MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 15 September 2020 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Aden, Daly, Ethampemi, Hector, Lloyd, Long (Substitute), Shahzad, and Thakkar, and co-opted members Alloysius Frederick, Mr Simon Goulden and Rev. Helen Askwith (from 6:20pm). ***All members were present in a remote capacity.***

Also Present: Councillor McLennan and Councillor M Butt

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

Apologies for absence were received as follows:

- Councillor Sangani, substituted by Councillor Long

2. **Declarations of interests**

Personal Interests were declared as follows:

- Councillor Ketan Sheth – Lead Governor, Central and North West London NHS Foundation Trust
- Councillor Ethapemi – Spouse employed by the NHS
- Councillor Shahzad – Spouse employed by the NHS
- Mr Simon Goulden – Spouse Chair of governors of a Brent School

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meeting**

AGREED: That the minutes of the previous meeting held on 21 July 2020 be approved as an accurate record of the meeting.

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

There were no matters arising.

6. **Order of Business**

RESOLVED: that the Chair would take item 7, **BAME communities and the impact of Covid-19 in Brent** first, item 6, **Brent NHS and Covid-19 response and recovery** second, and item 8, **Single CCG for North West London and the development of the Integrated Care System (ICS)** last.

7. **BAME communities and the impact of Covid-19 in Brent**

Councillor Neil Nerva (Cabinet Member for Public Health, Culture and Leisure, Brent Council) introduced the report which provided an overview of the underlying causes of the patterns of

infection and mortality from Covid-19 among Brent's Black and Minority Ethnic (BAME) communities. Councillor Nerva pointed to report paragraphs 6.8.1 onwards regarding community health meetings that had taken place the previous week with community leaders in Church End and Alpterton. There was a proposal to create Community Champions roles for outreach in those communities.

Dr Melanie Smith (Director of Public Health, Brent Council) noted when thinking about the disproportionate impact of Covid-19 on BAME communities it was important to think about the potential causes, such as occupational exposure, increased susceptibility to severe infection from underlying health conditions and access to appropriate healthcare, and Brent's possible response to those regarding exposure to the virus. Dr Melanie Smith acknowledged the entrenched structural inequalities within society and expressed that there was a need to act in the immediate and longer term, with immediate actions aimed at reducing exposure to the virus, increasing resilience and ensuring access to healthcare.

The Chair thanked both for their introduction and invited questions from the Committee, with the following issues raised:

The Committee queried what actions would be taken forward as a result of the findings that BAME communities were disproportionately impacted by Covid-19. Dr Melanie Smith advised they would be acting to reduce the exposure of BAME communities to the virus. For example, Public Health England research had shown that national messaging was not culturally competent therefore Brent had developed local messaging and were part of the 'keep London safe' campaign which had produced materials more appropriate for a diverse London population. The Council wanted to work with the community and engage Community Champions to ensure messaging was reaching all communities effectively. Dr Melanie Smith expressed it was important the Council worked with the community to develop the action plan rather than presenting an action plan produced for them, as Public Health England qualitative research showed many BAME communities felt disempowered.

Further discussing the action plan, the Committee heard that the Council and health colleagues were reducing exposure by getting people tested and self-isolated. There was a hyper-local walk-in testing site in Harlesden which had adapted the national model to ensure it was accessible to local people, and increasingly those getting tested at that site were reflective of the ethnic diversity of the communities who lived there. It was also highlighted that BAME communities were more susceptible to severe levels of infection, some of which was associated with higher levels of diabetes, hypertension and cardiovascular disease in those communities. Dr Melanie Smith explained that there was evidence those conditions, if poorly controlled, contributed to worse outcomes. The Public Health department were working hard with Brent Clinical Commissioning Group (CCG) to ensure people with those long term conditions were contacted and helped to maximise the control of their condition in preparation for a second wave. Work on the flu vaccination programme had also begun to increase resilience, and NHS colleagues were working with the Local Authority to look at new models of primary care, and would be piloting those models in Church End and Alperton. Dr MC Patel (Chair, Brent CCG) added that primary care clinical directors and operational managers were looking at the government provided shielded list in Brent and had made the decision to include more people on that list to ensure appropriate advice was going to more people. The list would be extended to include BAME communities and people with associated co-morbidities, who were not necessarily on the government list. Dr Melanie Smith acknowledged that some factors associated with increased exposure to the virus in BAME communities would not be possible to action in the short term and required long term focus, such as overcrowding and housing issues which were very important issues to address.

In relation to the meetings with Church End and Alperton, Councillor Nerva expressed they had been very important to look Brent wide at standards of social distancing and review the

methods employed to keep residents safe. The meetings highlighted structural issues for BAME communities, such as housing, jobs and health co-morbidities resulting in people being more at risk and in his new role Councillor Nerva expected to pick these up in the next Health and Wellbeing strategy. Dr MC Patel agreed that the community meetings were an opportunity for health colleagues and the local authority to tackle issues they had known about for years. There was a joint commitment to make things happen in Brent and do things differently.

In response to comments regarding the abolition of Public Health England and the refusal to allow local authorities autonomy over testing, Councillor Neil Nerva stated that it was disappointing but important not to stand back and pass blame. He highlighted there was a need to restore confidence in the NHS so that people were receiving treatment and support.

The Committee asked why BAME communities in Brent were so severely hit by the pandemic. Professor Mala Rao OBE (Imperial College London) explained to the Committee that there had been 2 or 3 fairly rapid investigations into the potential risk factors for the excess and disproportionate impact of Covid-19 on BAME communities, including the 'Open Safely Collaborative' which was done by academics in Leicester who specialised in underlying conditions such as diabetes. She expressed that there had not been a large amount of time to understand the novel virus and how it worked, therefore there was not complete understanding, but the work done so far had been impressive. Data sets had looked at thousands of hospital admissions to see what could explain the disproportionate impact, with findings pointing to similar conclusions - that it was likely to be a combination of all the risk factors already discussed. Professor Rao highlighted that those impacted were likely to live in overcrowded circumstances, may be nutritionally deprived, their health physiology was likely to be impacted by micro-aggressions and racism they had encountered through life, and air pollution was worse in urban areas. Those factors reinforced each other and made the impact worse. Professor Rao informed the Committee of research funding opportunities in the UK for researchers with some of that allocated to research groups at UCL and Leicester, and she queried whether any of that research was being conducted in Brent or whether there was an opportunity for the Council to offer to those groups that the research be undertaken in the Brent community. Dr Melanie Smith replied that in Brent they had participated in academic research particularly on the management of diabetes in black communities and would be interested in making links going forward.

Further querying research conducted, a member of the Committee asked whether researchers had looked at countries of origin and whether Western diseases experienced in BAME communities with higher co-morbidity were also experienced by those in their countries of origin. Dr MC Patel agreed that it was useful to look at other countries and there was learning that could be taken but felt that was a longer term approach and enough was already known to protect people quickly and effectively, as there was a present and clear danger and a need to ensure practical solutions were in place. This would be done through effectively communicating with all communities in the Borough.

The Committee heard from Veronica Awuzudike (Healthwatch Brent Manager) that some residents of BAME communities felt the communications being received were not as clear as they could be. Queries were raised as to the level of engagement with different communities and whether it was sufficient to mitigate mass deaths. Dr MC Patel agreed that going forward the most important thing would be ensuring engagement with communities and community leaders that would help deliver messages to all the diverse communities in Brent. He hoped through the work with the 10 practices in Church End and Alperton they would gain a better understanding more rapidly of the needs affecting those communities. Robyn Doran (Chief Operating Officer, Central and North West London NHS Trust) explained that she had taken learning from working with the Grenfell community and applied it to her work in Brent as part of the Working Group on health inequalities. She noted the importance of directly involving the community affected by the issue. She had personally met community

leaders in the Somalian community in Church End with Dr MC Patel and in partnership with the Local Authority and heard that people felt they did not have the right information on Covid-19. Community leaders wanted to co-design training with infection control nurses delivered to the community, and they had commissioned local tailors working with nurses to make masks community leaders could distribute. The Working Group was also working with faith leaders and the third sector.

The Committee highlighted that the BAME communities that had been hit hard across Brent may also experience other difficulties which could be contributing factors to the impact of Covid-19 such as language barriers and poor access to GP services. Councillors shared their experience of speaking with BAME residents who were scared to go into hospital and had no access to GPs who were not answering phone calls and had queues outside of practices. Dr MC Patel agreed that many people were scared to go to hospital for fear of contracting the virus and there was a general view access could be improved. He offered to join Councillors to talk to communities in small groups of 5, adhering to the Covid-19 guidelines, to gain feedback and take actions to improve access. Councillor Nerva hoped that the Committee would seek a further report on communications with the next report demonstrating measurable differences.

The Chair thanked the Lead Member and Officers from Public Health and the NHS for their contributions and drew the item to close.

8. **Brent NHS and Covid-19 response and recovery**

Sheik Auladin (Managing Director, Brent CCG) introduced the report which provided an overview of the operational response by Brent's local NHS to the Covid-19 pandemic and the recovery plans and operational recovery, including planning for a possible second wave. He drew the Committee's attention to key aspects of the report including mortality rate and data analysis, the immediate response, the Covid-19 recovery phase, lessons learnt, and financial implications, noting that many factors were complex and intersectional. He highlighted that at the beginning of the pandemic in March 2020 during the immediate response, NHS England had issued guidance for acute trusts to prepare to manage capacity and ensure facilities were there, therefore non-elective and non-urgent patients were discharged to create capacity in the system. At the same time in the CCG GPs were informed to start seeing patients by e-consultation, which he advised was easy to do as GPs had begun e-consultations pre-Covid. The recovery phase for GPs required them to offer face to face appointments and operate 100% capacity while following the guidelines. Work was being done to ensure the flu vaccination campaign was underway and well-established, with faith establishments supporting the message to get vaccinated. A Covid escalated care planning hot-hub was launched on 27 March 2020 to manage and see Covid-symptomatic patients and care and monitor them in the community instead of putting pressure on hospitals. The hub continued to operate at a low level and remained in place to escalate if needed. Sheik Auladin advised that learning had shown more efficient use of NHS resources when all partners and providers worked together, including the local authority, acute hospitals and all CCGs and providers. He added that there was now work underway at both a national and local level addressing health inequalities. A substream of work involved the CCG working with primary care networks and 10 GPs to tackle health inequality issues in Church End and Alperton, looking at a new model of work for a multi-disciplinary approach in relation to managing long-term conditions, including mental health, specialist nurses and GPs. The model was in its very early stages but there had been good response from all major providers.

The Chair thanked Sheik Auladin for the introduction to the report and invited comments and questions from the Committee, with the following issues raised:

The Committee heard that Northwick Park was at the forefront during the early stages of the pandemic and was the second busiest A & E in London, so there were challenges regarding the number of places in critical care facilities. Northwick Park had been supported by the system, particularly Royal Brompton Hospital, with the transfer of patients to receive critical care. There was positive news coverage about the response to Covid, with community testing noted and innovative treatments and drug regimes used for Covid patients, such as CPAP oxygen use. Simon Crawford (Deputy Chief Executive, London and North West Hospitals Trust) advised the Committee that Central Middlesex Hospital, GPs and UTC were now running and had been for some time. There were safe segregated pathways for patients to access and testing was done immediately if there was a suspected Covid case, with isolation if needed, and anyone attending hospital had their temperature taken and were required to wear a mask, sanitise and social distance. The focus of the past 3 months had been on the recovery of diagnostics, outpatients and surgical procedures. Those attending for surgical procedures were tested for Covid-19 3 days prior to the procedure, with surgery only going ahead if the result was negative. At the time of the meeting there were 12 Covid patients in Northwick Park. In Imperial College Healthcare NHS Trust there were similar precautions in place and a large amount of work had been done with Lay partners about how to communicate the actions taken and pathways in place.

The Committee queried whether the antigen testing centre in Brent was linked to national laboratories, as nationally there was limited testing capacity. Sheik Auladin confirmed that the antigen testing site was linked to the national laboratories and the local provider for diagnostics, GDL, had not reported any issues. Regarding testing, Committee members requested the number of testing centres in Brent and whether it was sufficient to meet the demand in Brent and wanted to know how often testing was carried out, particularly in care homes. Dr MC Patel (Chair, Brent CCG) advised that testing had been an issue, such as people being offered tests away from where they lived and there was a need to ensure all essential workers had access to rapid testing, therefore this had been raised as a concern at North West London Chairs meeting. Practices were being encouraged to do regular testing, which they were responsible for, and in care homes the government had set a minimum of 28 days for residents and weekly for staff. Dr Melanie Smith (Director of Public Health, Brent Council) advised that in the last few weeks testing had fallen short of demand but the re-introduction of testing in care homes was now being seen. With regard to Brent residents on the whole getting tested, there was evidence that around a quarter of those being tested should not have been getting tested, therefore there was an important role for the Council to play regarding messaging on who should get tested. It was anticipated that the situation would be resolved two or three weeks from the Committee meeting. The Public Health Department in Brent was working with the Department of Health to increase access to testing and on new models including home testing kits to increase capacity.

The Committee asked about pathways of care and how Covid-19 was impacting, and had impacted, certain pathways. Specifically the Committee asked for the numbers of the non-urgent waiting list in July 2019 and then July 2020, how many 2 week cancer referrals had been done in July 2019 and then July 2020 and what the current care pathways were for those seeking medical attention for changed bowel habits, breast lumps, and a new continuous cough that had lasted for 3 or more months. NHS colleagues agreed to provide written responses on the data requested, but advised that they were monitoring what these were pre-Covid and now. Waiting lists had gone up but were now being focused on. There was a target to get back to 90% of elective care by October and in London and North West Hospitals Trust that was at around 68% at the time of the meeting. Dr MC Patel advised that there were established care pathways that had not changed, and now that hospitals were re-opening 2 week cancer referrals and non-urgent referrals ought to be seen as they were pre-Covid. For changed bowel habits, an urgent patient should be seen within the national targets (2 weeks, or 48 hours for very urgent patients), and hospitals appreciated GPs doing some tests before referral as this was a good screening tool. Simon Crawford advised that they had contracts

with the independent sector including Clementine Churchill Hospital and London Clinic who had clean Covid pathways and some cancer patients had been taken there. Those critical pathways had been facilitated as much as possible throughout the pandemic even if they were not delivered on site and consultants had reviewed all prioritisations on waiting lists. Claire Hook (Imperial College Healthcare NHS Trust) advised that they had been able to prioritise and treat all urgent patients (those who fell into categories 1 or 2 of the Royal College guidelines) throughout the pandemic through cancelling routine surgery. The Royal Marsden was in the process of reinstating services and treating more patients. Due to the number of people being referred onto waiting lists the list sizes had decreased by around 50% for cancer referrals. Those numbers were now restoring and services were set up to accommodate those referrals as they entered the pathway, although there may be delays in the pathway getting to diagnosis. The focus was on ensuring diagnostic services and surgical services were running as soon as possible.

The Committee noted that, in comparison to nationally, Brent had done well to keep Covid in care homes under control, and queried what Brent had done differently. Simon Crawford advised that when patients stabilised and no longer needed to be in an acute hospital arrangements were made for an appropriate discharge through the discharge hub set up in early April 2020, with all patients who were discharged supported with appropriate packages of care. It was ensured that care home staff knew the status of a discharged patient so that they could support appropriately.

A query was raised regarding oxygen line connections at Northwick Park Hospital, to which Simon Crawford highlighted that Northwick Park had never run out of oxygen and the referral to using CPAPs in the report was regarding an alternative pathway to support specific patients with presentations and who did extremely well on oxygen rather than mechanical ventilation. When the critical care bed capacity was increased there was a requirement to pipe more oxygen into those areas and capital works were undertaken to do that in a co-ordinated process. He expressed there had been a co-ordinated process across ICS with readiness to respond to winter and Covid.

The Committee queried whether planned digital access to GPs would be by choice and not default. During the pandemic GPs had been told to move to e-consultation, and Dr MC Patel explained that now the message was clear from NHS England that GPs should offer digital consultation if appropriate, however GPs should make a clinical judgement on the best course of action. He expressed that if a patient wanted a face to face appointment they should be offered one. Simon Crawford clarified that the vast majority of ‘digital’ or ‘virtual’ clinics were done by telephone consultations.

Regarding the new pilot project looking at a new model of care for the areas of Church End and Alperton, Sheik Auladin confirmed that while it had been spoken about by several colleagues during the meeting it referred to 1 model of care where all partners came together for the benefit of the health of local residents and to manage health inequalities in the Borough. Regarding access moving forward, there were 10 Primary Care Networks in Brent therefore the plan was to have 10 GP access centres.

The Committee noted how many services had closed during the early stages of the pandemic, such as the memory clinic, with some services such as IAPT moving online, and noted there were no online services for Asian languages. The Committee queried what plans were in place for the future with regard to social care and how community organisations could be involved in that plan. Robyn Doran (Chief Operating Officer, Central and North West London NHS Trust) informed the Committee that she was part of the 3rd sector Working Group for Mental Health where colleagues had come together regarding Covid. Community Mental Health Teams had carried on delivering services with 2/3 of work face to face and 1/3 online and had supported care home staff and the homelessness team with clients in hotels. The decisions to

close services were unprecedented as staff were severely affected by Covid, with around 1000 out of 7000 staff off sick, shielding, or caring for others at any one time, therefore quick decisions were made prioritising what services would stay open. The dementia care service was stepped down along with other services and IAPT already operated online. There was agreement that things needed to be moved back to face to face as that was patient preference, and Robyn Doran offered to pick up specific issues with Committee members. Dr MC Patel noted that work was being done with Healthwatch on a community project, with a baseline analysis of various organisations and a list of community organisations being brought together. Community engagement meetings had notified colleagues of groups they did not know about so they would be making contact with those groups. The pilot project spoken about aimed to send health teams into the community to work with those people who did not typically engage with health services to deliver essential health screenings where required.

Regarding resident engagement, Rory Hegarty (Director of Communications and Engagement, North West London CCGs) felt that it was very important to engage with local residents. Each provider was responsible for the changes to their service and it was important for residents to be informed of changes and be clear of information when they attended a service. Where that was not happening Rory Hegarty asked to be informed so that they could work on messaging. There was now a very clear protocol for getting the message out for providers. Rory Hegarty advised that routes for hearing the patient voice included the weekly Healthwatch meeting and the Community Voices programme that had focused on BAME communities during the pandemic. Members of the Committee hoped to see further partnership with the voluntary sector and local organisations, bringing together clinical aspects and social care. This was a priority for the NHS Communications department.

Access to healthcare was a concern for Committee members and health colleagues alike. Committee members noted that councillors were picking up many of the issues surrounding access, and felt that frontline staff were creating barriers, particularly for those with language barriers. Dr MC Patel agreed that there was a problem with access that needed to be addressed and moved forward.

The Committee queried reference in the report to a ‘talk before you walk’ pilot. Lesley Watts (Senior Responsible Officer, North West London Health and Care Partnership) advised that this meant talking to a health professional to get advice before going to A & E. Discussions on the pilot had only just begun therefore Lesley Watts offered the Committee a written answer.

As there were no further questions, the Chair thanked Committee members and health colleagues for their contributions and drew the item to a close.

9. **Single CCG for North West London and the development of the Integrated Care System (ICS)**

Lesley Watts (Senior Responsible Officer, North West London Health and Care Partnership) introduced the report which set out the background and context of how the NHS were operating and seeking to operate as an Integrated Care System (ICS) and the rationale for merging the 8 North West London CCGs into one. The belief behind the merge was that the provider / commissioner split needed to come to an end. Lesley Watts expressed that the essence of the ICS meant that together they would use all the resources available to drive up the quality of care, drive out duplication and variation, address inequalities and learn from each other to get the best outcomes for patients and provide the vast bulk of care together. Direction had been increased in Boroughs with senior directors from community care, mental health and primary care who would work with the Local Authority as a result of discussions with Local Authority Chief Executives at joint meetings with Local Authority providers and Chief Executives.

Dr MC Patel (Chair, Brent CCG) added that as a member of the CCG and Board he had supported the principle of a single North West London CCG as it offered significant opportunities such as improved efficiency and the ability to address the severe problems of deprivation and inequality of access to healthcare. The merge meant they could start to address the shifting of resources with emphasis on particular areas to ensure everyone across North West London had an equitable offer and break down barriers that had traditionally existed. There was a desire to build on the good history of working with the Local Authority, local acute trusts and community services. Dr MC Patel advised that they should be looking at the population of North West London and its diversity particularly in terms of inequalities.

Sheik Auladin (Managing Director, Brent CCG) echoed this, stating that over the previous year health and the Local Authority had started working together more closely and collaboratively due to the pandemic, which had helped to galvanise all the work going forward from an ICS and system perspective. He informed the Committee that Brent CCG members had now voted in favour of the merge to a single North West London CCG.

The Chair thanked health colleagues for their introduction and invited members to ask questions, with the following issues raised:

In response to queries about the consultation process with the community and service users, Rory Hegarty (Director of Communications and Engagement, North West London CCGs) explained that the recent consultation had shared the Case for Change with each Borough's Scrutiny Committees, Local Authority Chief Executives and Leaders, Cabinet leads for health, and was presented at Joint Health Scrutiny Committees, to the local Healthwatch organisations, community groups, all patient participation groups and campaigning organisations such as Brent Patient Voice and Save Our NHS. The case for change had also been published online for public comment, with a press release and social media activity. The legal consultation with the Local Authority had lasted 6 weeks and the results of that were now being analysed.

Members were concerned that resident engagement would be lacking once the merge happened, noting that at the moment there were 8 CCGs that residents could engage with whereas at a single CCG level there may not be any representation from a particular Borough. Rory Hegarty acknowledged the risk of losing resident voice at Borough level and advised they were working on a project called the EPIC Programme to get the patient voice heard. This programme involved working with local Healthwatch organisations, voluntary sectors and Local Authorities to shape how they worked together with the public. The desire was to co-produce the programme with local residents, Councillors, Healthwatch and the voluntary sector, and an invitation to Committee members to attend the next networking meeting for the programme was extended. In response to queries on how the success of the programme would be measured, Lesley Watts advised that it would be measured with Public Health in Brent as to whether the outcomes for patients and inequality measures had improved. Health colleagues expressed that the reason they wanted to make the proposed changes was to tackle inequalities in deprived areas such as Brent as they wanted services to be equitable across all areas of North West London.

Further relating to communications with residents, Julie Pal (Chief Executive, Healthwatch) advised that, having spoken to around 500 different types of residents about the changes, a lot of residents did not understand what the impact of the merge would be for them as individuals and sought assurance that the local response would recognise local needs. There was a concern amongst residents on what difference the change would make to their lives. Rory Hegarty advised that this was a change to how the NHS was organised and not to patient care or services and that there had been no requirement to consult the general public. There was a desire to enhance patient engagement through this change to the single CCG through the EPIC Programme. Dr MC Patel added that he would not agree with a change that he did

not feel was for the benefit of his patients and the intention was to see better services and access to services through a combination of targeted interventions and breaking down barriers such as easier referral pathways. He highlighted that they already had begun to improve referral pathways such as the new self-referral mechanism for physiotherapy. Julie Pal noted the response and advised that it was a matter of perception and suggested that the message of reassurance to residents that services would not change was not coming through. Julie Pal and Rory Hegarty agreed to meet to share the findings of the resident engagement Healtwatch had undertaken.

Regarding funding, members wanted reassurance that Brent would receive adequate funding for services. Concern was raised that Brent was one of the most deprived areas of North West London and members queried how funding between the 8 Boroughs would be divided. Lesley Watts advised that centrally funding would come down to the ICS and the intention was to work towards fair shares, with movement of money over time between the more over-capitated Boroughs to more deprived Boroughs such as Brent. It was not yet clear what the allocations over 6 months or a year's time would be but a commitment had been made to move at a quick time scale to deliver fair shares. Sheik Auladin added that Brent CCG was one of the worst allocated Borough's in London and that it would have taken ten years to level up with other Borough's across North West London, whereas the merge to the single CCG would give Brent the opportunity to level up within four years.

Reassurance was sought that the new single CCG would be able to provide the sort of procurement services needed for each particular Borough and in Brent. Lesley Watts informed the Committee that her teams would work more locally with Local Authority teams regarding the procurement of services, and in response to requests from Brent Officers during the consultation a structure for integrated delivery of care had been established. Deciding how to spend budget and allocations would be done in an integrated way, and health, social care and the Local Authority would prioritise together and attempt to direct that money to deal with inequalities. An example given was the commitment of health monies to the placement of patients to bridge the funding gap where patients came out of hospital and into Local Authority care. It was noted that there was a large majority of patients who went out of Borough for health services and Lesley Watts felt that it would be easier to standardise care received in those acute units, but the intention was where work could be done in-Borough, particularly integrated work and the lettings of contracts to local people, those would be done through Borough partnerships

The Committee asked about decision making and governance, including who would award contracts and how they could be answerable to the public, as the ICS meetings were closed to the public unlike Borough Committees and CCG meetings. Lesley Watts agreed that there was a need to refine the way the ICS was grown and how it received the public voice. She highlighted that the vision for the ICS was built together with Local Authority Officers and patients at multiple engagement events where the strategy for the ICS was agreed and she offered to share those documents from individual care partnerships on their priorities with the Committee. At an ICS level the Committee was Chaired by an ICS Chair which had all leaders of Council's and Chief Executives on, which fed into the ICS Board. When the STP was in place there was patient representation on the overarching body and they would look to do that again with the new partnership board.

Members of the Committee addressed the equality impact assessment submitted with the Case for Change in August as they felt it had not addressed the separate issues relating to each equality consideration including age and disability. Members also addressed what they felt was a lack of consideration for children's health within the paper with regards to population health. Lesley Watts advised that there were multiple work streams which Local Authority Officers were helping to deliver including a work stream for the elderly, Mental Health and

children. She offered to systematically bring those work streams back to Committee to discuss what was being done in each of those areas. Sheik Auladin added that the proposals would give the opportunity to conduct referral pathways at an ICS level together for a pathway for children.

Concerns regarding reference in the reports to demand management within a sustainable budget were raised, with members feeling that would mean no referrals. Dr MC Patel informed the Committee that referral to demand management within the papers did not mean no referrals would take place but rather was about referring the right people to the right places at the right time, and about what primary care colleagues could do before sending a patient to hospital so that the initial investigation made sure the referral was the most appropriate. Dr MC Patel gave the example of pathology services which over the years had changed dramatically by stopping some tests that were previously done as a matter of routine that were not useful and using that money for more informative tests. He expressed from a GP perspective he did not want to be told not to refer a patient and that Brent GPs would fight for what was right.

In relation to the involvement of Brent Council in the proposals and consultation period, Phil Porter (Strategic Director Community Wellbeing, Brent Council) advised that the Council had a range of inputs the Committee may not have been aware of. There had been meetings with the Chief Executive and Leader and those of other Local Authorities also. He met on a weekly basis with a regional group from ADASS. He expressed that the proposals were a significant change with a lot to be worked out and that it was being worked on together, with the sense from Officers that it was happening therefore they needed to work with it.

Reassurance was given to Committee members that the proposals were not related to privatisation and Sheik Auladin expressed that it was about breaking down barriers between providers and commissioners. He highlighted that the systems were coming together to improve services for patients and this was the direction of travel for the NHS.

As no questions were raised, the Chair invited the committee to make recommendations. The committee subsequently **RESOLVED**:

i) For Brent Senior Officers involved in the engagement process to host a briefing session for Community and Wellbeing Committee members regarding the input they had on the proposals and answer further questions about the impact of the move to a single CCG for North West London.

ii) That Committee members withheld support for the proposals pending further information at the members briefing session.

8. **Any Other Urgent Business**

None.

The meeting closed at 21.30pm

Councillor Ketan Sheth, Chair