67.8%) residents with a low proportion of residents aged 65 and over (11.3%) and the fifth lowest number of children of any London borough[3].
- The mean average age is 35, five years below the UK average (40).
- The area has high levels of migration in and out of the borough, and significant ethnic and cultural diversity.
- 66% of the population is from Black, Asian and Minority groups (BAME).
- People between 0–15 y/o comprise 21% of the total population. Those 16-64 y/o, working age population makes up 67.8% of the population and the 65 and over population makes up 11.3% of the population.
- Brent has the largest proportion of residents born abroad (55%). This ranges from Asia (23%), followed by Europe (18%) and Africa (10%) to Central and South America (3%) and North America (1%). 14.5 per cent of households have no people that speak English as a main language; this is the thirteenth highest proportion in England & Wales.
- Life expectancy for men is 79.9 years and 84.9 years for women. Life expectancy is 5.8 years lower for men and 4.0 years lower for women in the most deprived areas of Brent than in the least deprived areas.

[2] Google maps https://www.google.com/maps/dir/Central+Middlesex+Hospital,+Acton+Ln,+Park+Royal,+London+NW10+7NS/Northwick+Park+Hospital,+Watford+Road,+Harrow/

[3] Brent JSNA 2015/16 Refresh - https://www.brent.gov.uk/media/16412103/jsna-2015-brent-overview-report.pdf

1.2 Financial challenges

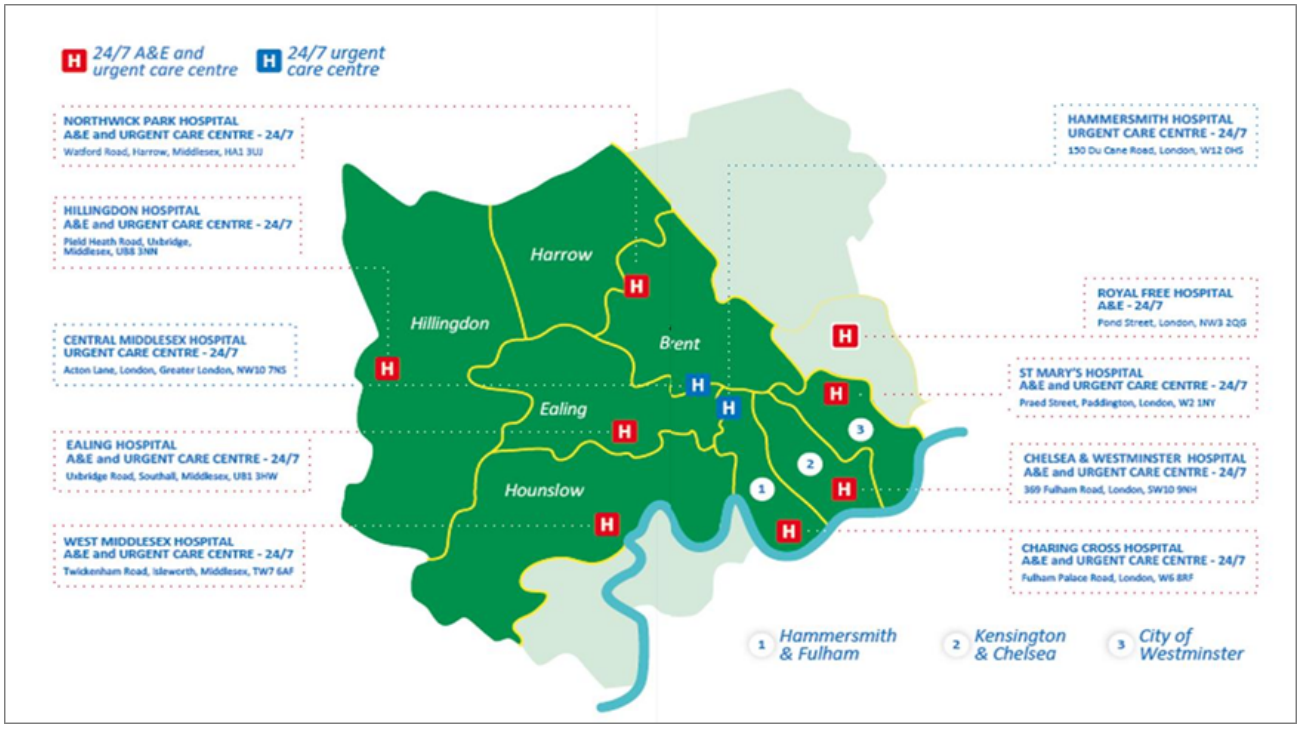
- NHS Brent CCG is in a challenged financial position. Like other CCGs across England, it has limited amount of money to spend and needs to ensure budget is used as effectively and efficiently as possible. It is therefore appropriate to look at the services we provide are of good quality, effective, well utilised and provide good value.

- It is estimated that the financial implication for reducing opening hours (ie close overnight from 12midnight to 8am) would save in the region of £450k per year for NHS Brent CCG. The CMH UTC will still be open for 16 hours a day which is in line with national principles and standards[4], which at a minimum must operate for at least 12 hours per day.

- NHS Brent CCG is taking this forward by looking at the status quo to understand the utilisation of CMH UCC service, whether the current operating hours are the most appropriate and how alternative options were considered before arriving to close service operating hours from midnight to 8am.

2. Status quo

- CMH UCC is currently open 24/7 and based at Central Middlesex Hospital in the south of the borough of Brent. This is bordered by the Boroughs of Hammersmith & Fulham to the south and Ealing to the west. The rest of the borders of CMH are within Brent's geography.



[4] Urgent Treatment Centres – Principles and Standards (July 2017) - https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

- CMH UCC has been a standalone (not co-located with an A&E) site since the Emergency Department (A&E) at CMH closed in September 2014. It was at this point that CMH UCC became a 24/7 UCC service as part of the implementation of "Shaping a Healthier Future (ShaHF)". CMH UCC is a contract commissioned by NHS Brent CCG and operated by Greenbrook Healthcare from 31st March 2018.

2.1 CMH UCC Attendance Levels

- CMH UCC saw just over 45,000 patients in 18/19, an average of 866 a week. Just under 8% of all attendances occur in the period between 12 midnight and 8am. This is an average of 10 visits a night and, although this can vary, 90% of all night time visits are 1 per hour. More than half of these attendees are registered with a Brent GP, the remainder came from neighbouring Boroughs and/or further afield. Please refer to Appendix 1 and 2 for further details.

Night - 8pm - 8am (All Attendances, 18/19)

Average per Week - 18/19

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total		
20:00-21:00	8	6	6	7	7	6	6	46		
21:00-22:00	5	5	5	5	5	6	5	36		
22:00-23:00	5	4	4	4	4	4	5	30		
23:00-00:00	3	2	3	3	3	3	3	19		
00:00-01:00	2	2	2	2	2	2	2	13		
01:00-02:00	1	1	1	1	1	2	2	9		
02:00-03:00	1	1	1	1	1	1	1	6		
03:00-04:00	1	1	1	1	1	1	1	5		
04:00-05:00	1	0	0	0	1	1	1	4		
05:00-06:00	1	1	1	1	0	1	1	5		
06:00-07:00	1	1	1	1	1	2	1	8		
07:00-08:00	2	2	2	2	2	3	2	16		
08:00-09:00	5	5	4	4	4	5	5	32		
09:00-10:00	11	8	9	8	8	7	6	57		
10:00-11:00	12	9	10	9	9	9	9	66		
11:00-12:00	11	10	10	9	9	10	10	68		
12:00-13:00	10	9	9	9	9	9	10	63		
13:00-14:00	10	8	9	8	8	9	9	60		
14:00-15:00	9	7	8	7	8	8	8	55		
15:00-16:00	8	8	7	8	8	9	8	55		
16:00-17:00	8	8	7	7	7	8	7	53		
17:00-18:00	9	8	8	7	7	7	7	53		
18:00-19:00	8	9	8	8	7	7	6	54		
19:00-20:00	8	8	8	8	7	6	6	52		
Total	138	122	124	118	119	123	122	866		

198 116 67 668

Table 1: CMH UCC - Average number of night time "All" attendances per week, 18/19

Night - 8pm - 8am (BRENT specific attendances, 18/19)

Average per Week - 18/19

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total		
20:00-21:00	5	4	4	4	4	4	4	29		
21:00-22:00	3	3	3	3	3	4	3	22		
22:00-23:00	3	3	2	3	2	2	3	18		
23:00-00:00	2	2	2	2	2	2	1	11		
00:00-01:00	1	1	1	1	1	1	2	8		
01:00-02:00	1	1	1	1	1	1	1	5		
02:00-03:00	1	0	1	0	0	1	1	4		
03:00-04:00	0	0	0	0	0	0	0	3		
04:00-05:00	0	0	0	0	0	1	1	2		
05:00-06:00	0	0	0	0	0	1	1	3		
06:00-07:00	1	1	1	0	1	1	1	5		
07:00-08:00	1	1	1	1	1	2	1	9		
08:00-09:00	3	3	2	3	2	3	3	20		
09:00-10:00	7	5	6	5	6	5	4	39		
10:00-11:00	8	6	7	6	6	6	6	44		
11:00-12:00	7	6	7	6	6	7	7	46		
12:00-13:00	7	6	6	6	6	5	6	42		
13:00-14:00	7	5	6	5	5	6	6	39		
14:00-15:00	6	5	4	5	6	5	5	35		
15:00-16:00	6	5	4	5	5	6	5	36		
16:00-17:00	6	5	5	5	5	5	4	34		
17:00-18:00	6	5	5	5	5	5	4	34		
18:00-19:00	5	6	5	5	5	5	4	35		
19:00-20:00	5	5	5	5	5	4	4	33		
Total	90	79	79	77	78	78	76	557		

119 68 39 438

Table 2: CMH UCC – Average number of night time "Brent" attendances per week, 18/19

There are about 6 on average, night (12mn – 8am) time attendees who are residents of Brent (registered with a Brent GP) as compared to "All CCG attendances" of 10 on average (see Table

4). The most common number of attendees per night range between 6 to 14 (12mn – 8am and 8pm – 8am) for “Brent only activity”.

Brent Only Activity	Attendances		
	8pm-8am	10pm-8am	12mn-8am
Average per Night	17	10	6
Most Common per Night	14	10	6

Table 3: CMHUCC - Average number of night time attendances, Brent GP registered, 18/19

All CCGs	Attendances		
	8pm-8am	10pm-8am	12mn-8am
Average per Night	28	17	10
Most Common per Night	28	13	8

Table 4: CMHUCC – Average number of night time, All attendances, 18/19

Five out of 10 night time attendances are for working age adults, with the rate of visiting higher (average 52%) for this group than for children and older people across “All” attendances (see Table 5). This is similarly reflected on residents of Brent, where 20-44 age groups are attending nearly 50% of the time on average compared to the rest of the other age groups from 12mn – 8am.

The average attendance per night is around 1 patient visiting per hour.

	8pm-8am				10pm-8am				12pm-8am			
	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%
0-4	15	65	783	13%	8	36	429	12%	5	20	234	11%
5-19	26	112	1,339	22%	12	52	625	18%	6	25	305	15%
20-44	52	225	2,698	43%	32	139	1,666	47%	19	81	976	48%
45-64	21	93	1,114	18%	13	55	656	18%	8	34	408	20%
65+	5	23	278	4%	3	15	181	5%	2	10	125	6%
Total	**119**	**518**	**6,212**		**68**	**296**	**3,557**		**39**	**171**	**2,048**	

Table 5: CMHUCC - Night time attendances by Age Profile, All attendances, 18/19

	8pm-8am				10pm-8am				12pm-8am			
	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%
0-4	24	104	1,249	12%	13	58	693	11%	7	29	350	10%
5-19	38	166	1,994	19%	19	81	967	16%	9	40	484	14%
20-44	94	408	4,894	48%	59	254	3,050	51%	35	150	1,802	52%
45-64	34	146	1,754	17%	20	89	1,062	18%	13	56	668	19%
65+	8	34	411	4%	5	22	259	4%	3	14	173	5%
Total	**198**	**859**	**10,302**		**116**	**503**	**6,031**		**67**	**290**	**3,477**	

Table 6: CMHUCC - Night time attendances by Age Profile, Brent attendees only, 18/19

The gender split at night is representative of the general population, unlike during the day, where women outnumber men. Between 51-57% of night attendances are from men. The

same goes true for those men from Brent. More information on the social-demographic breakdown of attendances is available in Appendix 3.

All Attendances		8pm-8am				10pm-8am				12mn-8am			
	General Population	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%
Female	**49.7%**	96	418	5,010	49%	54	232	2,787	46%	29	126	1,508	43%
Male	**50.3%**	102	441	5,287	51%	62	270	3,242	54%	38	164	1,967	57%
Not Known	**0%**	0	0	5	0%	0	0	2	0%	0	0	2	0%
Total		**198**	**859**	**10,302**		**116**	**503**	**6,031**		**67**	**290**	**3,477**	

Table 7: CMHUCC - Night-time attendances by Gender Profile, All attendances, 18/19

	12pm-8am								8pm-8am								10pm-8am							
	Average per Week		verage per Mont		Total		% of Total Day/Nigh		Average per Week		verage per Mon		Total		% of Total Day/Night		verage per Wee		Average per Month		Total		% of Total Day/Night	
CCG	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day
NHS Brent CCG	39	518	171	2,243	2,048	26,918	59%	65%	119	438	518	1,896	6,212	22,754	60%	65%	68	489	296	2,117	3,557	25,409	59%	65%
NHS Ealing CCG	11	129	48	557	571	6,689	16%	16%	35	105	151	454	1,817	5,443	18%	16%	20	120	86	519	1,029	6,231	17%	16%
NHS Harrow CCG	2	15	7	65	82	776	2%	2%	4	12	18	54	211	647	2%	2%	2	14	10	61	125	733	2%	2%
NHS Hammersmith and Fulham CCG	1	14	6	60	73	723	2%	2%	4	11	17	49	203	593	2%	2%	2	13	10	56	123	673	2%	2%
NHS Barnet CCG	1	12	5	54	64	648	2%	2%	4	10	15	44	185	527	2%	2%	2	12	9	50	110	602	2%	2%
NHS West London (K&C & QPP) CCG	1	12	4	50	53	603	2%	1%	3	9	14	41	164	492	2%	1%	2	11	9	46	102	554	2%	1%
NHS Hillingdon CCG	1	7	4	29	45	347	1%	1%	2	6	9	24	103	289	1%	1%	1	6	6	27	71	321	1%	1%
NHS Hounslow CCG	1	7	3	28	36	340	1%	1%	2	6	7	24	89	287	1%	1%	1	6	4	27	51	325	1%	1%
NHS Central London (Westminster) C	1	6	3	24	32	290	1%	1%	2	4	9	17	113	209	1%	1%	1	5	6	21	76	246	1%	1%
Not NHS England	1	5	3	22	37	267	1%	1%	2	4	9	17	102	202	1%	1%	1	5	6	20	66	238	1%	1%
Total	**58**	**723**	**253**	**3,133**	**3,041**	**37,601**			**177**	**605**	**767**	**2,620**	**9,199**	**31,443**			**102**	**679**	**443**	**2,944**	**5,310**	**35,332**		

Table 7: CMHUCC: Night-time attendances by Top 10 CCG areas, 18/19

More than half of night time attendances are people coming from NW10 district which largely forms part of the London Borough of Brent followed by nearly a quarter from Ealing, Harrow, Hammersmith & Fulham, combined.

Over half are from a 1.4 mile radius, such as from the wards of Harlesden and Stonebridge. This area more deprived than average for London. People from these areas may have slightly higher rates of illness and disability than typical. Maps showing the location of attendees and average distance travelled are in Appendix 4,5 and 6.

2.2 CMH UCC Clinical Summary of Attendances

2.2.1 Mode of Arrival and Sources of Referral

Overnight, 99% of attendees self-present to CMH UCC and practically no one came in via an ambulance.

	8pm-8am				10pm-8am				12pm-8am			
	Average per Day		% of Total Day/Night		Average per Day		% of Total Day/Night		Average per Day		% of Total Day/Night	
Mode of Arrival	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day
Brought in by Ambulance	0	0	0.3%	0.3%	0	0	0.4%	0.3%	0	0	0.5%	0.3%
Other	28	95	99.7%	99.7%	16	107	99.6%	99.7%	9	114	99.5%	99.7%
Total	**28**	**95**			**17**	**107**			**10**	**114**		

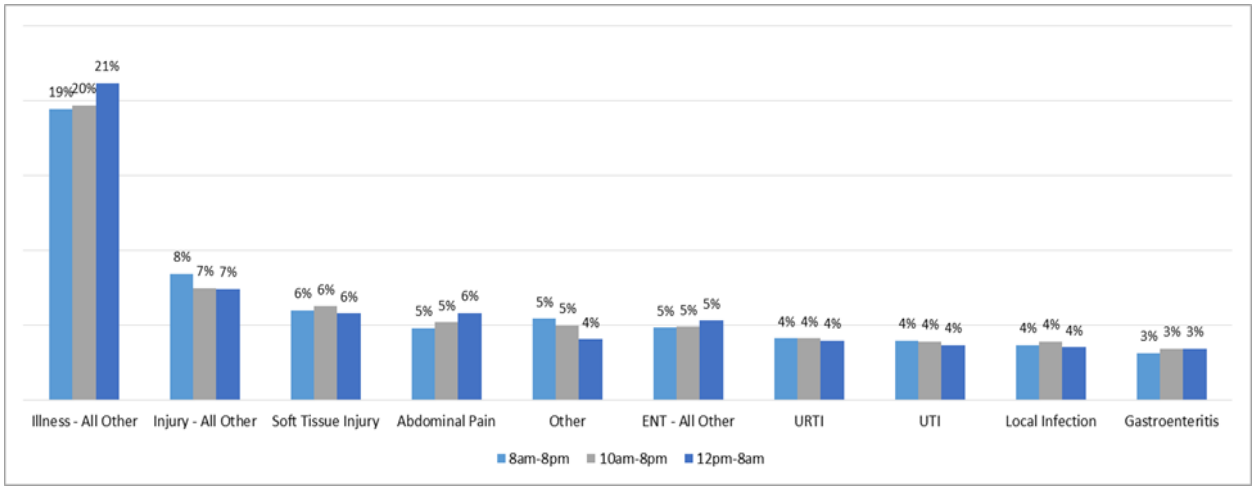
Table 8: CMHUCC – Number of attendances by mode of arrival, 18/19

	8pm-8am				10pm-8am				12pm-8am			
	Average per Day		% of Total Day/Night		Average per Day		% of Total Day/Night		Average per Day		% of Total Day/Night	
Source of Referral	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day
Self Referral	25	87	87.9%	91.4%	15	97	88.9%	90.9%	9	103	91.9%	90.5%
111	3	6	10.2%	6.3%	2	7	9.3%	6.9%	1	8	6.4%	7.3%
111 Referral	0	1	1.2%	0.8%	0	1	1.0%	0.8%	0	1	0.9%	0.9%
Emergency Services	0	1	0.4%	0.6%	0	1	0.5%	0.5%	0	1	0.5%	0.5%
Health care provider: same or other	0	0	0.2%	0.3%	0	0	0.1%	0.3%	0	0	0.1%	0.3%
GENERAL MEDICAL PRACTITIONER (GP)	0	0	0.0%	0.2%	0	0	0.0%	0.2%	0	0	0.0%	0.2%
Other	0	0	0.1%	0.1%	0	0	0.1%	0.1%	0	0	0.2%	0.1%
Educational Establishment	0	0	0.0%	0.1%	0	0	0.0%	0.1%	0	0	0.0%	0.1%
Work	0	0	0.0%	0.1%	0	0	0.0%	0.1%	0	0	0.0%	0.1%
Police	0	0	0.0%	0.0%	0	0	0.0%	0.0%	0	0	0.0%	0.0%
Local Authority/Social Services	0	0	0.0%	0.0%	0	0	0.0%	0.0%	0	0	0.0%	0.0%
GENERAL DENTAL PRACTITIONER	0	0	0.0%	0.0%	0	0	0.0%	0.0%	0	0	0.0%	0.0%
Unknown	0	0	0.0%	0.0%	0	0	0.0%	0.0%	0	0	0.0%	0.0%
Total	**28**	**95**			**17**	**107**			**10**	**114**		

Table 9: CMHUCC – Number of attendances by source of referral, 18/19

2.2.2 Reasons for attendance

Data analysis was carried out by Brent CCG of the 3,477 records of 18/19 night time attendances, the top presenting complaints/diagnosis are illness – all other (21%) and all other injuries at 7% with around 17% presents with abdominal pain, soft tissue injury and ENT-related complaints, combined. The graph below summarises the results of the data analysis with regards to the presenting complaints/diagnosis of those attending CMH UCC overnight from 8pm/10pm/12mn to 8am.



Graph 3: CMH UCC – Presenting complaint/diagnosis of night time attendees, All CCGs, 18/19

2.2.3 Treatment and investigations

More than three quarters of attendances, the treatment provided was Other/NA – this constitutes advice and/ or simple medication. This is followed by the need for X-ray, pregnancy tests and ECG.

	8pm-8am				10pm-8am				12pm-8am			
	Attendances		% of Total Day/Night		Attendances		% of Total Day/Night		Attendances		% of Total Day/Night	
Treatment	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**
Other/NA	8,465	28,344	82%	82%	4,999	31,810	83%	82%	2,933	33,876	84%	81%
Xray	1,061	4,365	10%	13%	561	4,865	9%	12%	287	5,139	8%	12%
Pregnancy Test	471	1,129	5%	3%	269	1,331	4%	3%	136	1,464	4%	4%
ECG	305	906	3%	3%	202	1,009	3%	3%	121	1,090	3%	3%
Total	**10,302**	**34,744**			**6,031**	**39,015**			**3,477**	**41,569**		

Table 10: CMHUCC – Treatment and investigations by day and night, 18/19

Specifically, for 12mn-8am attendances, data suggested that there are about 15% of patients needing investigation at these hours, compared to 19% during the day. On average, this equates to about 10 patients/week (or = 1.43/night) needing investigations, compared to 151 patients (21.64/day) per week during the day time.

2.1.4 Outcomes & alternative care pathway

An average of 67 patients attending during night time per week, of whom, around 54 (81%) were discharged and only 5 (8%) was referred to an emergency department (ED) per week. This equates to less than 1 (0.71) per night.

	8pm-8am						10pm-8am						12mn-8am					
	ave/wk		Total		% of Total Day/Night		ave/wk		Total		% of Total Day/Night		ave/wk		Total		% of Total Day/Night	
Outcome of Attendance	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**	**Night**	**Day**
A&E Referral	13	27	668	1,412	6%	4%	8	32	432	1,648	7%	4%	5	35	264	1,816	8%	4%
Discharged	159	537	8,275	27,903	80%	80%	93	603	4,825	31,353	80%	80%	54	642	2,802	33,376	81%	80%
Other Referral	16	71	833	3,686	8%	11%	9	77	491	4,028	8%	10%	5	81	282	4,236	8%	10%
Redirected	3	13	173	658	2%	2%	3	13	134	697	2%	2%	2	14	80	751	2%	2%
Did Not Wait	7	20	353	1,063	3%	3%	3	24	149	1,267	2%	3%	1	26	49	1,367	1%	3%
Other	0	0	0	22	0%	0%	0	0	0	22	0%	0%	0	0		23	0%	0%
Total	**198**	**668**	**10,302**	**34,744**			**116**	**750**	**6,031**	**39,015**			**67**	**799**	**3,477**	**41,569**		

Table 10: CMHUCC – Number of attendances by outcome of attendance, 17/18

As reflected in table 10 above, the data analysis found that suitable care for around 12% of those attending at night per week would have been a GP appointment during the day.

2.3 CMH UCC Workforce

- There has been an initial discussion between Brent CCG and Greenbrook, the Provider, about the proposed changes to CMH UCC subject to further engagement, review and approval. The CCG will need to give 3 months' notice for making changes to operating times.

2.3.1 Performance

- CMH UCC has been fully compliant with the contractual clinical quality and key performance indicators.

2.3.2 Friends and Family Test

- The friends and family test results from March and April 2019 show that 93.5% would recommend the service at CMH UCC to their friends and families. This was out of 130 monthly average responses that Greenbrook received.

2.3.3 Care Quality Commission (CQC)

- The 2019 CQC inspection of Urgent and Emergency Care at CMH was recently completed. We are now waiting for CQC to publish their report and will add this to the appendix when it becomes available.

3. Involvement

3.1 Principles and overview

- NHS Brent CCG has principles of engagement and co-design which have been developed with our patient partners. This sets out the importance of involving our residents and stakeholders from the start and listening to all views in the development of our plans.

3.2 Public engagement

- To date, the CCG has engaged with members of the public on primary and urgent care at the Health Partners Forum, Primary Care Forum and during outreach to number of local community events over the winter period 2018/19. Some of the views from the public with regards to urgent care services[5],[6].

- We have discussed the proposed engagement at the Brent Equalities, Engagement and Self-Care Sub-committee (BEES) on 11th of April with stakeholders from Healthwatch, CVS Brent, Public Health (LA) and Strategy and Partnerships (LA). The proposed engagement was also discussed at a meeting with CVS Brent separately.

- Feedback from the BEES subcommittee has been summarised in the points below and fed into our planned engagement approach as appropriate.

[5] http://brentccg.nhs.uk/en/publications/patient-and-public-engagement/doc_download/4254-urgent-and-emergency-care-you-said-we-did

[6] http://brentccg.nhs.uk/en/news/551-discussing-urgent-and-emergency-services-at-our-health-partners-forum

Feedback from BEES

- Case for change is strong
- Makes sense to reduce times
- In its communications, the CCG should be open and transparent about the cost savings of the proposed change, the re-distribution of resources in the wider system and the need to use resources more efficiently.
- It would be helpful for the CCG to be open about the recovery plan going forward in light of the deficit for 2019/20.
- Partners will assist with raising awareness
- Ensure patient information is accessible in terms of language, using a range of methods.

3.3 Stakeholder engagement

3.3.1 Local Authority and political stakeholders

- NHS Brent CCG has had conversation with the Cllr Sheth, Chair, Overview and Scrutiny Committee prior to this paper going into the Governing Body on the 26th of June 2019.
- CMH UTC site visit was also arranged for councillors for Friday 28th June from 2pm-4pm.

3.3.2 Healthwatch and community stakeholders

- On 15th May, the CCG's Head of Engagement and Head of Urgent Care met with a Healthwatch representative to update on proposed engagement. Feedback received is as follows:

Feedback from Healthwatch

- Useful if CCG could contextualise the proposed changed within the wider picture of NWL, as members of the public have been highlighting perceived lack of coordinated approaches and planning that is 'not joined up' across the CCGs
- Good that the CCG is indeed taking a more coordinated approach by waiting until the Hammersmith and Fulham engagement has ended.

- The CCG has held a workshop with patients, community partners including Healthwatch to develop the EHIA

Feedback from workshop

- Case for change strong
- Ensure communications are tailored to reach protected characteristic groups
- Alternative services offer a range of access methods which cater to the different needs of protected groups

- The CCG will then have on-going discussions with stakeholders including Healthwatch, CVS, etc., and will continue to ensure that Healthwatch is closely involved throughout the engagement process.

3.3.3 GP Practices

- Brent CCG will update GP members on the decision of the Governing Body at the start of the engagement phase with sign posting information online. Practices will be encouraged to cascade the information to patient lists.

3.3.4 London North West Hospital University NHS Trust

- The LNWHUT A&E Delivery Board on the 25th of June 2019 has been fully sighted on the CMH UCC proposals. Brent CCG will write to LNWHUT informing them of the Governing Body decision and the engagement approach.

3.3.6 Greenbrook

- Brent CCG has initially engaged with Greenbrook, the Provider, with regards to activity utilisation including staffing implications at CMH UCC last 26th of February 2019. Greenbrook has been pro-active in preparing a workforce impact analysis on the potential number of posts that may be affected by the proposed change in its opening/closing hours. Greenbrook is supportive of the review plans. We will continue to work with Greenbrooks' management team during the engagement period to discuss supporting further staff engagement.

3.3.7 London Ambulance Service NHS Trust

- London Ambulance Service will be notified and engaged around the clinical pathways related to alternative care access they require during out of hours whereby patients who were downgraded into category 3 and 4 (non-emergency) who needed urgent care intervention, where would LAS convey if CMH UCC are to change its opening/closing hours.

4. Data Interpretation & Synthesis

4.1 Proposal for CMH UCC

- Closer analysis of data shows sharp decrease in activity at three key points: 8pm – 8am; 10pm – 8 am and 12mn – 8am. The preferred option is closing from 12mn – 8am based on the data analysis findings from earlier chapters.

4.1.1 Rationale for plan and evidence base

- As highlighted by the 18/19 data analysis, which results were outlined in section 2.1 and 2.2, there are:
    - *Low volume of attendance* of patients with low levels of acuity at CMH UCC between 12 midnight and 8am, with 82% of patients attending, leave with no investigation and minimal treatment.
    - *Considerable volume of attendance* of patients with considerable levels of acuity at CMH UCC between 10 midnight and 8am, with 82% of patients attending leave with little investigation and treatment.
    - *Significant volume of attendance* of patients with significant levels of acuity at CMH UCC between 8pm and 8am, with 84% of patients attending leave with investigation and treatment.

- Closing the standalone unit overnight moves us to a safer urgent and emergency care offering in Brent by reducing the entry points to out of hours services to improve the ease in which patients get to the right place, at the right time, quicker.

4.1.2 Impact on patients

- The data analysis demonstrated no anticipated negative impact to patients subject to stakeholders' engagement.
- The data analysis based on "reasons for attendance" showed that from the average of ten (10) patients attending per night, the following would be the appropriate course of action if CMH UCC were to close overnight:
    - Less than 1 per night would continue to require ED either urgent treatment or referral to specialty review
    - One (1) per night would need to attend an alternative UCC such as Charing Cross, St Mary's, Ealing or Northwick Park
    - Four (4) per night could access an alternative night service such as GP out of hours
    - Four (4) per night could access alternative provision, including their own GP, the next day
- It is recognised that whilst, on average, five patients a night (12mn – 8am) per week attending CMH UCC needed to attend ED, they have already chosen to do so and so it is prudent to assume they would continue to seek help overnight. That is reasonable to assume to address in the following section on impact on neighbouring trusts. Should they attend from 12mn – 8am, they will be advised to contact 111 in the first instance.

- The alternative offering being implemented by the CCG will aim to drive down those inappropriate attendances, helping to provide choice and direction to those seeking advice and care. The majority of attendees overnight are between 20 and 44, the age group most likely to have internet access at home, or own a smartphone, and therefore be best place to benefit from digital signposting.

4.1.3 Patient transport implications

- Charing Cross and Northwick Park Hospital UCCs are the closest alternatives to CMH UCC:

Charing Cross Hospital UCC	5.4 – 6.5 miles by car (~ 14-20 mins drive) via Western Ave / A219	~ 48 mins ride by bus 266 or bus 220	Using google maps, searched 06/06/19 for 02:00 arrival mode at CCH UCC.
Northwick Park Hospital UCC	5.5 – 6.6 miles by car (~ 14-22 mins drive) via Watford Road / A404	~ 50 mins ride by night bus N18	
St. Mary's Hospital UCC	5.8 – 6.0 miles by car (~16 – 20 mins drive) via A40	~ 54 mins ride by bus 266 or bus 220	
Ealing Hospital UCC	6.4 – 6.8 miles by car (~ 14 – 20 mins drive) via Western Ave. / A4127	~ 1hr 13 mins ride by night bus N18 or N83	

- There are a few options depending on whether you take the option with shortest walking routes or the option with fewest bus changes. According to TfL data, accounting for waiting times and slower walking speeds, transport time at 2am varies from 16 – 46 minutes to Charing Cross and up to 41 minutes to Ealing. See Appendix 7 for sample illustration.

- If the CCG were to progress with the proposals, impact on transport and access times would be a key part of the engagement.

4.1.4 Impact on neighbouring Trusts and services

- The impact is most likely to be on Charing Cross and Northwick UCCs due to their closer proximity. Whilst the data analysis showed approximately one patient a night would need to attend a UCC, we are assuming all ten (10) patients who currently choose to attend CMH overnight could defer to neighbouring UCCs or their GP out of hours service.

- Any patients currently attending CMH UCC overnight and needing to be transferred to ED are currently most likely to be transferred to Northwick Park Hospital (subject to specialist needs) due to CMH site being part of LNWHUT. With less than 1 per night (5

per night per week) on average, there is not expected to be any “additional” impact on Northwick Park Hospital ED.

- From the time the CMH overnight closure take place, the CCG will monitor data on a regular basis to see if there has been an impact on other sites..

4.1.5 Risks and mitigations

- The key risk relates to CMH UCC being a standalone unit meaning there is no alternative service on site during the proposed closure hours. Whilst there is a low volume of patient attending CMH UCC overnight, the following mitigations would be discussed as part of the engagement process:
    - Clear clinical pathways for all patients arriving at the UCC – with specific reference to pathways for patients arriving closer to closing time.
    - Clear on-site signposting for those arriving outside opening hours
    - Road signage changes around the hospital and on approaching roads
    - Consideration of overnight patient transport service based on-site between 12 midnight and 8am for a set period of time after the change of hours
    - Consideration of free-phone outside the UCC which goes straight through to 111 between 12 midnight and 8am.
    - Communications campaign in the areas where most attendees come from
- There would be an on-going review of patient numbers at both UCCs and the ED. Any expected changes to patient flow would be addressed within the contracting for the updated UCC (UTC) specifications.
- During engagement, we would also undertake equalities assessments to identify any specific health inequalities in the local area or groups with protected characteristics who would be adversely impacted including those hard to reach groups.
- EHIA and QIA have been completed. See appended documents respectively, for details. Both EHIA and QIA will be further developed during the engagement phase before closure of night hours.

4.2 Equalities Impact and Quality Impact Analysis

- An Equality & Health Inequality Impact Analysis Screening Tool (EHIA screening) has been completed. The screening document has been presented to the Clinical Effectiveness Quality & Safety Panel, who provided recommendations moving forward which will be incorporated into the refreshed EHIA following further engagement with stakeholders.
- The purpose of the EHIA screening is:
    - To better understand the impact on the nine protected characteristic groups of the proposals outlined above
    - Examine any barriers to accessing relevant care for these groups
    - Examine benefits of introducing a introduction of a digital front end for accessing healthcare for these groups

- It is important to undertake this analysis from the user-perspective, to focus on the various impacts as the patient may experience them. With this in mind, in addition to gathering data from a wide range of sources including JSNAs and National Audit Office reports the CCG will:
    - collate all our community feedback received over the past year relating to primary and urgent care to consider where our gaps are
    - undertake an engagement with a range of groups focusing on primary and urgent care access

4.3 Wider NW London picture

- Shaping a Healthier Future (SaHF), in 2012, set out the NW London vision for improving care across the eight boroughs. It looked at improving out of hospital provision, centralising key services and ensuring that people had access to the right care at the right time and in the right place.

- A significant number of improvements have been made across NW London as a result of SaHF and the vision is continued in the NW London sustainability and transformation plan and towards the journey into integrated health and care partnership.

- One element of SaHF related to making the nine urgent care centres 24/7. It created a specification for UCCs that was higher than the national specification and agreed that a consistent 24/7 offering to all residents would ensure a more efficient and equitable service.

- For safety reasons, the ED at CMH was closed. The UCC onsite increased to 24/7 as part of the mitigation to the closure.

- Brent is one of the boroughs in NW London to have two UCCs, one of which is co-located with an ED. It is now over five years since the closure of CMH ED and there is awareness of the lack of ED service at the site.

- NHS Brent CCG are clear that the proposals outlined in this paper remain in line with the clinical vision of SaHF. The borough continues to provide a 24/7 UCC services in the borough and continues to provides an increased UCC provision to its residents, compared to other boroughs, during the day time. A map of all current urgent and emergency care provision in NW London is in page 7.

5. Next steps

5.1 Regulator assurance

- We sought assurance with NHS England and following their recommendations, we will engage with our stakeholders.

5.2 Governance and decision making

- This report is provided to this committee to inform them of the endorsement of the Governing Body subject to letter from chair of AEDB that there will be limited impact to the trust.

6. Appendices

Appendix 1: Number of Attendees by time of Day and Night, All CCGs, 18/19

Night - 8pm - 8am (All CCG's, 18/19)

Total in Year - 18/19

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total			
20:00-21:00	398	334	319	338	350	310	327	2,376			
21:00-22:00	281	261	254	263	267	304	265	1,895			
22:00-23:00	247	216	205	228	211	206	236	1,549			
23:00-00:00	136	127	145	144	159	157	137	1,005			
00:00-01:00	94	90	107	97	88	102	123	701	3,477	6,031	10,302
01:00-02:00	67	54	53	52	71	84	87	468			
02:00-03:00	48	34	39	35	34	59	62	311			
03:00-04:00	28	31	38	34	29	39	47	246			
04:00-05:00	39	23	23	19	33	44	42	223			
05:00-06:00	32	31	38	28	21	39	49	238			
06:00-07:00	77	62	53	52	52	81	64	441			
07:00-08:00	112	125	125	108	122	131	126	849			
08:00-09:00	257	267	227	213	211	238	264	1,677	34,744		
09:00-10:00	546	429	477	403	425	377	332	2,989			
10:00-11:00	604	466	521	469	463	447	473	3,443			
11:00-12:00	574	498	519	449	453	530	529	3,552			
12:00-13:00	507	444	468	457	443	455	498	3,272			
13:00-14:00	528	417	447	402	397	460	474	3,125			
14:00-15:00	444	369	401	383	427	412	425	2,861			
15:00-16:00	423	391	354	392	414	446	431	2,851			
16:00-17:00	434	427	369	385	378	399	356	2,748			
17:00-18:00	458	404	429	371	387	374	340	2,763			
18:00-19:00	424	451	410	415	387	379	318	2,784			
19:00-20:00	407	402	425	409	373	335	328	2,679			
Total	**7,165**	**6,353**	**6,446**	**6,146**	**6,195**	**6,408**	**6,333**	**45,046**			

Average per Week - 18/19

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total			
20:00-21:00	8	6	6	7	7	6	6	46			
21:00-22:00	5	5	5	5	5	6	5	36			
22:00-23:00	5	4	4	4	4	4	5	30			
23:00-00:00	3	2	3	3	3	3	3	19			
00:00-01:00	2	2	2	2	2	2	2	13	67	116	198
01:00-02:00	1	1	1	1	1	2	2	9			
02:00-03:00	1	1	1	1	1	1	1	6			
03:00-04:00	1	1	1	1	1	1	1	5			
04:00-05:00	1	0	0	0	1	1	1	4			
05:00-06:00	1	1	1	1	0	1	1	5			
06:00-07:00	1	1	1	1	1	2	1	8			
07:00-08:00	2	2	2	2	2	3	2	16			
08:00-09:00	5	5	4	4	4	5	5	32	668		
09:00-10:00	11	8	9	8	8	7	6	57			
10:00-11:00	12	9	10	9	9	9	9	66			
11:00-12:00	11	10	10	9	9	10	10	68			
12:00-13:00	10	9	9	9	9	9	10	63			
13:00-14:00	10	8	9	8	8	9	9	60			
14:00-15:00	9	7	8	7	8	8	8	55			
15:00-16:00	8	8	7	8	8	9	8	55			
16:00-17:00	8	8	7	7	7	8	7	53			
17:00-18:00	9	8	8	7	7	7	7	53			
18:00-19:00	8	9	8	8	7	7	6	54			
19:00-20:00	8	8	8	8	7	6	6	52			
Total	**138**	**122**	**124**	**118**	**119**	**123**	**122**	**866**			

Appendix 2: Number of Attendees by Time of Day and Night, Brent specific, 18/19

Night - 8pm - 8am (BRENT specific attendances, 18/19)

Total in Year - 18/19

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total			
20:00-21:00	255	218	213	204	215	193	189	1,487			
21:00-22:00	160	167	135	169	179	197	161	1,168			
22:00-23:00	152	132	123	132	116	128	133	916			
23:00-00:00	83	78	84	94	94	85	75	593			
00:00-01:00	52	59	64	57	53	62	79	426			
01:00-02:00	47	26	31	31	42	51	48	276			6,212
02:00-03:00	27	22	26	20	23	31	33	182		3,557	
03:00-04:00	15	21	24	21	20	20	21	142	2,048		
04:00-05:00	23	11	13	7	19	29	26	128			
05:00-06:00	18	20	20	20	11	26	32	147			
06:00-07:00	37	42	34	25	30	47	40	255			
07:00-08:00	75	68	68	55	72	85	69	492			
08:00-09:00	168	175	126	136	122	165	164	1,056			
09:00-10:00	369	283	324	273	293	245	227	2,014			
10:00-11:00	417	319	344	330	315	301	287	2,313			
11:00-12:00	364	334	346	306	317	352	354	2,373			
12:00-13:00	341	297	317	300	293	284	332	2,164			
13:00-14:00	348	272	293	275	271	288	293	2,040	22,754		
14:00-15:00	303	239	230	239	293	256	266	1,826			
15:00-16:00	296	242	223	283	270	288	271	1,873			
16:00-17:00	290	278	251	243	254	248	216	1,780			
17:00-18:00	293	258	283	248	260	245	199	1,786			
18:00-19:00	270	306	249	265	263	240	205	1,798			
19:00-20:00	264	259	276	269	252	197	214	1,731			
Total	**4,667**	**4,126**	**4,097**	**4,002**	**4,077**	**4,063**	**3,934**	**28,966**			

Average per Week - 18/19

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total			
20:00-21:00	5	4	4	4	4	4	4	29			
21:00-22:00	3	3	3	3	3	4	3	22			
22:00-23:00	3	3	2	3	2	2	3	18			
23:00-00:00	2	2	2	2	2	2	1	11			
00:00-01:00	1	1	1	1	1	1	2	8			
01:00-02:00	1	1	1	1	1	1	1	5			119
02:00-03:00	1	0	1	0	0	1	1	4		68	
03:00-04:00	0	0	0	0	0	0	0	3	39		
04:00-05:00	0	0	0	0	0	1	1	2			
05:00-06:00	0	0	0	0	0	1	1	3			
06:00-07:00	1	1	1	0	1	1	1	5			
07:00-08:00	1	1	1	1	1	2	1	9			
08:00-09:00	3	3	2	3	2	3	3	20			
09:00-10:00	7	5	6	5	6	5	4	39			
10:00-11:00	8	6	7	6	6	6	6	44			
11:00-12:00	7	6	7	6	6	7	7	46			
12:00-13:00	7	6	6	6	6	5	6	42			
13:00-14:00	7	5	6	5	5	6	6	39	438		
14:00-15:00	6	5	4	5	6	5	5	35			
15:00-16:00	6	5	4	5	5	6	5	36			
16:00-17:00	6	5	5	5	5	5	4	34			
17:00-18:00	6	5	5	5	5	5	4	34			
18:00-19:00	5	6	5	5	5	5	4	35			
19:00-20:00	5	5	5	5	5	4	4	33			
Total	**90**	**79**	**79**	**77**	**78**	**78**	**76**	**557**			

Appendix 3: CMH UCC - Socio-demographic characteristics of attendees, 18/19

		8pm-8am				10pm-8am				12mn-8am			
	General Population	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%
Asian or Asian British	**37%**	39	171	2,050	20%	22	96	1,146	19%	12	53	639	18%
Black or Black British	**21%**	49	212	2,547	25%	29	126	1,517	25%	17	72	869	25%
Mixed	**8%**	6	26	309	3%	3	15	174	3%	2	8	98	3%
Other Ethnic Groups	**1%**	28	122	1,462	14%	17	74	889	15%	9	41	490	14%
White	**33%**	76	328	3,934	38%	44	192	2,305	38%	27	115	1,381	40%
Total		**198**	**859**	**10,302**		**116**	**503**	**6,031**		**67**	**290**	**3,477**	

CMH UCC: Ethnicity demographics of night attendees compared with general population ethnicity

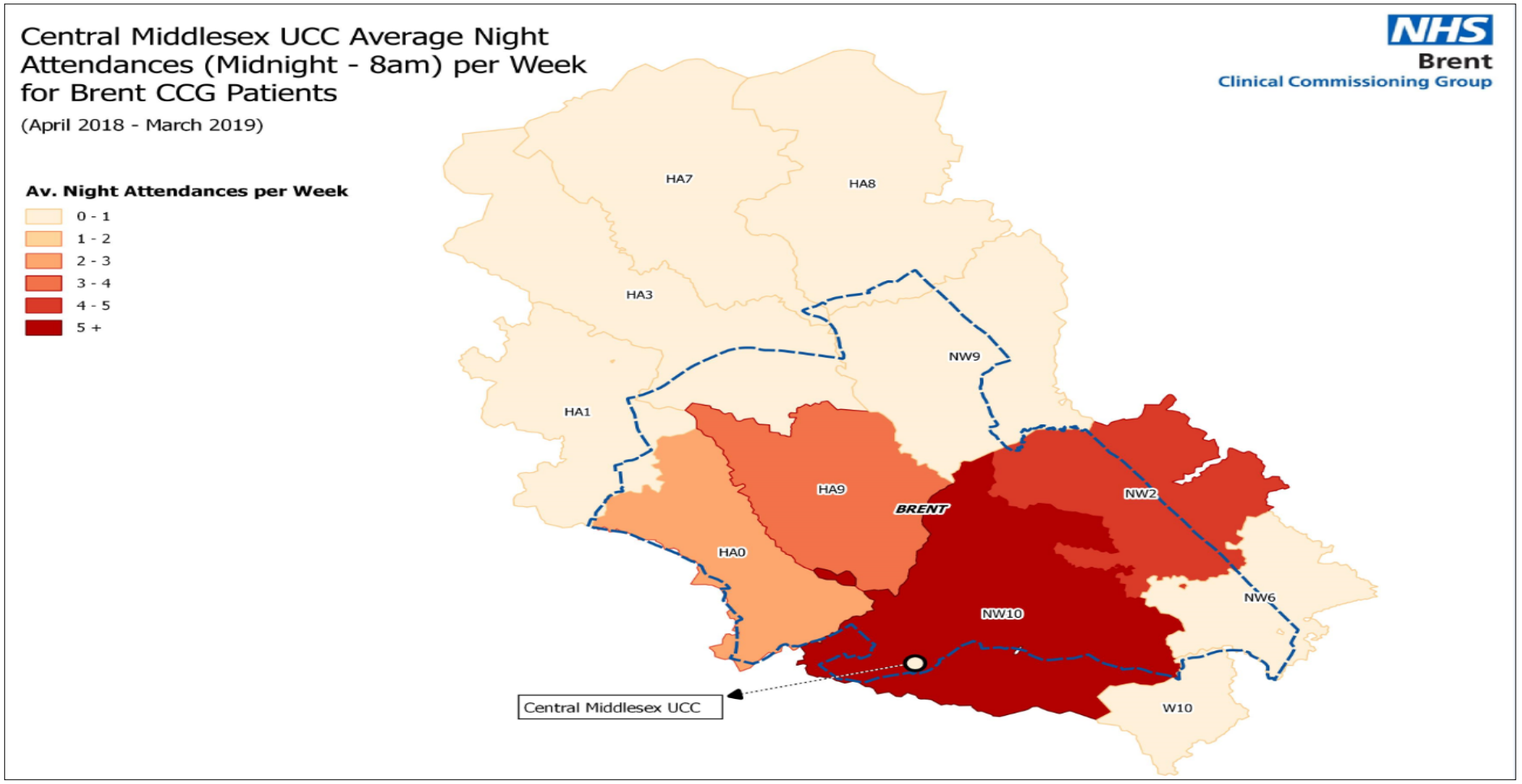
		8pm-8am				10pm-8am				12mn-8am			
	General Population	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%
0-4	**8%**	24	104	1,249	12%	13	58	693	11%	7	29	350	10%
5-19	**15%**	38	166	1,994	19%	19	81	967	16%	9	40	484	14%
20-44	**45%**	94	408	4,894	48%	59	254	3,050	51%	35	150	1,802	52%
45-64	**21%**	34	146	1,754	17%	20	89	1,062	18%	13	56	668	19%
65+	**11%**	8	34	411	4%	5	22	259	4%	3	14	173	5%
Total		**198**	**859**	**10,302**		**116**	**503**	**6,031**		**67**	**290**	**3,477**	

CMH UCC: Age demographics of night attendees compared with general population Age profile

		8pm-8am				10pm-8am				12mn-8am			
	General Population	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%	Av. Per Week	Av. Per Month	Total	%
Female	**49.7%**	96	418	5,010	49%	54	232	2,787	46%	29	126	1,508	43%
Male	**50.3%**	102	441	5,287	51%	62	270	3,242	54%	38	164	1,967	57%
Not Known	**0%**	0	0	5	0%	0	0	2	0%	0	0	2	0%
Total		**198**	**859**	**10,302**		**116**	**503**	**6,031**		**67**	**290**	**3,477**	

CMH UCC: Gender demographics of night attendees compared with general population Gender profile

Appendix 4: CMHUCC – Map of night attendees, average per week, 18/19



Appendix 5: CMHUCC – Attendance by GP Practices in Brent, average per week, 18/19

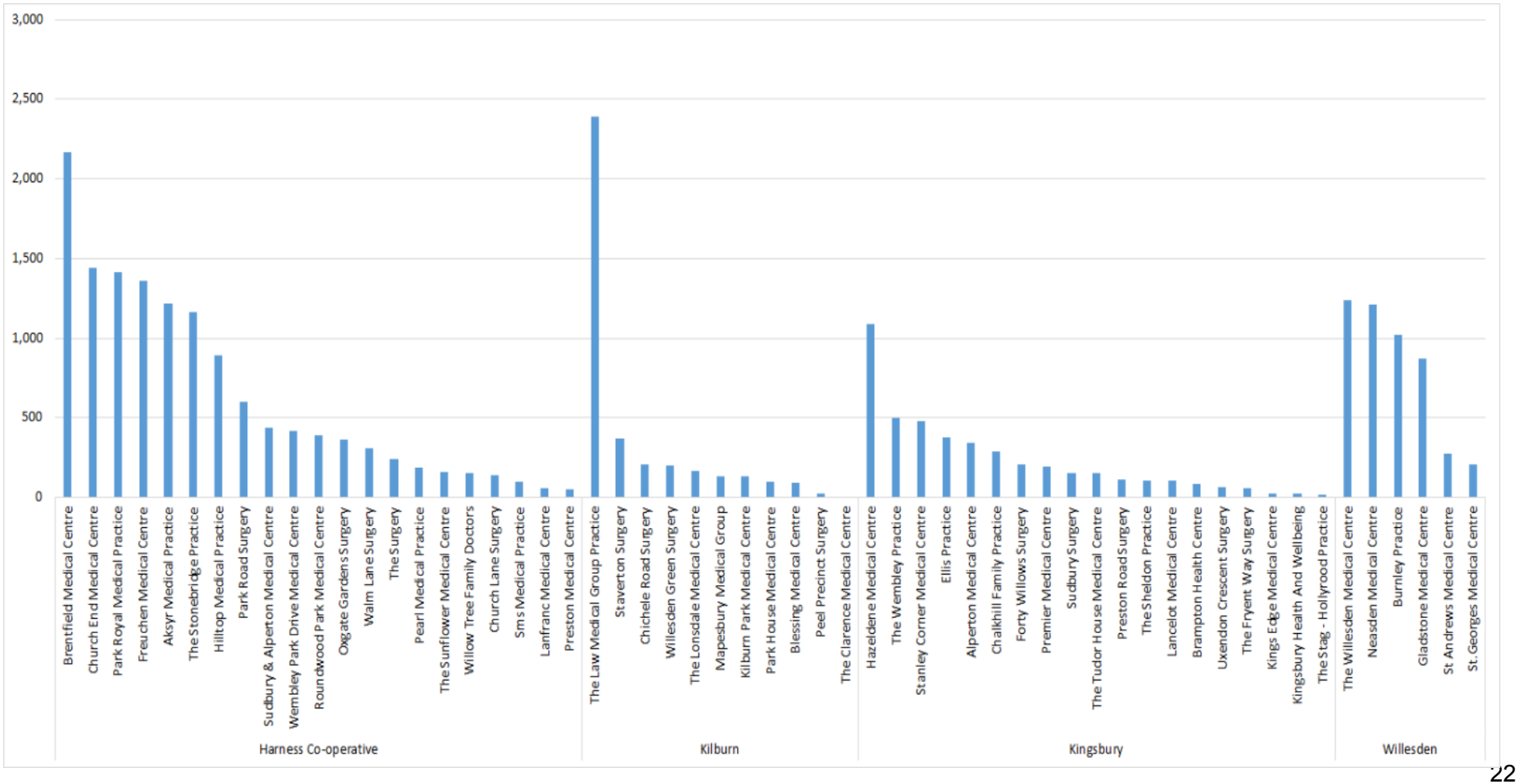
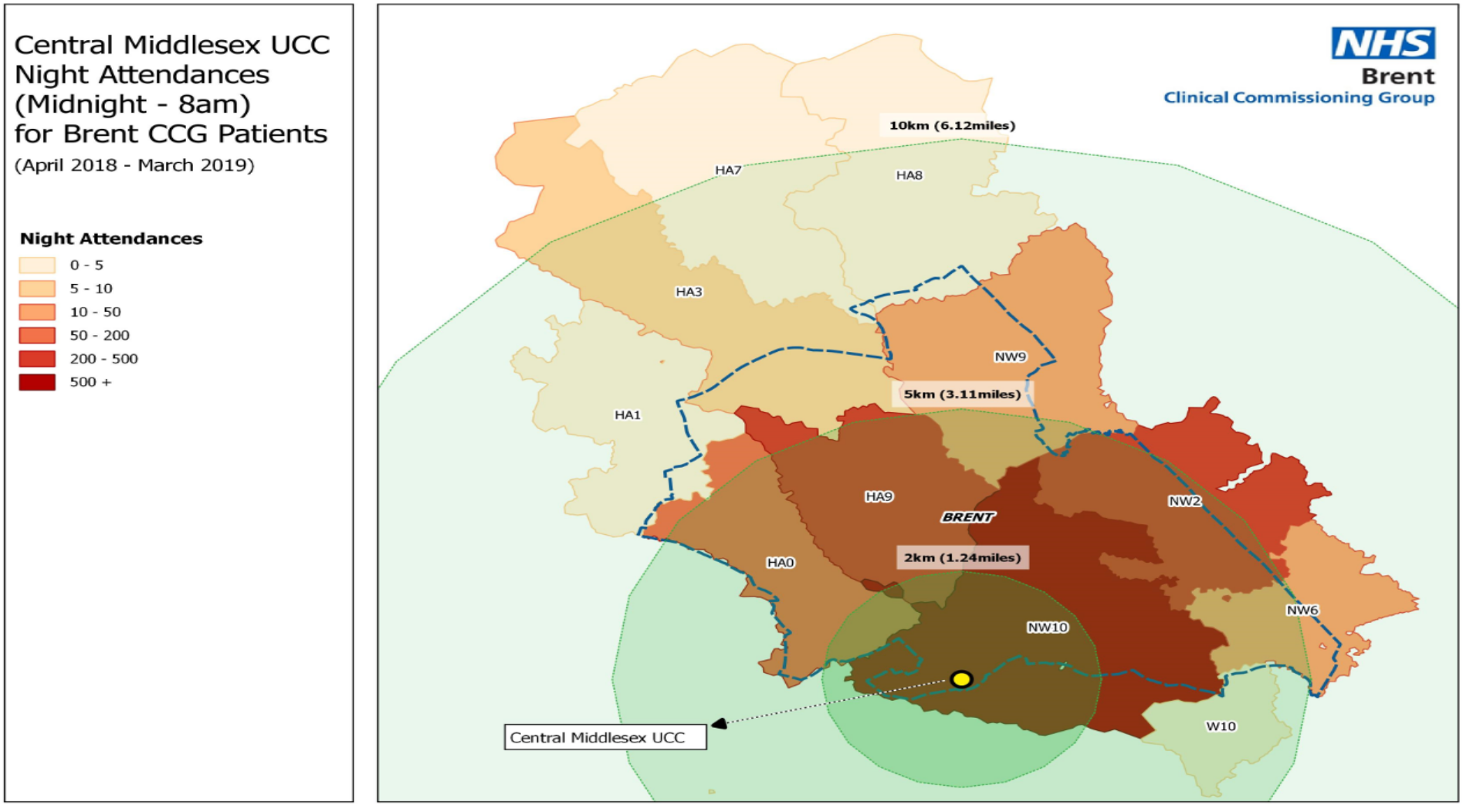


Fig. 4. CMH UCC Attendances by GP Practices in Brent, 18/19

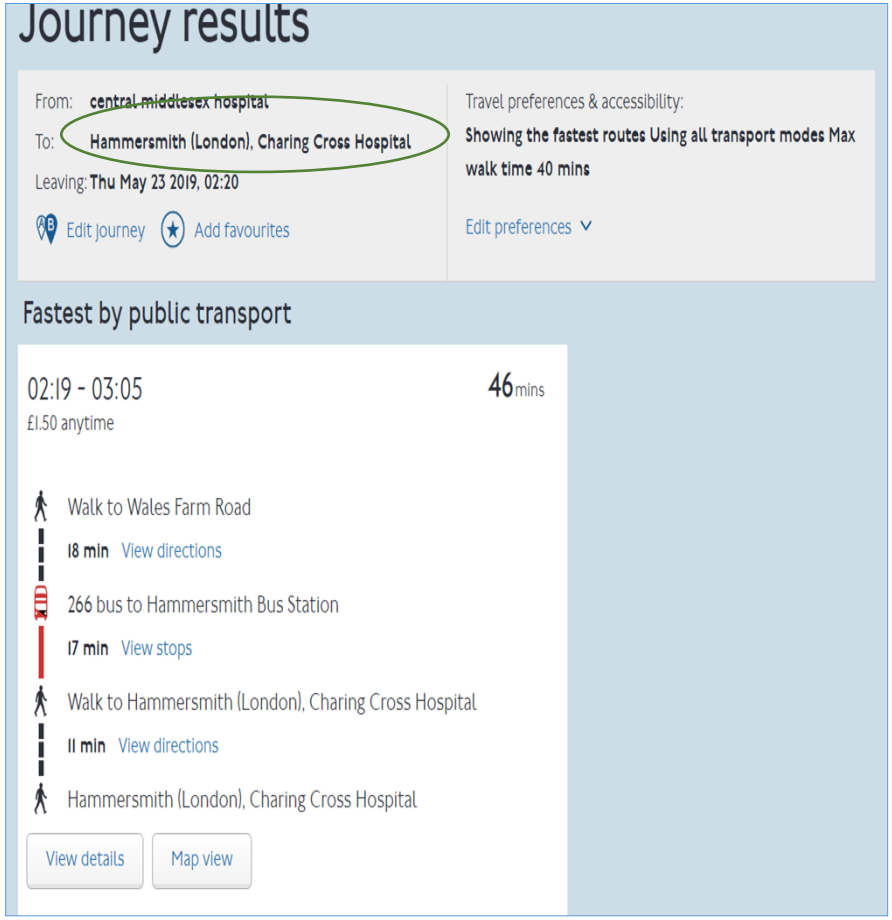
			Attendances								
			8pm-8am			10pm-8am			12pm-8am		
Locality	PracticeName	Attendances	Av. per Week	Av. per Month	Total	Av. per Week	Av. per Month	Total	Av. per Week	Av. per Month	Total
Harness Co-operative	Brentfield Medical Centre	2,165	8	33	392	4	19	223	3	11	131
	Church End Medical Centre	1,445	6	26	311	3	13	161	2	8	91
	Park Royal Medical Practice	1,412	6	26	310	3	14	166	2	9	105
	Freuchen Medical Centre	1,361	4	17	206	3	11	132	2	7	89
	Aksyr Medical Practice	1,218	5	20	234	2	11	129	2	7	78
	The Stonebridge Practice	1,161	4	18	221	3	11	136	2	7	89
	Hilltop Medical Practice	893	4	17	202	2	9	107	1	6	67
	Park Road Surgery	600	2	10	124	1	6	77	1	4	52
	Sudbury & Alperton Medical Centre	437	2	8	99	1	5	54	1	3	35
	Wembley Park Drive Medical Centre	419	2	8	101	1	5	65	1	3	40
	Roundwood Park Medical Centre	390	1	6	74	1	4	44	0	2	19
	Oxgate Gardens Surgery	363	2	8	92	1	4	51	0	2	18
	Walm Lane Surgery	312	1	6	66	1	3	33	0	2	21
	The Surgery	244	1	4	42	0	2	22	0	1	10
	Pearl Medical Practice	185	1	3	35	0	1	17	0	1	8
	The Sunflower Medical Centre	163	1	3	40	0	2	23	0	1	15
	Willow Tree Family Doctors	153	1	3	33	0	2	19	0	1	10
	Church Lane Surgery	143	1	3	31	0	1	16	0	1	9
	Sms Medical Practice	97	0	1	17	0	1	10	0	1	6
	Lanfranc Medical Centre	60	0	1	16	0	1	10	0	1	7
	Preston Medical Centre	49	0	1	13	0	1	12	0	1	8
Kilburn	The Law Medical Group Practice	2,394	9	38	457	5	23	270	3	13	152
	Staverton Surgery	370	2	9	102	1	6	66	1	3	35
	Chichele Road Surgery	208	1	4	52	0	2	25	0	1	13
	Willesden Green Surgery	201	1	4	53	1	3	30	0	1	14
	The Lonsdale Medical Centre	169	1	4	43	0	2	23	0	1	10
	Mapesbury Medical Group	135	1	4	42	1	2	28	0	2	21
	Kilburn Park Medical Centre	133	1	3	32	0	2	20	0	1	9
	Park House Medical Centre	101	1	2	28	0	1	17	0	1	10
	Blessing Medical Centre	91	0	1	17	0	1	8	0	0	4
	Peel Precinct Surgery	24	0	0	4	0	0	3	0	0	2
	The Clarence Medical Centre	2	0	0	0	0	0	0	0	0	0
	Total A	17,098	67	291	3,489	38	166	1,997	23	98	1,178

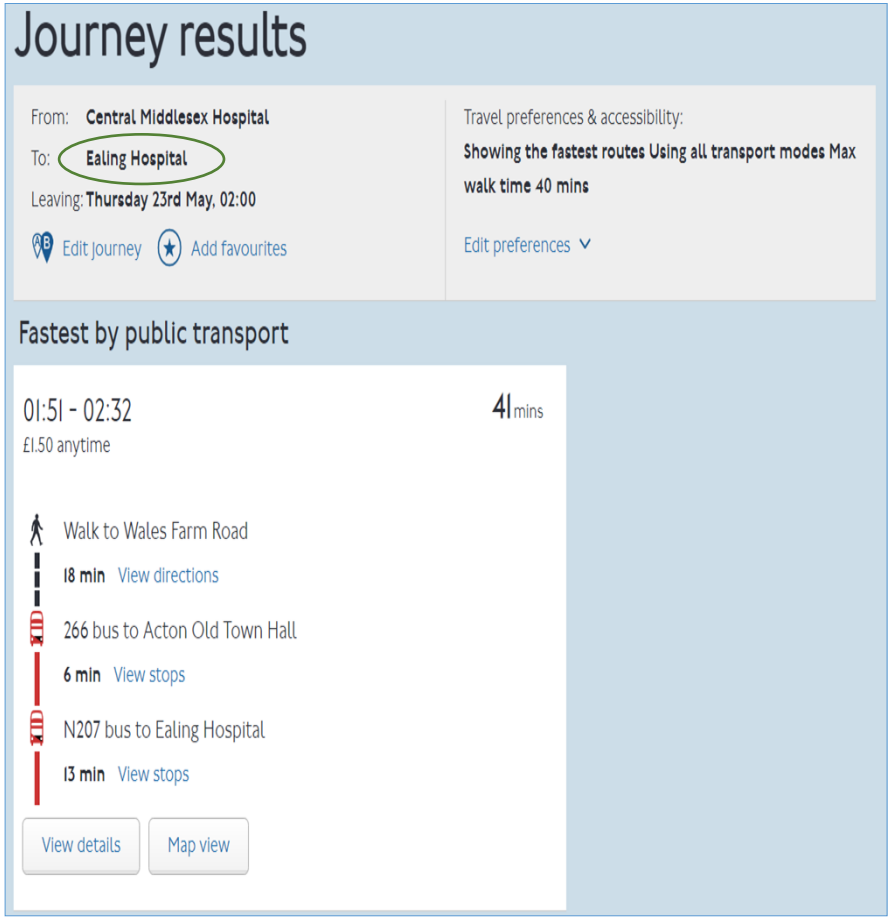
			Attendances								
			8pm-8am			10pm-8am			12pm-8am		
Locality	PracticeName	Attendances	Av. per Week	Av. per Month	Total	Av. per Week	Av. per Month	Total	Av. per Week	Av. per Month	Total
Kingsbury	Hazeldene Medical Centre	1,090	4	17	204	2	9	106	1	5	55
	The Wembley Practice	502	2	8	99	1	4	48	0	2	25
	Stanley Corner Medical Centre	481	2	7	82	1	4	52	1	3	32
	Ellis Practice	379	2	8	101	1	5	63	1	2	29
	Alperton Medical Centre	342	1	5	60	1	3	34	0	2	19
	Chalkhill Family Practice	293	2	7	88	1	4	45	0	2	22
	Forty Willows Surgery	205	1	4	53	1	3	37	0	2	20
	Premier Medical Centre	195	1	3	37	0	2	19	0	1	8
	Sudbury Surgery	156	1	2	27	0	1	16	0	1	8
	The Tudor House Medical Centre	152	1	3	33	0	2	18	0	1	11
	Preston Road Surgery	114	1	2	27	0	1	9	0	0	4
	The Sheldon Practice	107	0	2	22	0	1	15	0	1	9
	Lancelot Medical Centre	105	0	2	19	0	1	11	0	1	8
	Brampton Health Centre	83	0	2	22	0	2	18	0	1	9
	Uxendon Crescent Surgery	66	0	2	18	0	1	11	0	1	6
	The Fryent Way Surgery	57	0	1	7	0	0	3	0	0	1
	Kings Edge Medical Centre	28	0	1	6	0	0	4	0	0	2
	Kingsbury Health And Wellbeing	28	0	0	4	0	0	2	0	0	1
	The Stag - Hollyrood Practice	17	0	0	2	0	0	2	0	0	2
Willesden	The Willesden Medical Centre	1,241	5	23	278	3	13	161	2	8	90
	Neasden Medical Centre	1,210	6	24	291	3	15	176	2	8	100
	Burnley Practice	1,023	4	16	196	2	9	109	1	5	58
	Gladstone Medical Centre	873	4	19	222	2	10	118	1	6	73
	St Andrews Medical Centre	275	1	3	38	0	2	22	0	1	7
	St.Georges Medical Centre	210	1	5	58	1	3	32	0	1	15
	Total B	9,232	38	166	1,994	22	94	1,131	12	51	614
	Grand Total (A+B)	**26,330**	**105**	**457**	**5,483**	**60**	**261**	**3,128**	**34**	**149**	**1,792**

Appendix 6: CMHUCC – Map of night attendees and their distance of travel, 18/19



Appendix 7: Illustrative sample of TfL journey details between CMH UCC and neighbouring UCCs





Appendix 6: EHIA screening *(initial)*

Equality & Health Inequality Impact Analysis Screening Tool
CMH UCC

Introduction

The purpose of this Screening Tool is to help you decide whether or not you need to undertake an Equality and Health Inequalities Analysis (EHIA) for your project or piece of work. It is your responsibility as the project lead/policy owner to take this decision having worked through the Screening Tool.

Once completed, please email the CCG's Executive Equalities Lead who will convene an EHIA meeting to sign off the Screening Tool and approve your decision i.e. to either undertake an EHIA or not to undertake an EHIA.

When completing the Screening Tool, we suggest you consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

NHS England has agreed an additional definition which relates to inclusion health and people with lived experience. Inclusion health has been used to define a number of groups of people who are not usually provided for by healthcare services and covers people who are *homeless, rough sleepers, vulnerable migrants, sex workers, Gypsies or Travellers and other multiply excluded people.* The definition also covers *Female Genital Mutilation (FGM), human trafficking and people in recovery.* Please consider these groups too in your analysis.

Part A

Title of procedural document: Access to Urgent Care Centre in Central Middlesex Hospital in Brent

Proposals:
The Urgent Care Centre currently opens 24 hours per day, 7 days per week. Brent CCG is considering closing the Centre overnight, due to underutilisation. A Communications and Engagement Plan has been created to support this piece of work.

Current opening times	New closing times	New opening times
24 hours, 7 days per week	12 midnight to 8 am	8am to 12 midnight

What are the intended outcomes of this work? *Include outline of objectives and function aims*

A review of urgent care services in Brent has indicated that the CMH UCC is under-utilised and does not offer value for money. After an analysis of three potential options, the option to close from midnight to 8am was adopted.

- UCC attenders can be diverted during these hours to alternative options including digital offer (ie e-consult)[1], NHS 111 (telephone), NHS 111 Online[2], next day primary care services, community pharmacies, alternative care pathways, Health Help Now App, mini DOS (mini Directory of Services).

The aim of this EHIA is:

- To better understand the impact on the nine protected characteristic groups of the proposals outlined above
- Examine any barriers to accessing relevant care for these groups
- Examine benefits of current digital technologies for accessing healthcare for these groups
- It is important to undertake this analysis from the user-perspective, to focus on the various impacts as patients may experience them. With this in mind, the CCG held a workshop with community groups to develop this EHIA on 13th June.

Who will be affected? *e.g. patients, staff, service users etc.*

- Patients who attend CMH UCC overnight
- Staff working the night shift at CMH UCC
- Other urgent care providers such as UCCs at Ealing Hospital, St. Mary's Hospital, Charing Cross Hospital and Northwick Park Hospital

Evidence

What evidence have you considered? *List the main sources of data, research and other*
sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.

Demographic background of Brent

Brent is an outer London borough in North West London. It has a population of 336, 659[3] with a population density of 76.8 persons per hectare. The population has grown

[1] http://brentccg.nhs.uk/en/digital

[2] https://111.nhs.uk/

[3] Brent Joint Strategic Needs Assessment, 2015

significantly since 2001 and is predicted to continue to grow (see Fig. 1). Wembley Central and Kensal Green wards have seen the largest growth in population in the borough, with the least growth being in Kenton and Northwick Park wards. It is part of the NW London Collaboration of CCGs which includes eight London Boroughs and is also part of the NW London Health and Care Partnership (or STP).

2001	2011	2018	2021	2026
263,500	311,000	336, 659	346, 437	363, 285

Figure 1: Projections for population growth

Brent currently has 56 GP practices with a registered population was 392,366 (May 2019). The CCG is responsible for its registered population. A patient does not necessarily have to live in Brent to be registered with a Brent GP.

Figure 2: GP practice distribution in Brent

The Brent population is young, dynamic and growing. Our long history of ethnic and cultural diversity has created a place that is truly unique and valued by those who live and work here.
Despite these strengths Brent is ranked amongst the top15 % most-deprived areas of the country. This deprivation is characterised by high levels of long-term unemployment, low average incomes and supported through benefits and social housing. Children and young people are particularly affected with a third of children in Brent living in a low-income household and a fifth in a single – adult household.

The proportion of our young people living in acute deprivation is rising. Living in poverty generally contributes to poorer health, wellbeing and social isolation. Statistics show that people on low incomes are more likely to have a life limiting health condition, take less exercise and have a shorter life. While overall life expectancy is in line with the rest of London there are significant health inequalities within the borough.

Our diversity is a great strength and our various communities are valuable assets to bring about real change for families and individuals. But at the same time, many new communities are still not accessing the information and services available to help them improve their health and wellbeing. Furthermore, the area has high levels of migration in and out of the borough, and significant ethnic and cultural diversity:

- 64.7% of the population is Black, Asian or other minority ethnicity (BAME).
- Life expectancy between the most affluent and the most deprived parts of the borough is 8.8 years.
- People between 0 – 15 y/o comprise 21% of the total population. That 16-64 y/o, working age population makes up 67.8% of the population and the 65 and over population makes up 11.3% of the population.
- Brent has the largest proportion of residents born abroad (55%). This ranges from Asia (23%), followed by Europe (18%) and Africa (10%) to Central and South America (3%) and North America (1%). 14.5 per cent of households have no people that speak English as a main language; this is the thirteenth highest proportion in England & Wales.

The Central Middlesex Hospital (CMH) Urgent Care Centre (UCC)

Brent CCG has completed extensive analysis of attendance at the CMH UCC. This was used to successfully present a case for change to the CCG Executive on March 2019. A decision to consult on proposals is pending a Governing Body meeting on 26th June, at which a Business Case will be presented. This EHIA will be included in the supporting documents.

The following factors have been considered:

- Brent CCG will need to commission revised services in line with the new national specification for urgent treatment centres in 2019
- Opportunity to review current urgent care services and determine whether changes need to be made
- Based on current service utilisation the CMH UCC does not provide value for money
- Workforce challenge of resourcing over night shifts
- Suitable alternative urgent care provision is available including Northwick Park, St. Mary's, Charing Cross and Ealing UCCs
- Brent CCG is rolling out e-consultation for GP practices which will improve timely access and reduce the need for face to face consultation

1. Age. *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*

Demographics

Brent has a young population. The proportion of people aged 20-40, is higher than England, but in line with London. People between 0 – 15 years comprise 20.9% of the total population. The 16-64, working age population makes up 67.8% of the population and the 65 and over population makes up 11.3% of the population. Important to note that the older population is growing at a higher rate than the adult population, which will have an impact on population health and service commissioning.

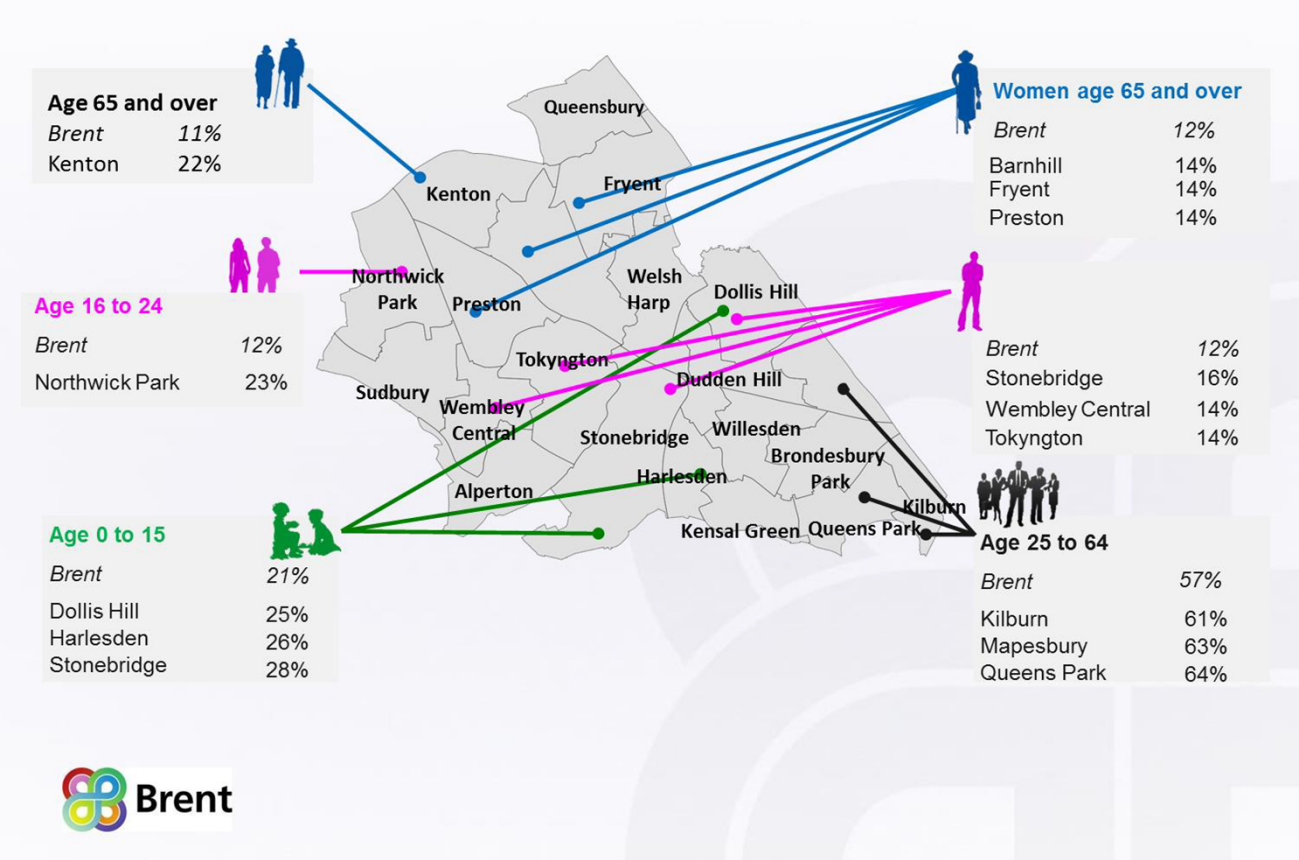


Figure 3: Cross borough distribution by age

Urgent Care Centre Activity Profile

Activity data for the last two years shows an average 8 people attended the service between 12 midnight and 8am. Approximately 71% of attendances are by working age adults, 24% are 0-19 years and 5% 65+ years. 0-4 year olds represent 10% (7 children per week) of all patients using the CMH UCC between 12 midnight and 8am. See Appendix 2 for details.

Consideration needs to be given to access to alternative services for these age categories. There are a number of services including digital, telephone and face to face, which are available 24 hours a day, 7 days a week. Digital services include 111 online, Health Help Now App. Patients and/or their carers may also access 111 by phone for urgent advice.

In terms of face to face services, alternative UCCs exist at Northwick Park, Charing Cross and Ealing Hospitals. There appears to be a nominal impact for this cohort of people, as some of them may potentially have to travel further to access alternative UCCs (see table 1). Transport links have been analysed to describe access to alternative urgent care services by car and public transport.

UCC	Distance	Travel time by car at 2am	Travel time by public transport at 2am

Northwick Park	6.4 miles	16-18 minutes	Up to 42 minutes
Ealing	6.7 miles	14-20 minutes	1 hour to 1 hour 20 minutes
Charing Cross	5.4 miles	16-22 minutes	48 minutes to 1 hour 20 mins

Table 1: Distance from CMH UCC to nearest UCCs by car and public transport[4]

CMH UCC is situated in Park Royal, which is in the south of the borough. In Brent, deprivation is more generally distributed in the south. The majority of people who attend the UCC are from the NW10 or NW2 post codes, which include Brent's most deprived wards[5]. People from lower socio-economic groups tend to be the most common users of walk-in centres[6]. The percentages of people affected by income deprivation and child poverty are higher in the south. The majority of people on low incomes tend not to have access to a car and face a number of barriers in accessing healthcare that relate both to problems with travel and the location of service[7]. Although there are good bus routes outside the CMH location, the impact of travelling to more distant UCCs on those in the more deprived wards near the CMH UCC may be significant due to potential financial constraints that prohibit them accessing public transport[8]. Parents with young children may experience anxiety about taking children late at night, by public transport, to sites that are distant and unfamiliar.

This impact can be mitigated by providing information on the range of alternative urgent care services that are available and/or do not require travel far from home. These include digital and telephone-based service options such as 111 on line, 111 by phone and Health Help Now App, which provide people with advice and sign posting to appropriate care. However, this will be sense checked with local people as part of our engagement.

2. Disability. *Consider and detail (include the source of any evidence) on attitudinal, physical and social barriers.*

Demographics

Physical disability and sensory impairment

Currently, 4% of residents in Brent were assessed as being permanently sick or disabled. Estimates suggest that around 14,900 people in Brent aged between 18 and 64 have a moderate physical disability. This represents 7% of the total population who are aged

4 https://www.google.com/maps/dir/Central+Middlesex+Hospital,+Acton+Ln,+Park+Royal,+London+NW10+7NS/Charing+Cross+Hospital,++Palace+Rd,+Hammersmith,+London+W6+8RF/@51.5090615,-0.2682902,14z/data=!3m1!4b1!4m18!4m17!1m5!1m1!1s0x487611edb739e1c7:0x69bc49a31336efe1!2m2!1d-0.2686757!2d51.530965!1m5!1m1!1s0x48760fbbc7f7ed75:0x6cd065c43bb8bbf5!2m2!1d-0.2207573!2d51.4870272!2m3!6e0!7e2!8j1558663500!3e0

5 Deprivation, Brent JSNA (2015)

6 Monitor. Walk-in centre review: final report and recommendations. February, 2014. www.monitor.gov.uk

7 Social Exclusion Unit (2003): 'Making the Connections', p.37

8 Social Exclusion Unit (2003): 'Making the Connections', p.37

between 18 and 64, which is similar to the England average of 8%. The Brent JSNA Summary Report, (2014/15) suggests that:

- By 2030, the number of people aged 18 to 64 in Brent who will have a moderate physical disability will be 16,725, an increase of 12% from 2014;
- By 2030, the number of people aged 18 to 64 who will have a severe disability will be 4,763, an increase of 16% from 2014;
- The number of people aged 65 and over who are unable to manage at least one self-care activity living on their own will rise to 17,590 in 2030, from 11,516 in 2014.

Hearing impairment

Current estimates suggest that 20% of people in Brent aged between 65 and 74 are living with a moderate or severe hearing impairment. With age, the incidence of people with a hearing impairment increases. Estimates show that 11,065 people in the borough aged 75 and over have a moderate or severe hearing impairment.

Visual impairment and sight deterioration

As with hearing impairment, sight loss can affect people of all ages and can impact a person's independence. Older people are particularly at risk of sight loss. Around 2 million people in the UK live with sight loss and by 2050 this is predicted to double to 4 million. Current estimates show that 2,021 people aged 75 and over in Brent are predicted to have a moderate or severe visual impairment (figure 41). This represents 12% of the population aged 75 and over in Brent. By 2030, 3,001 people aged 75 and over are predicted to have a moderate or severe visual impairment. This equates to a 48% increase on current predictions.

Adults with autism

National estimates are that approximately 1% of the adult population are regarded as having an autistic spectrum disorder (ASD). Currently estimates are that 2,158 adults aged 18 to 64 in Brent have an ASD. National rates of ASDs are higher in adult males (1.8%) compared to females (0.2%) 37. Forecasts show that between 2014 and 2030 the number of adults aged 18 to 64 with an ASD in Brent is predicted to rise by 10% overall (figure 37), with males accounting for the majority (Brent JSNA Highlight Summary Report, Winter 2014/15 NHS Brent CCG and LB Brent)

Adults with learning disabilities

Between 2014 and 2030, the number of adults aged 18 to 64 with a learning disability is predicted to rise by 8%. Furthermore, the number of adults aged 65 and over in Brent predicted to have a learning disability is projected to increase by 52% between 2014 and 2030. Accommodation is a key factor for people with learning disabilities and settled accommodation can have a strong impact on their quality of life, safety and social inclusion. In 2011/12, 73% of people aged 18 to 64 with a learning disability were living in settled accommodation in Brent (figure 39). This equates to 510 adults and is above the England average of 70% and the London average of 65.7%.

Urgent Care Centre - Activity Profile

Data regarding disability status for attendees at UCC is not available. However, from data analysis all attendees are walk-in (i.e. are not conveyed by ambulance nor directed by 111). 91% of attendees are discharged with no investigations and no significant treatment.

Barriers, Impact and Mitigation

Physical access/transport can act as a barrier to healthcare for disabled people. Any patient being directed to UCCs by 111 or other, have to make their own way to those services. Public transport links are accessible to people with physical disabilities that may use a wheelchair. However, similarly to parents with young children, there may be some anxiety about travelling to distal unfamiliar sites outside Brent.

There is no anticipation that this cohort of patients would be adversely affected by the closure of CMH UCC overnight. They will be diverted to the nearest alternative urgent care services. There are good public transport links between the CMH UCC and the UCC at Northwick Park Hospital. Alternative UCCs in Northwick Park Hospital, Ealing Hospital, Charing Cross Hospital are purpose-built sites, with a range of adjustments in place to meet the needs of people with disabilities. Drop off zones near reception areas are available for people being dropped off by car or taxi. Clearly marked disabled car parking spaces are available at these sites. These are free to those who are registered disabled and have a Blue Badge. Pedestrian entrances at the alternative UCCs are suitable for wheelchair users. The sites also have disabled toilets in key locations. Both digital and telephone services offer a route to GP care without the need for a person to travel for an initial conversation.

Those with visual impairment can experience difficulties making their way to clinic sites. UCCs are furnished with signage and people can receive directions on site to get to the service via reception. Those with hearing impairment may have difficulties hearing information given during their UCC appointment. Written information is provided.

Depending on their sensory impairment patients may be able to use alternative services such as NHS 111 online or telephone respectively. E-consultation might make access easier for this group – e.g., a 'playback' voicemail facility. Using written or text (SMS) communications may also reduce any negative impact for people with hearing impairments.

The needs of those with sensory impairment will be further sense checked during engagement through discussions with the voluntary sector with special interest in disability. The accessible information standard offers an opportunity for further improvements.

Although the data suggests that there is likely to be a lower proportion of patients with disabilities accessing CMH UCC services, it will be important to take into consideration accessibility of alternative services during the decision-making process – taking into account mobility issues and distance of travel.

Patients with a learning disability are known to face barriers accessing healthcare services[9]. They tend to be lower users of Urgent Care Services than other sections of the population. There is no data available on people with learning disabilities using the CMH UCC. Brent patients should be encouraged to bring a copy of their LD

[9] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities

Passport with them should they attend a UCC to improve the quality of experience and outcomes. The passport gives UCC staff important information about them and how they prefer to communicate, their medical history and any support they might need while at the UCC. If they don't bring one, UCC staff can consider providing them with a blank copy to complete for themselves or with help from their carer. Patients with learning disabilities may experience anxiety over the prospect of travelling to less familiar services outside the borough. Local service data does not reflect high attendance from this cohort, therefore, impact cannot be measured.

Patients with mental health conditions that mean that leaving their home is a challenge (or their carers) may access advice from 111 online and/or telephone, Health Help Now App 24 hours per day, 7 days per week. The GP e-consult offer could provide a route to GP care without the need for a person to travel for an initial conversation.

Any potential negative impacts for this cohort may be mitigated by providing information on the range of alternative urgent care services that are available and/or do not require travel far from home. These include digital and telephone-based service options such as 111 on line, 111 by phone and Health Help Now App, which provide people with advice and sign posting to appropriate care. However, this will be sense checked with local people as part of our engagement work.

3. Gender reassignment. *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment*

Demographics
It has been estimated that there are 20 transgender people per 100,000 population in the UK.

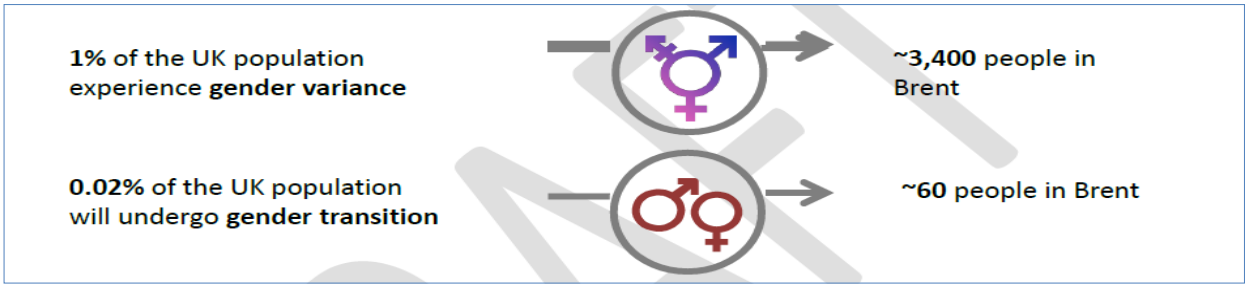


Figure 4. Estimated make of Brent people who are lesbian, Gay, Bisexual, experience gender variance or may undergo gender transition.

Urgent Care Centre – Activity Profile

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of CMH UCC overnight (and being diverted to other alternative urgent care services), However, we will sense check this with LGBTQ groups during our engagement process.

Barriers, Impact and Mitigation

Research shows Transgender people face widespread discrimination in healthcare settings. One in seven LGBTQ people (14 per cent) avoid seeking healthcare for fear

of discrimination from staff[10]. Although there is relative paucity of available evidence, the little that is available indicates that transgender people experience health inequalities[11], including sexual health inequalities, which may include higher rates of STIs, and difficulties accessing services and relevant information. One in seven LGBTQ people (14 per cent) have avoided treatment for fear of discrimination because they are LGBTQ. Some individuals who have undergone gender reassignment may have a greater need for privacy when accessing services than other sections of the population. The first appointment of the day may be preferred if waiting areas are less occupied, offering the most discretion. Closing the UCC overnight may have no impact on this group given the preference for daytime appointments.

Digital access might help in offering the confidentiality sought by the transgender community for initial consultations and a 'safe space' for healthcare. The CCG is also investigating options to roll out an initiative called "Pride in Practice" to help address feedback and reduce health inequalities for this protected group.

We will seek to sense check this information with transgender persons as part of our engagement process. There is a data gap when it comes to the LGBTIQ community due to a lack of robust equality monitoring. When rolling out the digital offer, it may be worth considering addressing this by ensuring a robust and consistent monitoring approach across commissioned services.

Gender Reassignment is not a factor that influences eligibility or access to the service changes being consulted on. Therefore, it is not anticipated that service users will be disproportionately affected by the proposals.

4. Marriage and Civil Partnership

Demographics GP recording of marriage and civil partnership exists but is not of sufficient quality to carry out analysis.

Barriers, Impact and Mitigation
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Brent UCC overnight (and being diverted to other alternative urgent care services). However, this will be sense checked with local people as part of our engagement.

5. Pregnancy and maternity

Demographics
No data available

Barriers, Impact and Mitigation

The maternity status of the patient is not a factor that influences eligibility or access to the services changes being consulted on. However, not unlike other vulnerable groups,

[10] https://www.stonewall.org.uk/lgbt-britain-health
[11] Transgender Sexual and Reproductive Health: Unmet Needs and Barriers to Care April 2012 National Centre for Transgender Equality

pregnant women may experience anxiety travelling to unfamiliar distal sites for urgent care services.

Urgent Care Centre - Activity Profile

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Brent UCC overnight and being diverted to other alternative urgent care services. A smaller proportion of women attend the UCC in the night compared to the day.

It is worth noting that NHS England considers it advisable for women who are pregnant or planning to become pregnant to have on-going face to face consultation and review, therefore a digital offer might be of less use to this cohort.

6. Race. Consider and detail (including the source of any evidence) **on different ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers**

Demographics

Brent is ethnically diverse: 64.7% of the population is Black, Asian or other minority ethnicity (BAME). The Indian ethnic group currently makes up the largest minority group representing 17.6% of the population, followed by Other Asian (12%). The White ethnic group represents 33%. to the London average and larger than average proportions from the 'Mixed' and 'Arab' categories.

Night attendances at UCC by ethnicity (Ethnic profile of service users during the day very similar to during the night) – see Appendix 2 for details.

Barriers, Impact and Mitigation

Urgent Care Centre – Activity Profile

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Brent UCC overnight (and being diverted to other alternative urgent care services), this will be sense checked with local people as part of our engagement.

Evidence from a range of studies have highlighted the barriers experienced by Black, Asian and Minority Ethnic Groups (BAME) in accessing healthcare services. Some of the main reasons for poor satisfaction have been cited as poor language proficiency; lack of acculturation, and provider side discrimination (stereotyping and bias).

Community engagement undertaken to date suggests that the availability of an accessible route for an interpreter is highly important for BAME groups who experience language barriers. It would therefore be important to consider how services could better meet these accessibility needs and to engage BAME groups and relevant community and voluntary sector leads when promoting and explaining how to access services in general.

For the service change being proposed, this issue is not anticipated as likely to have an adverse impact. However, in terms of proposed plans to sign post patients to alternative urgent care services, the CCG would be advised to engage with community groups to ascertain the most effective ways of signposting patients who experience language barriers to the available services. The alternative services, as listed previously, such as NHS 111 have language interpretation services available. Any potential negative impacts

for this cohort may be mitigated by providing information in a range of languages and services such as 111 (telephone), as mentioned above. The CCG may need to gather information on language interpretation service offer at alternative UCCs for Brent patients. However, it is not anticipated that Brent patients experiencing language barriers would be worse off if sign posted to other similar services elsewhere. There are no immediately apparent reasons why BAME groups would be disproportionately impacted by proposed changes. The engagement process will allow us to sense check this with local people.

Patients for whom language makes access a challenge may be less confident leaving their home to travel out of borough for services. As above, access advice from 111 telephone is available 24 hours per day, 7 days per week. GP services have access to language interpretation services, which can be used for e-consult and also provide a route to GP care without the need for a person to travel for an initial conversation.

7. Religion or belief. Consider and detail (including the source of any evidence) **on people with different religions, beliefs or no belief**
Demographics

Information from the 2011 Census suggests the most common religion in BRENT is Christianity (54%), followed by Islam (10%).

Estimated religion of patients attending the Urgent Care Centre based on 2011 Census data applied to location of attendances.

Barriers, Impact and Mitigation

Urgent Care Centre – Activity Profile

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Brent UCC overnight (and being diverted to other alternative urgent care services), However, we will sense check with local people as part of our engagement.

Brent Council has a Social inclusion Forum which brings together key officers from public, private, voluntary, community & faith sector organisations to deliver improved social inclusion outcomes for local residents. The CCG will contact that group to engage with them over the coming months. We also plan to engage with Brent Multi-Faith Forum.

Digital and phone services Offers more choice for appointments at times that do not conflict with religious / faith commitments

Some faith groups restrict how women (and sometimes children) interact with health providers e.g. some women not able to see GP without permission from husband or other male in household or without male accompanying them. Online consultation allows for this to happen from own home.

Introducing a digital method of accessing care may allow women greater freedom in being able to access care in their own home; however, this is of course dependent on their level of digital access at home. Timings for religious activities such as prayer can make attending set appointment times outside the home more challenging. It is possible that a digital offer could make this easier, depending on appointment times etc within this.

8. Sex. *Consider and details (including the source of any evidence) on men and women (potential link to carers below)*

Demographics

According to the 2011 census, there were 1,721 more males (156, 468) than females (154,747) in Brent, giving a gender ratio of 50.3 to 49.7.

Urgent Care Centre – Activity Profile

A smaller proportion of women attend the UCC in the night compared to the day. See Appendix 2 for details.

Barriers, Impact and Mitigation

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of CMH UCC overnight (and being diverted to other alternative urgent care services), However, we will sense check with local people as part of our engagement.

Young white males have been shown to be unlikely registered in primary care and use services of greater convenience such as walk-in services[12]. A digital offer could potentially be developed which helped to target key messages to this cohort via approaches such as app notifications. There is also research suggesting that women attempt self-treatment more often and are more likely to consult a lay person for support. The digital offer such as Health Help Now App includes a symptom checker and offers self-care advice.

9. Sexual orientation. *Consider and detail (including the source of any evidence) on heterosexual people, as well as lesbian, gay and bi-sexual people*

Demographics

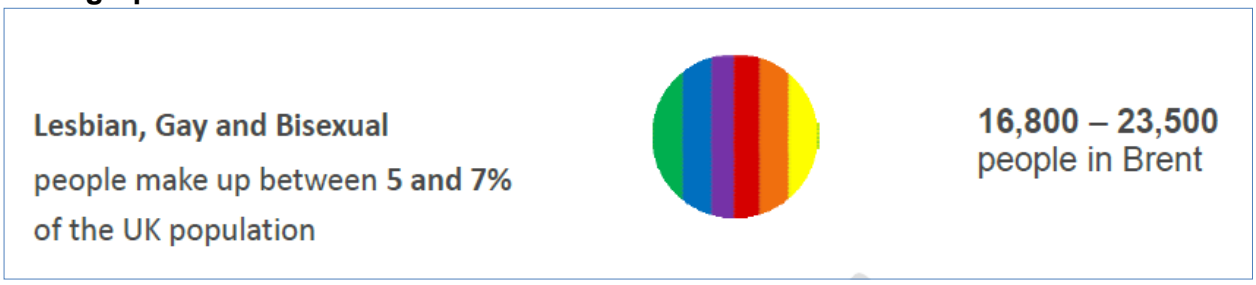


Figure 5: Proportion of LGB in Brent

- Around 3.3 million lesbian, gay and bisexual people in England - Stonewall
- 1.7% of adults in the UK identify themselves as lesbian, gay or bisexual
- 2.5% in London. 3.3% of 16-24 year olds identify as gay, lesbian or bisexual – annual population survey 2015

There is a data gap when it comes to the LGBT community, as the sexual orientation monitoring standard is less well established and has not been fully embedded across

[12] Monitor. Walk-in centre review: final report and recommendations. February, 2014. www.monitor.gov.uk

providers. When introducing a digital offer it may be worth considering addressing this by ensuring a robust and consistent approach towards this monitoring across BRENT practices.

Barriers, Impact and Mitigation

Research shows LGBTQ people face widespread discrimination in healthcare settings. One in seven LGBTQ people (14 per cent) avoid seeking healthcare for fear of discrimination from staff[13], including sexual health inequalities, which may include higher rates of STIs, and difficulties accessing services and relevant information. One in seven LGBTQ people (14 per cent) have avoided treatment for fear of discrimination because they're LGBTQ.

Historic social or health system discrimination can impact a patient's comfortableness during a consultation for example those who identify as Lesbian, Gay or Bisexual were about one and a half times more likely to report unfavourable experiences especially relevant to primary care intervention. Engagement with young LGB persons undertaken to date suggests that this is an issue locally, as it is nationally, which needs addressing. Digital access might help in offering the confidentiality sought by the LGB community for initial consultations and a 'safe space' for healthcare.

We will seek to sense check this information with transgender persons as part of our engagement process. There is a data gap when it comes to the LGBTIQ community due to a lack of robust equality monitoring. When rolling out the digital offer, it may be worth considering addressing this by ensuring a robust and consistent monitoring approach across commissioned services.

10. Carers. *Consider and detail (including the source of any evidence) on part-time working, shift- patterns, general caring responsibilities.*

Demographics

GP recording of provision of unpaid care is a significant undercount compared to 2011 Census data and can therefore not be reliably analysed. Census data identifies around 1 in 14 local residents in Brent who provide unpaid care (7%). Around 1 in 70 residents provide 50 or more hours a week.

Barriers, Impact and Mitigation

Urgent Care Centre – Activity Profile

Carers may have to travel to distal or out of borough sites for walk in services. The development of the digital first offer may also help this cohort of residents' access primary or urgent care in a more convenient way without the need for a face to face attendance. Often carers of disabled people use the internet to access services. Carers may benefit from use of a digital first offer as this will allow them to consult a primary care practitioner whilst continuing with their care responsibilities.

[13] https://www.stonewall.org.uk/lgbt-britain-health

Local carers have expressed preferences for continuity of care, which is much less likely to be available via urgent care centres. GP e-Consult offers that continuity with the added benefit of being virtual, thereby eliminating the need to travel to initial appointment. Brent CCG will engage with Brent Carers Centre. It will be important to consider the needs of carers in any new offer and to engage with carers.

11. Other identified groups

NHS England has agreed an additional definition which relates to inclusion health and people with lived experience. Inclusion health has been used to define a number of groups of people who are not usually provided for by healthcare services and covers people who are **homeless, rough sleepers, vulnerable migrants, sex workers Gypsies or Travellers** and other multiply excluded people. The definition also covers **Female Genital Mutilation (FGM), human trafficking and people in recovery**. Please consider these groups too in your analysis

Demographics
Data regarding other identified groups' status for attendees at UCC is not available.

Barriers, Impact and Mitigation

Urgent Care Centre – Activity Profile

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Brent UCC overnight (and being diverted to other alternative urgent care services). However, this will be sense checked with local people as part of the engagement.

Recently arrived migrants may experience barriers to accessing GP services due to stigma, lack of understanding of how services work and a lack of community networks. Some might benefit from widening access to incorporate a digital offer, and it will be important to consider the need to undertake outreach and advertising once decisions have been made around the future of primary and urgent care to ensure that this and other community groups are aware of what is available to them from their local NHS. We have not identified data to suggest that this cohort of attendees would be adversely affected by the reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. However, this will be sense checked with local people as part of the engagement.

While some of these groups might not use the digital access route themselves it is hoped that they will benefit indirectly, from the increased capacity of healthcare services with more patients accessing the right care first time.

12. Consider and detail (including the source of any evidence) on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access

Demographics

Brent is ranked amongst the top15 % most-deprived areas of the country. This deprivation is characterised by high levels of long-term unemployment, low average incomes and supported through benefits and social housing. Children and young people

are particularly affected with a third of children in Brent living in a low-income household and a fifth in a single – adult household.

The proportion of our young people living in acute deprivation is rising. Living in poverty generally contributes to poorer health, wellbeing and social isolation. Statistics show that people on low incomes are more likely to have a life limiting health condition, take less exercise and have a shorter life. While overall life expectancy is in line with the rest of London there are significant health inequalities within the borough.

Attendances to UCC by area deprivation (IMD 2015) – night and day

People from the areas surrounding the UCC may have slightly lower rates of illness and disability compared to London and deprivation is broadly similar

Barriers, Impact and Mitigation

Urgent Care Centre - Activity Profile

CMH UCC is situated in Park Royal, which is in the south of the borough. In Brent, deprivation is more generally distributed in the south. The majority of people who attend the UCC are from the NW10 or NW2 post codes, which include Brent's most deprived wards. People from lower socio-economic groups tend to be the most common users of walk-in centres. The percentages of people affected by income deprivation and child poverty are higher in the south.

The majority of people on low incomes tend not to have access to a car and face a number of barriers in accessing healthcare that relate both to problems with travel and the location of service. Although there are good bus routes outside the CMH location, the impact of travelling to more distal UCCs on those in the more deprived wards near the CMH UCC may be significant due to potential financial constraints that prohibit them accessing public transport. Parents with young children may experience anxiety about taking children late at night, by public transport, to sites that are distal and unfamiliar.

This impact can be mitigated by providing information on the range of alternative urgent care services that are available and/or do not require travel far from home. These include digital and telephone-based service options such as 111 on line, 111 by phone and Health Help Now App, which provide people with advice and sign posting to appropriate care. However, this will be sense checked with local people as part of our engagement.

Summary on analysis. *Considering the evidence please summarise the impact of your proposals. Consider whether the evidence shows potential for differential impact; if so, state whether adverse or positive and for which groups. How will you mitigate any negative impacts? How will you include certain protected groups in services or expand their participation in public life?*

The National Framework reflects the new NHS framework and structures created by the Health and Social Care Act 2012 effective from 1 April 2013. Standing Rules Regulations have been issued under the National Health Service Act 2006, and directions are issued under the Local Authority Social Services Act 1970 in relation to The National Framework.

Considering the evidence there is nothing to suggest potential for differential impact and any adverse outcome caused by the closure of Brent UCC overnight (and being diverted to other alternative urgent care services). The development of the digital offer (ie e-consult) may also help residents' access primary and urgent care in a more convenient way without the need for a face to face attendance. Where we have identified barriers for certain protected groups, we are engaging in a continuous process of examining how these can be mitigated and addressed in how we develop our proposals.

It is important to note that although this screening has been a desktop review:

- It has been fully informed by and references feedback from community groups collected by the CCG over the past year and as part of our engagement work.
- Based on the information gathered through this screening process it will be important to sense check our findings with local residents and members of different protected groups. Any gaps in evidence will be addressed via on-going engagement.

Data sources

- Public Sector Equality Report (2018), accessed online: http://brentccg.nhs.uk/en/publications/doc_download/4529-public-sector-equality-duty-report-2018

- Bhatia R, Wallace P. Experiences of refugees and asylum seekers in general practice: a qualitative study. BMC Fam Pract 2007; 8:48

- O'Donnell CA, Higgins M, Chauhan R, et al. Asylum seekers' expectations of and trust in general practice: a qualitative study. Br J Gen Pract 2008; 58:e1–11

- Lindenmeyer A, Redwood S, Griffith L, et al. (2016) Experiences of primary care professionals providing healthcare to recently arrived migrants: a qualitative study. BMJ Open

https://www.stonewall.org.uk/lgbt-britain-health

Source: ONS 2005 (35)

Transgender Sexual and Reproductive Health: Unmet Needs and Barriers to Care April 2012 National Centre for Transgender Equality

The Gender and Access to Health Services Study (2008) University of Bristol (37), Walsh, et al 2004.

Brent CCG Health Partners Forum You Said, We Did Reports on Urgent Care Services January and August 2018

Brent CCG Winter Outreach Engagement Reports

Population Profile, Brent (2018): https://airdrive-secure.s3-eu-west-1.amazonaws.com/brent/dataset/population-change-in-brent---key-facts/2019-03-13T10%3A45%3A14/Population%20change%20in%20Brent%20-%20Summary%20Factsheet%202019-02.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAJJDIMAIVZJDICKHA%2F20190523%2Feu-west-1%2Fs3%2Faws4_request&X-Amz-Date=20190523T082756Z&X-Amz-Expires=300&X-Amz-signature=958cb523ec03ccf949eaf957433f5b9ed52fd61ff5eacd75e84ad54e1c5663c8&X-Amz-SignedHeaders=host (accessed online 23.05.2019)

Health Profile, Brent (2017): https://files.datapress.com/sport/dataset/health-profiles-2017/2017-07-27T15:30:48.60/LSR266%20Public%20Health%20England%20-%20Health%20Profiles%202017%20Brent.pdf (accessed online 23.05.2019)

People and Place, Brent (2015): https://airdrive-secure.s3-eu-west-1.amazonaws.com/brent/dataset/jsna-2015---people-and-place/2018-11-15T12%3A00%3A00/JSNA%202015%20-%20People%20and%20place.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAJJDIMAIVZJDICKHA%2F20190523%2Feu-west-1%2Fs3%2Faws4_request&X-Amz-Date=20190523T165223Z&X-Amz-Expires=300&X-Amz-Signature=65c28baf25e1ff8d03c5531c07f6792f02990c527252d984c187511f8a07c8a7&X-Amz-SignedHeaders=host (accessed online 22.05.2019)

The English Indices of Deprivation, Department for Communities and Local Government
(2015):https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf (accessed online 24.05.2019)

Part B

B	The Public Sector Equality Duty

B1	*Could the initiative help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?* **YES** As part of the access review and proposals, it may be possible to tackle reported feelings from members of local BAME and LGBT groups that they experience a level of discrimination or that their experience is affected negatively by memories of historic discrimination.
B2	*Could the initiative undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? If yes, for which of the nine protected characteristics?* **NO**
B3	*Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics?* **YES** The development of the digital first offer may help residents' access primary and urgent care in a more convenient way without the need for a face to face attendance. This may benefit residents including carers and those who require greater levels of privacy of access such as members of the transgender community.

Part C	The duty to have regard to reduce health inequalities
C1	*Will the initiative contribute to the duties to reduce health inequalities?* **YES** The development of the digital first offer may help residents' access primary and urgent care in a more convenient way without the need for a face to face attendance.
	Could the initiative reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups? This may benefit residents including carers and those with a disability
C2	*Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?* **YES** The development of the digital first offer may help residents' access primary and urgent care in a more convenient way without the need for a face to face attendance. This may residents including carers

Part G

Name and job title of person/s who carried out this analysis: • Rashesh Mehta, Assistant Director of Urgent Care and Long Term Conditions, BCCG • Heena Mistry, Business Intelligence Information Manager, NWL CCCGs • Leah Nelson, Business Intelligence Information Analyst, NWL CCCGs • Josefa Baylon, Head of Urgent & Unscheduled Care, BCCG • Michelle Johnson, Engagement and Communications Manager, BCCG
Date of analysis completed:
Date analysis signed:
Name of Executive lead / reviewer:
Signature of Executive lead / reviewer:

Brent	**Community Wellbeing Scrutiny Committee** 9 July 2019
	Report from Brent Clinical Commissioning Group

Palliative and End of Life Care in Brent

Wards Affected:	All
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
No. of Appendices:	1
Background Papers:	
Contact Officer(s): (Name, Title, Contact Details)	Rashesh Mehta; Dr. Lyndsey Williams

1.0 Summary

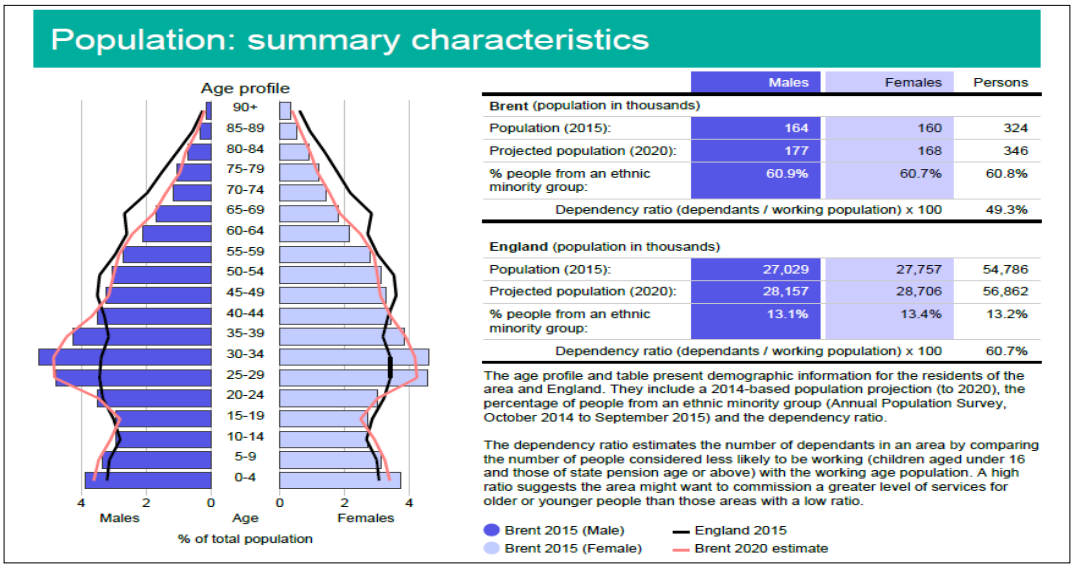
This report provides an update for the Overview and Scrutiny Committee on Community Palliative and End of Life Care (EOLC) services in Brent. The report describes demographic data and activity, the current range of local acute and community specialist palliative care services and the CCG's strategy and commissioning intentions that address some of the challenges in the delivery of EOLC services in Brent.

The suspension of Central London Community Healthcare Trust (CLCHT) Pembridge hospice inpatient unit has provided the CCG with an opportunity to review its End of Life (EOL) strategy and look at the current capacity and demand for community specialist palliative care services and to consider whether the service provided is of sufficient quality, clinically safe and if the service provides good value for money. The CCG has the statutory responsibility to manage its finances effectively and efficiently which meets local population needs. Likewise, any proposed changes to commissioned services must be evidence-based.

The purpose of this report is to identify the current status of service provision, clinical effectiveness and safety. We are initiating a review of palliative care services and depending on that, and further engagement, decisions on the service profile will be taken.

Demographics of EOLC population in Brent

- Brent is a diverse London borough and large proportion of the population are young working age (67.8%) residents with a low proportion of residents aged 65 and over (11.3%) and the fifth lowest number of children of any London borough[1].
- The mean average age is 35, five years below the UK average (40).
- The area has high levels of migration in and out of the borough, and significant ethnic and cultural diversity.
- 66% of the population is from Black, Asian and Minority groups (BAME).
- People between 0–15 y/o comprise 21% of the total population. Those 16-64 y/o,
    - working age population makes up 67.8% of the population and the 65 and over
    - Population makes up 11.3% of the population.
- Brent has the largest proportion of residents born abroad (55%). This ranges from Asia (23%), followed by Europe (18%) and Africa (10%) to Central and South America (3%) and North America (1%). 14.5 per cent of households have no people that speak English as a main language; this is the thirteenth highest proportion in England & Wales.



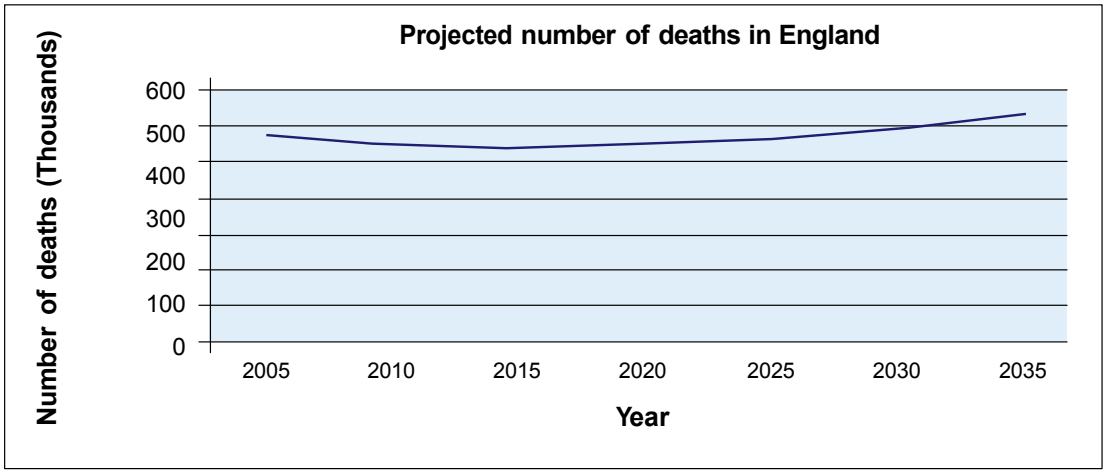
Graph 1: Summary Characteristics of the Population of London Borough of Brent (Feb. 2019)

- Life expectancy for men is 79.9 years and 84.9 years for women. Life expectancy is
    - 5.8 years lower for men and 4.0 years lower for women in the most deprived areas of Brent than in the least deprived areas.

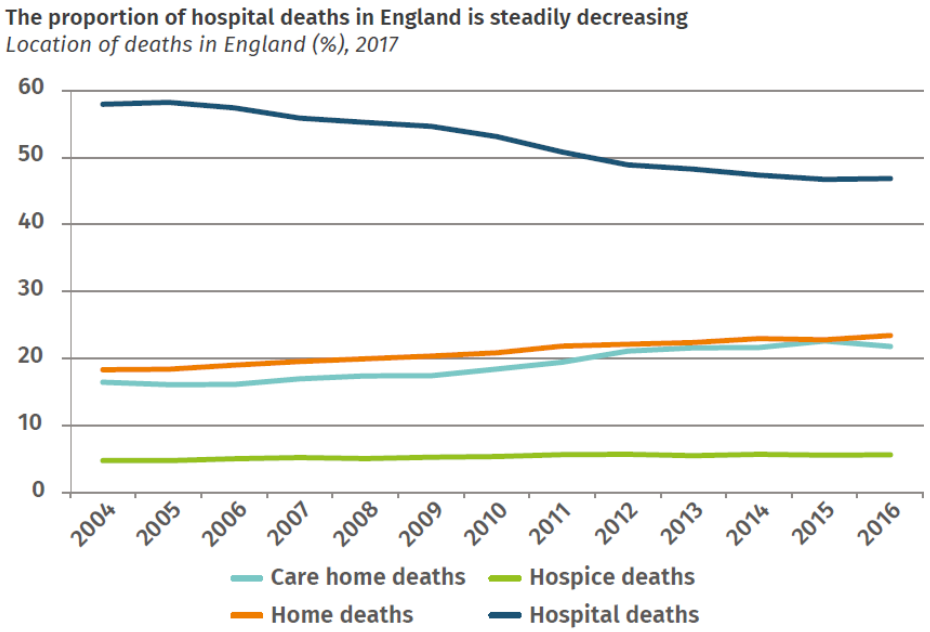
[1] Brent JSNA 2015/16 Refresh - https://www.brent.gov.uk/media/16412103/jsna-2015-brent-overview-report.pdf

- As a result of the UK's aging population, the number of deaths per year is expected to rise by 17% between 2012 and 2030
- Many more people will be dying at an older age and therefore more likely to have complex needs and multiple co-morbidities as they near the end of their lives.
- To deliver quality care effectively requires a shared vision for end of life care to encourage commissioners and providers to work together.

Office for National Statistics:



- According to the most recent data, just under half of all deaths in England occur in hospital. This number has been steadily decreasing over the past decade, from 58.2 per cent in 2005 to 46.7 per cent in 2015.



Source: PHE 2017a

- The picture at a national level obscures considerable variation in the likelihood of dying in hospital by region. In particular, there are a considerably higher proportion of hospital deaths in London (53.2%), and in the West Midlands (49.5%), North West (48.7%) and North East (48.1%).

Region	% hospital deaths	Region	% hospital deaths
South West	42%	North East	48%
South East	43%	North West	49%
East of England	45%	West Midlands	49%
Yorkshire and the Humber	46%	London	53%
East Midlands	48%	**England**	**47%**

Source: PHE 2017a

- In addition, there is a correlation between deprivation and likelihood of dying in hospital, with a higher proportion of people living in more deprived areas who die in hospital. This is perhaps to be expected: deprivation is linked to household finance, quality of housing, family situation, as well as health indicators, all of which are likely to affect people's ability and/or desire to spend their final days outside of hospital. This reflects the findings of the Marmot review, which demonstrated more generally that health inequalities flow from social inequalities[2]

- The latest figures on the number of Brent registered EOL patients with place of death are outlined in the table below[3]. It shows that in Brent over half of EOL patients were dying in hospital and in line with the national data, around 23% died at home. These figures are opposite to the national data on patients' preferred place of death.

		Underlying Cause of Death		
Place of death	**All Deaths (2017)**	**Cancer**	**Circulatory disease**	**Respiratory disease**
Hospital	946 (53.9%)	495 (28.2%)	561 (32%)	200 (11.4%)
Home	398 (22.7%)			
Care Home	256 (14.6%)			
Hospice	118 (6.7%)			
Other	36 (2.1%)			
Total	**1,754**	**495**	**561**	**200**

2.0 Description of current EOLC services in Brent

- The Brent population is supported by care from multiple providers across the sectors. The main providers of acute health services in Brent are London North West Healthcare NHS Trust (LNWHT), Central and North West London NHS Foundation Trust (CNWLT) and Imperial Healthcare Trust (IHT).

[2] Marmot M et al (2010) *Fair Society Healthy Lives (The Marmot Review).* http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

[3] Data source: http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/ccg_profiles

- Specialist palliative care is mostly provided for Brent patients in the following hospitals: Northwick Park and Central Middlesex Hospital (London North West Healthcare NHS Trust), Charing Cross and St Mary's Hospitals (Imperial College Healthcare NHS Trust) and the Royal Free Hospital (Royal Free NHS Foundation Trust).
- Specialist Palliative Care teams in acute setting are made up of specialist nurses and therapists led by a Specialist Palliative Care consultant who work alongside other specialist teams to control physical or psychological symptoms, ensure a smooth discharge from hospital and support families and carers.
- Community specialist palliative care is provided by services are provided by St Luke's Hospice (StL), CLCHT Pembridge Hospice (PH), St John's and Elizabeth Hospice (StJ) and Marie-curie Hospice Hampstead (MC).
- The 6 main elements of community hospice provision are described in Appendix 1 of this report and in the bullet points below:
    - In-patient Unit – Consultant led 24/7 in-patient beds for terminal care, symptom control and palliative rehabilitation.
    - Hospice at Home – 24/7 specialist palliative care in patient's homes for a maximum of 2 weeks that supports admission avoidance, respite care, facilitated discharge from acute care (StJ & StL)
    - Community Specialist Palliative Care – Support and care to patients in their own homes delivered Monday to Friday between 9am and 5pm (StL and PH)
    - Day Hospice – Therapy and peer support in a day centre delivered during the week including complimentary therapy (StJ, StL & PH)
    - Outpatient – Consultant or nurse led clinics at the hospices delivered 5 days a week (All)
    - Bereavement/Counselling for carers and families (all)

3.0 Description of CLCHT Pembridge Hospice Provision and Activity

- Pembridge is a 13 bedded hospice service run by Central London Community Healthcare Trust (CLCHT) located at St Charles Centre for Health and Wellbeing. Referrals come from Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster. The service is commissioned on behalf of Brent CCG by Central London CCG (CL CCG) as part of the CLCHT contract.
- The overall service at Pembridge comprises of three main areas of provision:
    - The in-patient unit -13 beds providing 24-hour care for patients with specialist palliative care needs who need continual assessment.
    - The day hospice - treatment, support and complementary therapies for patients visiting Pembridge available Monday to Friday.
    - The community specialist palliative care team - providing advice and support to patients in their own home, Mon-Friday 9am-5pm
- Current activity at the Pembridge Hospice is described in the table below:

Pathway (Activity)	Data Source	APR 18	MAY 18	JUN 18	JUL 18	AUG 18	SEP 18	OCT 18	NOV 18	DEC 18	JAN 19	FEB 19	MAR 19	YTD	Annual Plan
Bereavement Counselling - ACTUAL	BIPA	96	100	82	117	66	42	53	202	130	80	122	122	1212	999
Bereavement Counselling - PLAN		82	85	82	85	85	82	85	82	83	84	77	85	753	
Variance (%)		17%	18%	0%	38%	-22%	-49%	-38%	145%	57%	-5%	59%	43%	61.0%	
Community - ACTUAL	BIPA	500	554	462	469	549	383	594	789	620	703	591	626	6840	4380
Community - PLAN		361	372	361	372	372	361	372	361	369	370	337	372	3301	
Variance (%)		39%	49%	28%	26%	48%	6%	60%	119%	68%	90%	75%	68%	107.2%	
Day Care - ACTUAL	BIPA	177	138	168	195	129	110	435	512	356	209	202	231	2862	1746
Day Care - PLAN		139	139	148	148	156	139	156	156	130	148	139	148	1311	
Variance (%)		27%	-1%	14%	32%	-17%	-21%	179%	228%	174%	41%	45%	56%	118.3%	
Inpatients (Bed Days) - ACTUAL	BIPA	68	122	62	67	84	93	0	0	0	0	0	0	496	1124
Inpatients (Bed Days) - PLAN		92	95	92	95	95	92	95	92	95	95	86	95	847	
Variance (%)		-26%	28%	-33%	-30%	-12%	1%	-100%	-100%	-100%	-100%	-100%	-100%	-41.4%	

TOTAL - ACTUAL	BIPA	841	914	774	848	828	628	1082	1503	1106	992	915	979	11410	8249
TOTAL - PLAN		675	692	684	701	709	675	709	692	677	697	639	701	6211	
Variance (%)		25%	32%	13%	21%	17%	-7%	53%	117%	63%	42%	43%	40%	83.7%	

- The data for 18/19 requested from CLCH Pembridge is only available in the above format. The CCG has requested more detailed data around the protected characteristics, provision of service for any specialist groups of patients and also total number of patients into different services but have not received this as of to date.
- For Day Hospice the data recorded is based on contacts by face to face or telephone.

4.0 Background to CLCHT Pembridge In-patient Unit Suspension

- On the 19th September 2018, Brent CCG became aware, through another hospice provider that the specialist palliative care consultant had resigned in late July and they were unable to recruit an appropriate medical professional to replace this role. The impact of this member of staff leaving meant that the inpatients unit at the Pembridge Hospice did not have appropriate specialist palliative care clinical supervision and the inpatient unit was suspended as of 1st October.
- Brent CCG was advised by colleagues from the CLCHT Pembridge Hospice that attempts to recruit a lead consultant since then have failed.
- Key stakeholders have raised concerns regarding the viability of the remaining services being provided by the Pembridge Hospice without an available 24/7 in-patient unit on site.
- Interim arrangements have been in place since 1st October to ensure patients who would normally be expected to be an in-patient at Pembridge are transferred to other available hospices commissioned by the respective CCG. For Brent CCG that would be St John's Hospice, St Luke's Hospice and Marie Curie Hampstead Hospice.
- One of Brent CCG's alternative Hospice providers was able to accommodate the increased inpatient capacity within their current contractual arrangements.

5.0 Independent Review of Palliative Care

- Central London CCG communicated to all CCGs in November 2018 that it would conduct an independent review of the CLCHT Pembridge and other local service, Brent CCG agreed to this recommendation whilst reviewing their current end of life and community specialist palliative care provision with remaining community specialist palliative care providers.
- The review was launched on 14th December 2018 on behalf of three Inner North West London CCGs – Central London, Hammersmith & Fulham and West. It was led by an independent reviewer and overseen by a Specialist Palliative Care Review Steering Group.
- The terms of reference for the review were to review national strategy, policy and best practice alongside local context and report recommendations to CL CCG on options for a new commissioning model which ensured that local care is delivered in a way which provides the highest quality care for patients, their families and carers at the best value.
- As part of this review, the Clinical Steering Group invited experts, local stakeholders and patients, their families and carers to submit written evidence to support the development of its recommendations. Brent CCG was not part of the strategic review as CL CCG considered that Brent CCG had already conducted its End of Life Care review in 2017.
- The review was published in March 2019 and can be found at this link: https://www.centrallondonccg.nhs.uk/news-publications/news/2019/06/strategic-review-of-palliative-care-services.aspx
- The review highlighted the following: "The most consistent feedback from professionals and the public was inequity of service provision across the boroughs and in the services, poor co-ordination and communication between services, lack of ease of access to services at the appropriate time and the lack of urgency of response of most services. Also consistent was the high levels of satisfaction of patients and families once they were being cared for by a specialist palliative care service"
- The review report suggests various options but recommends the option, "to have one lead provider in the community, due to the significant transformational change needed in the specialist palliative care services…" This suggests the recommendation to go out to procurement for one lead provider for palliative care which will then subcontract with the other providers. It also has an additional recommendation regarding Pembridge Hospice in-patient bed provision, which the report states could probably be reduced as other available providers have managed the activity within their existing capacity.

6.0 Brent CCG Patient and Carer Engagement

- Brent CCG has been engaging with patients on End of Life and community Specialist Palliative Care services since a strategic review was conducted by the CCG in 2017 and with a particular focus on the Pembridge in-patient since

October 2018 when it was notified to the CCG that the consultant had resigned from his post.

- The suspension of the in-patient unit at Pembridge has provided the CCG with an opportunity to review all EOLC services in Brent and engage with local patients and other interested parties on what kind of services should be delivered to Brent patients.

- An on-line questionnaire had been distributed through a list of local stakeholders for wider distribution to EOLC patients and carers. The online questionnaire has been disseminated through the current community specialist palliative care services and was available on the CCG End of Life webpage. Hard copies of the questionnaire were also shared with patients at EOL stakeholders meetings.
- With regards to public engagement, Brent CCG has undertaken four public engagement events. The four engagement events were held at various locations as mention in the table below, to gain the views about the future of community specialist palliative care in Brent.

.

Date	Time	Venue
Monday 4th March	12 - 2pm	Boardroom, Brent CCG, 116 Chaplin Road, Wembley
Monday 25th March	1pm – 2pm	St John's Hospice Day Centre
Monday 1st April	1 - 2pm	St Luke's Hospice Kenton Grange, Kenton Rd, Harrow HA3 0YG
Monday 15th April	1.30pm – 2.30pm	Pembridge Hospice St Charles Centre for Health and Wellbeing, Exmoor Street, London W10 6DZ

- The CCG has been transparent with patients about commissioning a complete community specialist palliative care service across the whole of Brent that permits equity of access and the need for a better co-ordinated service with the opportunity to develop a 'first point of contact' and rapid response service for patients, carers and healthcare professionals.

7.0 Access to other In-patient Hospice Care during Suspension Period

- Since the closure of the Pembridge Hospice Inpatient Unit on 28th September 2018, St Luke's Hospice, Marie Curie Hampstead Hospice and St John's Hospice have provided additional Specialist Inpatient Palliative Care services

for Brent patients in order to ensure that there has been continuity in terms of available service.

- The Hospices have indicated a willingness to work with commissioners in Brent in order to provide Specialist Palliative Care services to meet the needs of patients who would otherwise have been accessed all services offered by Central London Community Healthcare NHS Trust at the Pembridge Hospice.

- Current Hospices commissioned by Brent CCG have the capacity to ensure continuity of service by seeking to assimilate existing services into our existing Community and Day Specialist Palliative Care services, and would work together with commissioners to determine an optimal service configuration that meets the needs of Brent patients.
- The current hospices have confirmed to continue to work together to ensure efficiency and effectiveness as we design more collaborative and integrated services.

- **8.0 Next Steps**

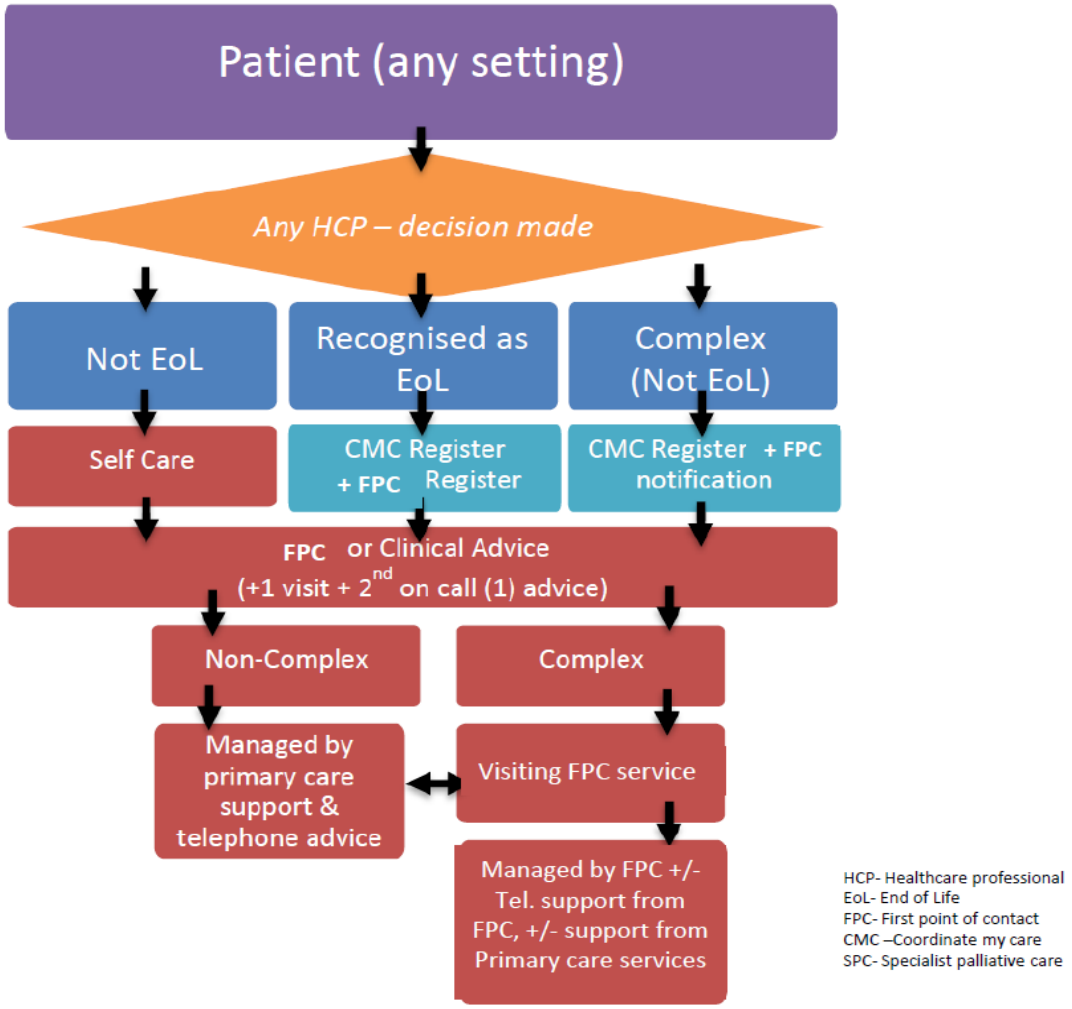
We are initiating a review of palliative care services that will be closely aligned with the tri-borough CCGs. Since we are moving towards a single CCG structure, and a new collaborative way of working between providers and commissioners, Brent CCG needs to have due consideration to the impact that any proposed service change will have on North West London providers and the other 7 CCGs.

Depending on the outcome of that review, and further engagement, decisions on the service profile will be taken.

Meetings will now be taking place between the commissioners to align the engagement processes for the next stage across the CCGs.

Appendix 1 The diagram below describes the proposed EOLC pathway for EOLC, with the advent of First Point of Contact to manage EOLC patient referrals.

Proposed Brent CCG End of Life (EoL) strategy 2019 and beyond



Brent	**Community and Wellbeing Scrutiny Committee** 9 July 2019
	Report from the Assistant Chief Executive

Update: Scrutiny Committee Work Programme 2019-2020

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	1
Background Papers:	None
Contact Officer:	James Diamond, Scrutiny Officer, Strategy and Partnerships, Chief Executive's Department, james.diamond@brent.gov.uk 020 8937 1068

1.0 Purpose of the Report

1.1 This report updates members on the committee's work programme for 2019/20 and captures scrutiny activity which has taken place outside of its meetings.

2.0 Recommendation(s)

2.1 Committee to discuss and note the contents of the report, including updates about scrutiny issues outside of the work programme.

3.0 Detail

3.1 The scrutiny committee's work programme sets out the policy areas and decision-making, which are the responsibilities of the Cabinet, that the committee will review and scrutinise during the municipal year. It also states the scrutiny task groups which it will set up as in-depth reviews. The committee's work plan for 2019/2020 is set out in Appendix 1. A scrutiny committee's work plan may change during the municipal year as new issues arise and items are added. An assumption of the work programme is that it will evolve according to the needs of the committee, and spare capacity would be left to look at new issues. In addition, for practical reasons it may be necessary to move items to be heard at a particular committee date.

3.2 As part of its remit set out in the constitution, the Community and Wellbeing Scrutiny Committee can scrutinise, and make recommendations, to NHS organisations. It reviews the provision and operation of health services in the borough and can make reports or recommendations to NHS bodies or Full Council.

3.3 There have been two meetings of the committee since the Annual Council Meeting. On 9 May there was a call-in by non-executive members of a decision by the Cabinet of approval to establish an Alternative Provision Free School with Integrated Youth Offer from the Roundwood Youth Centre. The scrutiny committee agreed that it did not wish to refer the decision back to Cabinet. The second meeting of the scrutiny committee was on 11 June, at which the committee discussed a report on the findings and recommendations of the Adult B Safeguarding Adult Review (SAR). The committee made two recommendations to the Cabinet on the basis of the discussion and report.

3.4 On 21 June there was a meeting of the North West London Joint Health Overview and Scrutiny Committee which was attended by Cllr Ketan Sheth as Brent Council's representative on the joint committee. The meeting focused on a discussion document, published on 28 May 2019 by the North West London Collaboration of Clinical Commissioning Groups, which proposes the merger of the eight clinical commissioning groups in North West London by April 2020, and creating a single clinical commissioning group for north-west London. As a result of the meeting, members of the joint committee are considering organising a separate meeting to discussed an expected updated version of the proposal document. This issue is on the work plan of the Community and Wellbeing Scrutiny Committee for 4 September 2019.

3.5 The committee has responded to the 2018/2019 Quality Accounts of Imperial Healthcare NHS Trust, and London North West Hospitals NHS Trust. These are expected to be published later in the summer.

4.0 Financial Implications

4.1 There are no financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising from this report.

6.0 Equality Implications

6.1 There are no equality implications arising from this report.

7.0 Consultation with Ward Members and Stakeholders

7.1 Ward members who are committee members will review this report.

REPORT SIGN-OFF

Peter Gadsdon
Assistant Chief Executive

Appendix 1: Community and Wellbeing Scrutiny Committee Work Programme 2019-20

Tuesday 9 July 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. Substance Misuse: Treatment, Recovery and Wellbeing Service	Cllr Krupesh Hirani, Lead Member for Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	No
2. Palliative and End of Life Care	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group	No	No	Yes
3. Urgent Care Centre, Central Middlesex Hospital	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group	No	No	Yes
4. Childhood Obesity: Members' Task Group Scoping Paper	Cllr Krupesh Hirani, Lead Member for Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 4 September 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Home Care Recommissioning	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing		Yes	No	No
2. Proposal for Single North West London CCG	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group	No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 27 November 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Brent Safeguarding Adults' Board Annual Report	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing	Independent Chair, Brent Safeguarding Adults' Board	No	No	No
2.Peer Review: Adult Safeguarding	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing	Independent Chair, Brent Safeguarding Adults' Board	No	No	No
3. Brent Local Safeguarding Children Board Annual Report	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People	Independent Chair, Brent Local Safeguarding Children Board	No	No	No
4. Overview and Scrutiny Task Group Report: Childhood Obesity	Cllr Krupesh Hirani, Lead Member for Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Tuesday 4 February 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Single Homeless Prevention Service	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No
2. Brent Council Housing Management Services	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No
3. Brent Council Housing Repairs	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

.

Monday 16 March 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. Early Intervention to Reduce Youth Crime	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People		No	No	No
2.Contextual Safeguarding Task Group: One-Year Update	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People	Independent Chair, Brent Local Safeguarding Children Board	No	No	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 22 April 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. School Standards and Achievement Report 2018-19, including Achievement of Boys of Black Caribbean Heritage	Cllr Amer Agha, Lead Member for Schools, Employment and Skills	Gail Tolley, Strategic Director Children and Young People		No	Yes	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013